Subregional high-level consultation
Lessons learned and best practice sharing between refugee-hosting countries in the context of the Ukraine crisis
18–19 April 2023, Bratislava

Report
Abstract

The 2023 Subregional high-level consultation on lessons learned and best practice sharing between refugee-hosting countries in the context of the Ukraine crisis, in Bratislava, Slovakia, attended by refugee-hosting countries, partner agencies, civil society and WHO, served as a platform to propose further cooperation and coordination between the hosting countries for improved refugee health in the coming years. The sessions revolved around health system frameworks and consolidated high-level commitments to joint action on health. A number of sustained and emerging issues, through 11 core sessions were explored, and key priorities for moving forward were identified, which will lead to in-depth work on relevant technical details, and the sharing of lessons and practices to make health a reality for all. The delegates emphasized the strength of international and interregional cooperation on health in times of multiple and ongoing health and humanitarian crises.

Keywords: DELIVERY OF HEALTH CARE; EMERGENCIES; UKRAINE; REFUGEES; INTERNATIONAL COOPERATION

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- A correction was made to section 2.2, page 4, changing “(see Annex I)” to “(see Annex III)”
- A correction was made to section 4, page 16, changing “Plenary session 9” to “Plenary session 8”.

These corrections were incorporated into the electronic file on 15 December 2023.
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**Abbreviations**

COVID-19  coronavirus disease 2019

CSOs  civil society organizations

EU  European Union

HIS  health information systems

IHR  International Health Regulations (2005)

IT  information technology

MHPSS  mental health and psychosocial and social support

NCDs  noncommunicable diseases

NGOs  nongovernmental organizations

PHC  primary health care

PRSEAH  prevention and response to sexual exploitation, abuse and harassment

UN  United Nations
1. Introduction

The overarching message of the Consultation:

The health of populations is a key societal asset as well as a crucial factor of general resilience of a country. Recognizing the fact that refugee health equals public health enables us to acknowledge the humanity of all and the complexity of the challenges faced together.

The humanitarian crisis in Ukraine, with more than eight million refugees having already fled into neighbouring countries, has been a challenge for even the strongest of health systems (1), which were already stretched by the coronavirus disease 2019 (COVID-19) pandemic. Therefore, following the request of high-level government representatives of neighbouring refugee-hosting countries, namely Hungary, Poland, Republic of Moldova, Romania and Slovakia (hereinafter host countries), during the 75th World Health Assembly, this Consultation brought together health experts and policy-makers from these countries and Czechia to discuss the challenges, as well as innovations and opportunities in advancing sustainable health service delivery to both host and refugee populations. The Consultation was jointly organized by the WHO Regional Office for Europe, the Ministry of Health of Slovakia, and other Regional WHO county offices, and provided a platform for the exchange of ideas, knowledge and best practices to expand understanding through the mutual exploration of experience gained within these countries, with the aim of improving health outcomes and the well-being of populations.

The format of the Consultation included a ministerial forum, followed by other plenary sessions, as well as parallel sessions, each with a focus on the key components of health systems such as leadership and governance, health information systems (HIS), the health workforce and essential health services, as well as “deep dives” on specific subjects, such as noncommunicable diseases (NCDs), communicable diseases, and mental health and psychosocial and social support (MHPSS). Special sessions were also dedicated to the role of nongovernmental organizations (NGOs) and the requirements of a national health sector to enable a complex and sustainable emergency response.

The opening remarks and discussions set out during the Consultation reflected on the significant efforts exerted by neighbouring countries to provide equitable and adequate health care to refugees within a very short time period. Participants welcomed the opportunity to engage in international dialogue on refugee health in emergencies and to present country experiences, challenges and lessons learned relating to the Ukrainian refugee response and similar examples of large-scale population displacement, as well as strategies and tools for addressing the health needs and the rights of the displaced populations. A whole of government approach and use of data for an evidence-based response in emergencies was postulated, and the need for further collective action to strengthen the nexus between governments, United Nations (UN) agencies, NGOs, local organizations, academia, the private sector and citizens to achieve access to universal health coverage was stressed. The list of participants and the planned programme sent out to participants can be found in Annex I and II respectively.
The following paragraphs provide summaries of the parallel and plenary session presentations and discussions that comprised the Consultation, and conclude with a reflection on the way forward.

2. Opening sessions

2.1. Plenary session 1: Moderated ministerial forum

The speakers of the ministerial forum provided a general overview of the Ukrainian refugee response in respective Member States and presented perspectives from WHO, the European Union (EU) and UN agencies. Several factors common to the host countries were noted by the speakers, namely, the unprecedented scale of the crisis; that host countries, even with relatively robust health systems, were not prepared for such a large-scale emergency, especially having already been overwhelmed as a result of the COVID-19 pandemic; and an inherent lack of human and infrastructure resources. Nevertheless, the innovative approaches implemented during the pandemic, such as online/remote services, patient fora and information platforms, proved beneficial to the refugee response, as many of the legal prerequisites were in place.

In the early phase of the response to the Ukrainian crisis, crisis management and resource allocation were major issues: multisectoral coordination at national and subnational levels was limited and legal provisions in some countries were initially not adequate for the response (i.e. required adaptation of humanitarian law and of special financial and resource management laws). Equally, the initial lack of specific quantitative and qualitative data related to the refugee population (including patient health data, vaccination data, health needs and expectations, data on provision of NGOs and volunteers, among others) needed to provide effective health services and equitable access to health and social care, were lacking.

Speakers stated that at the height of the crisis, tens of thousands of refugees were crossing the Ukrainian boarder each day. Some countries, with crucial support from NGOs, volunteers and UN agencies managed to set up temporary round-the-clock health posts at borders within days to aid refugees. The suppression of EU Minimal Standards and the application of the Temporary Protection Directive were also essential for refugee access to health care. It was also noted however, that the inclusion of refugees into the national health insurance schemes in some host countries needs to be operationalized. Ukrainian refugees have by and large free access to primary health care (PHC), and in some countries, including Czechia and Poland, refugees have the same rights of access to full health care as citizens, including preventative and curative care.

For some refugees, however, the Temporary Protection Directive has ended, and WHO and partners continue to monitor and follow up on these cases, providing support to local organizations and individuals. Based on United Nations High Commissioner for Refugees figures, 60% of refugees are registered under the Temporary Protection Directive or similar protection schemes that in principle grant refugees the same entitlement to health services as the local population.

However, as the refugee crisis enters its second year and the cost-of-living crisis impacts on citizens of host countries, some governments are making changes to the level of health care offered.
Speakers also reflected on the need to adapt from responding to the sudden influx of people to a more sustained phase of a possibly protracted crisis. Addressing the many mental health issues in both adults and children has been especially difficult. The lack of data was also noted as another common issue that needed to be solved, including the lack of documentation and health records. Further barriers to accessing care also included financial, language and cultural barriers.

Examples of initiatives

Examples of initiatives supporting the response to the refugee crisis were already presented during the initial opening session, as listed below.

- **The integration of the Ukrainian health workforce** to fill gaps in already strained PHC and social services increased access to equitable health-care services for the host and refugee population alike. Czechia, Poland, the Republic of Moldova and Slovakia are each taking active steps to support Ukrainian health professionals to work in their national health systems – recognizing the benefits for the refugee and host societies (this was also discussed in presentations 34–36 (as listed in Annex III). In the Republic of Moldova, the language barrier is not an issue, and many of the Ukrainian health qualifications are recognized. In the other countries, health professionals are assisted with language classes and attempts are being made to shorten the time period needed to obtain the necessary licences. Poland adapted, for example, the qualification requirements for paediatricians to enable earlier approbation and entry into the health workforce.

- **A multitude of information technology (IT) solutions**, have been utilized in the health and social sectors with regards to translation, information, communication, appointment bookings and targeted and tailored guidance, among others, with several solutions stemming from the COVID-19 pandemic (also discussed in presentation 6 (see Annex III).

- **Multisectoral collaboration** at national and subnational level was strengthened, especially with social services, in job creation and linkage with other sectors.

- **Working with NGOs** has been instrumental in providing and supporting access to emergency and essential health services, both in the short term and to complex MHPSS services in the longer-term. Community outreach is an essential function NGOs often provide – linking refugees to health and other specialized services, but this role is not recognized in all countries. NGOs are often seen as trusted sources of public health advice, and this work can be further scaled up, although NGOs are not part of national health systems and providing direct health care is seldom their mandate (discussed in presentation 16–19 (see Annex III)).

- **Engaging refugees** in the response is considered an excellent approach including in the ability to provide patient confidentiality, overcome barriers, build trust and empowerment, and to scale up service capacities.
The creation of coordination platforms such as the Refugee Health Extension (WHO partner coordination platform) and Blue Dot (a network of support hubs that the United Nations Children’s Fund jointly set up with its partners) has been rated as successful (discussed in presentation 30 (see Annex III).

2.2. Plenary session 2: Learning from other countries

In plenary session 2, positive examples from Canada, Germany and Sweden were presented as a basis for plenary session 3, where presenters were to reflect on the requirements of national health sectors to enable a good emergency response. The whole-of-society approach that these countries have embraced to provide health-care services to refugees, with a focus on community-based care was indicated, with all Ukrainian refugees having access to all health services in these countries.

Within Canada’s universal health-care system, comprehensive health data are routinely collected by provincial governments and linkages of immigration and vital statistics data are available through the International Migration Database (2). It was stated in the presentation from Canada that health-care workers have access to evidence-based screening guidelines that are based on health profiles of the migrant or refugee’s country of origin to facilitate diagnostic and therapeutic decision-making. Presenters introduced that the WHO collaborative centre for Research, Evidence and Impact at McMaster University in Ontario has developed, especially for migrants and refugees and together with Slovak and Polish experts, a framework for knowledge translation and knowledge mobilization with tools such as plain language recommendations that are translated according to the respective context. Ongoing research in Slovakia is evaluating the utilization of these tools among vulnerable and marginalized groups, including refugees. The tools could be considered for use in other refugee hosting countries to increase compliance to recommendations, strengthen the health of the target population and ultimately drive down costs.

Presenters from Sweden stated that to reduce barriers to health services, Sweden has introduced health communicators who provide help through regional health and social services systems. The requirements to be a communicator include having a migrant/refugee background, an education in health science and having undergone training. Also presented was the use of fast-track training programmes (2–3 years) to allow migrant/refugee qualified health professionals, identified through health screenings, to acquire a Swedish license to practice medicine.

In Germany, speakers presented various innovative mechanisms that have been rolled out to reduce barriers to health services, such as the Cloverleaf procedure, which distributes severely ill patients evenly across regional hospitals to reduce delays in treatment; medical translation through applications; and Medibus, a public private partnership providing screening, vaccination, examination and counselling to Ukrainian refugees (described in presentations 4–6 (see Annex III)).
2.3. Plenary session 3: What is required of a good health sector to enable a good emergency response?

In plenary session 3 the clear message was, that with over five million refugees registered for temporary protection of the eight million refugees having crossed the border into countries of the European Region, long-term planning for the needs of Ukrainian refugees must start today.

WHO presented the multitude of WHO programmes and guidelines that can support the basis for a good emergency response to refugees, including for refugee and migrant sensitive health systems, data collection, analysis and health system assessment – taking a systems approach (3). The WHO global architecture for health emergency preparedness and response (4) also supports predictable financing for preparedness and rapidly scalable financing for response. WHO is committed to supporting the development of capacity, coordination and collaboration with a focus on health emergency alert and response teams; standardizing approaches for coordinating strategy, financing, operations and monitoring of preparedness and response; and expanded partnerships and strengthened networks for collaborative surveillance, community protection, clinical care and access to countermeasures (as discussed in presentations 7 and 8 (see Annex III).

WHO is additionally committed to the prevention and response to sexual exploitation, abuse and harassment (PRSEAH) and has a zero-tolerance policy in this regard, which means that all personnel must be properly screened and trained, any misconduct will be investigated in a timely and fair manner and, if proven accurate, result in serious consequences. This also encompasses implementing partners which will be blacklisted and/or handed over to national law. Presenters highlighted that it is also important to remember that the receiving population must also be informed and trained in PRSEAH.

2.3. Plenary sessions 1–3: proposed way forward

Participants at the Consultation acknowledged that the early response to the influx of refugees in neighbouring countries to Ukraine was largely successful due to their capacity to be flexible, creative and practical. However, as the health needs of such a large population are immense, a more sustained approach to health care is required. To achieve this sustained response, all Member States agreed that multisectoral collaboration is vital, with weakness in one sector (the lack of fulfilment of one right) impacting all others. The Blue Dot approach was noted as having been a positive experience in this regard, serving as platform for multisectoral assistance and could be further expanded.

Furthermore, collaboration between all stakeholders, such as government, the EU, UN agencies, NGOs and communities and at all levels (national, subnational and community) was considered critical – strengthening the response.

It was additionally proposed that this Consultation could be the starting point for a Member States platform on collective/collaborative responses to refugee needs.
The overarching message of the opening sessions and the ministerial forum was, that moving forward, Member States collectively need to make sure that no one is left behind; be more sensitive in identifying barriers and addressing them; and to continue to invest in health systems for the benefit of refugees and the entire population – it takes a whole of society to respond to this scale of crisis.

3. Sessions on health system components

3.1. Plenary session 4: Health leadership and coordination, governance, and financing of the humanitarian emergency response

Especially in the early stages of the crisis, the challenges of responding to an unprecedented influx of refugees were numerous, ranging from the significant strain on health-care, education and housing systems and legal and language barriers to differences in accreditation of Ukrainian health-care workers from hosting countries, different vaccination requirements, and issues of stigma or discrimination regarding mental health issues, among others.

Panellists of this session noted that in the early stages of the crisis, health-care providers were not sufficiently equipped with the resources and expertise necessary to provide high quality care to the extent required, with the need for culturally appropriate and responsive care catering for the unique needs of refugees not initially insured. In this session, speakers repeatedly confirmed, that in the host countries the key to the acute crisis response was cross-government coordination, via interministerial taskforces or strategic groups, an all of society/government approach and the provision of a comprehensive package of assistance.

Furthermore, sustained financing and competent, data informed governance was highlighted as necessary to ensure the sustainability of health-care services for refugees, and also solutions for the pressure on the health insurance systems. The example of the – now institutionalized – multisectoral emergency coordination group, headed by health and social services in Czechia was presented as an example of how crises can provide opportunities to sustain/build initially short-term innovations into longer-term interventions, thus improving the health-care system (discussed in presentation 11 (see Annex III)).

Examples of how initial legislative barriers were circumvented were also introduced. Romania rapidly passed 20 legislative acts to support the protection and inclusion of refugees, including access to health care. Moreover, Poland decreed “tailored” laws, such as facilitating social assistance benefits and simplifying procedures that have enabled about 1 million Ukrainian citizens to take up work in Poland. Also, the Polish approach to co-financing accommodation and meals for Ukrainian refugees housed with Polish families have benefitted over 1.6 million Ukrainian citizens, and reduced the pressure on the rental market (discussed in presentation 9 (see Annex III)).

Also mentioned was how Ukrainian school-aged children had gradually been integrated into their respective host country’s school systems, despite education systems – as with health systems – struggling to cope with up to an additional 30% of their expected enrollment. Further capacity-building and support to pupils with special needs are still required.
To reduce language barriers and increase the access of Ukrainian refugees to reliable information – especially in navigating the health and social systems – various printed and electronic products were developed in all host countries. This ranged from bilingual leaflets, dedicated websites, teleplatforms for online doctor appointments and call-centres. Specific IT solutions were also presented during the session, such as internet patient accounts in Ukrainian, so that patients can access all their health information, or online applications providing general information about the respective health-care system dedicated to Ukrainian refugees.

The crisis amplified structural deficiencies in some countries, highlighting the importance of preparedness and in identifying and applying lessons learned. Slovakia and Romania, for example, are already preparing contingency plans for a protracted crisis.

In summary, the solutions of refugee-hosting countries to mitigate the above-mentioned challenges included the provision of a comprehensive package of assistance, granting the same access to free health care as citizens of the host country, simplifying processes to hire Ukrainian health-care staff, the provision of continued treatment or care started in Ukraine, and streamlining technological tools to accommodate Ukrainians.

3.2. Parallel session 1: Health information and evidence/data-based decision-making in emergencies

This parallel session provided detailed examples of experiences in data collection and analysis and of the available tools and approaches in this regard, at both national and subnational levels. The presenters of this session reflected on the importance of a strong incident management system team and a health information surveillance system for each crisis that can respond quickly to changing information demands, analyse increasing data sets, apply analytical tools and are flexible in being indicator and event based. An important tool to achieve this, is the early warning alert and response in emergencies tool that is being launched by the WHO Regional Office for Europe and will be piloted in July and August 2023 (described in presentation 15 (see Annex III)). While health data are available in all Member States in the European Region, they rarely can be disaggregated by migratory status. However, disaggregated data on refugees and migrants are important for understanding and addressing refugee health needs, developing inclusive public health approaches, tracking progress towards national and global health goals and enabling decision-makers to understand and respond to public health challenges.

In this session, representatives from Slovakia shared their national level perspective that moving from one crisis to the next has meant that timely data collection and analysis methods that were strengthened during the COVID-19 pandemic – such as PowerBI (data visualisation) dashboards – could be adapted and continued for the Ukrainian crisis. Real-time data collection tools are already in place for planning hospital capacity, providing daily numbers of inpatients to the Ministry of Health, and monitoring the bed occupancy rates of specific departments, such as cancer, communicable diseases and paediatrics. Yet, the main health insurance data cannot identify patients according to their refugee status nor a patient’s journey across referral pathways.
The siloed approach to data collection, which complicates data sharing between different entities/sectors, such as ministries of health, national health insurance companies, national statistical agencies or interior ministries, is predominant in the refugee-hosting countries. Further common issues include regulatory limitations preventing electronic medical record sharing between countries; the difficulty of tracking refugee use of health services over time; and data protection and sharing concerns.

In Eastern Slovakia, a survey, using a statistical sample strategy, was conducted by the Public Health Authority and WHO Country Office in 2022 and provided substantial information about health-care access and perceived morbidity among the refugee population. Such information was presented as being extremely valuable in the first months of the crisis to establish the health profiles and needs of the displaced population.

Stand-alone data collection systems, such as qualitative and quantitative surveys, do not however, adequately capture the whole situation, and such data need to be integrated and triangulated with existing sources of data in order to provide evidence-based information for response action. Further, hard to reach refugees or those lacking trust in systems are unlikely to share their data, reducing the accuracy of the denominator, which is in any case fluctuating according to inward- and outward-moving refugees.

Therefore, to highlight the importance of using different types of data for a more complete and nuanced understanding of barriers and facilitators, Statistics Poland together with WHO used a mixed methods approach to collecting data among refugees from Ukraine. Innovative approaches to data collection (building trust, using broad sets of questions and methods) according to the six components of the HIS (5), including four suggested core variables and four recommended variables, could help streamline data collection and integration into decision-making and action (described in presentation 12 (see Annex III)).

The widely spread lack of trust in sharing health data could be addressed by the European Health Data Space initiative (6), which aims at empowering individuals through increased digital access to and control of their electronic personal health data, at national and EU-wide levels. Such an initiative will vastly improve data transferability – the technology is available, but relevant legislation still needs to be implemented (described in presentation 14, (see Annex III)).

In summary, as presented in this session, while a plethora of data – collected through surveys, reviews, studies or by institutions – is available, there is still an urgent need for disaggregated data by refugee status, that are collected systematically and are representative of refugee populations, as well as comparable across countries and over time. Furthermore, a whole of government approach to national information systems is required to enable the effective use of data for an evidence-based response.
3.3. Parallel session 2: Role of NGOs and civil society organizations in the refugee emergency response

In this session, presenters and speakers reflected on the role of NGOs and civil society organizations (CSOs) in the refugee response. All participants agreed that NGOs play an essential and important role in health-care provision, although they are not health-care providers. CSOs strive on collaboration and partnership, valuing the need to work together to achieve better results. In the emergency response to the Ukraine crisis in host countries, the value of NGO and CSO engagement included them having access to the marginalized, vulnerable groups who are often left behind (for example, elderly people, people living with disabilities and the Roma community), and making their needs visible. NGOs and CSOs were noted as being highly trusted because their actions are often guided by listening to community needs and responding to them – also observed in behavioural insight studies and risk communication, community engagement and infodemic management assessment missions – and the demand for their services and support often comes from the community itself. Examples shared during this session of CSOs and NGOs addressing community needs through planned activities included a course on sexual and reproductive health for Roma youth in Slovakia; a dedicated Ukrainian clinic with Ukrainian doctors treating refugees in Poland; provision of mental health services in Slovakia; HIV services in Czechia; clinics for Ukrainian refugees in Romania; and the support of evacuations in Poland. CSOs are often the first to respond in an emergency due to their flexibility and ability to deploy actions without major delays and thus, help fill in gaps in the response during the early stage of the emergency (described in presentations 16–19 (Annex III)). CSOs and NGOs can reach different population groups, including the vulnerable; tackle rumours and misinformation; provide or link people to mental health, health and social support services both within clinics and centres specifically for refugees; build the capacity of health workers; help refugees with information about how to access a health system that differs from their own (for example by running helplines and producing health information); provide translation and interpretation services to overcome language barriers; and strengthen collaboration between ministries of health, general practitioners and local medical staff.

Involvement of CSOs and NGOs in the emergency response is not however without challenges: to collaborate more efficiently with the governmental response CSOs and NGOs that provide health services require recognition (accreditation). Furthermore, ensuring continuity of operations, including keeping staff ready and motivated, and allowing switching between response, preparedness and recovery modes, requires adaptive long-term financing from international or national partners/government and donors.

In summary, CSOs and NGOs are valued partners of governments in an emergency response but to be able to provide sustained and effective support they require close cooperation with health authorities and/or health facilities; sustained funding; capacity building; and support with tools and methodologies applicable to NGO emergency response operations from WHO and other international partners. Countries were encouraged to share their experiences on interventions and services provided by CSOs and NGOs and thus identify specific interventions affiliated to the health-care system that are best implemented by these organizations, and
approaches to empowering and involving communities in the response to address their needs – co-developing or co-creating, as opposed to imposing, interventions.

3.4. Plenary session 5: Essential health services

This session focused on common barriers and challenges for providing accessible health-care services and examples of best practices. Major problems highlighted by presenters included the scale of the influx of people and accommodating their complex health-care needs in health-care systems already struggling after the COVID-19 pandemic. Addressing the many mental health issues in both children and adults was also noted as being especially difficult. The lack of data was another common problem, including the lack of documentation and health records, as was different treatment protocols between refugee receiving countries and Ukraine. Financial, language and cultural barriers to accessing care were also noted. The difficulties of different health insurance schemes in each refugee-hosting country added further complexity.

Presenters provided examples of best practice, with some countries developing services for people from Ukraine run by Ukrainian health-care workers. Engaging refugees in the response was considered an excellent approach for many reasons, such as scale up capacities, addressing barriers, and building trust, empowerment and dignity. However, it was acknowledged that to improve social cohesion in the long term it is necessary to strengthen existing national services and incorporate MHPSS, communicable disease and NCD, nutrition, sexual and reproductive health and trauma care into PHC systems to provide essential services for all.

Since the beginning of the crisis all EU Member States have been providing health-care services for Ukrainian refugees under the Temporary Protection Directive. Also, it was noted that partnerships with civil society have help reach the most vulnerable people and have played a role in providing the sexual health and reproductive needs of a population comprising mainly women and children. Civil society partners have also played a critical role in filling gaps and mobilized more resources than governments could, but the use of partners may not be a sustainable solution for a protracted emergency, unless, as in Slovakia, NGOs and the government sign an memorandum of understanding for longer-term collaboration.

In Slovakia, a clinic financed by an external donor, was initially set up to provide support to the PHC system in issuing prescriptions, giving vaccinations and issuing occupational health records. However the clinic had to be scaled up to deliver more comprehensive PHC including newborn care and counselling as the health system in Slovakia was not able to absorb the influx of refugees. In this regard, Slovakian representatives provided the example of paediatrician shortages – already in demand before the crisis, with over 50% of paediatricians being of retirement age – a paediatrician now has to cater for four times as many patients as before. The huge need for paediatric MHPSS in particular was highlighted (described in presentation 21 (see Annex III)).

On another note, it was highlighted by Slovakian representatives that insurance schemes can sometimes add a barrier to access. For example, the reimbursement for a consultation with a refugee from Ukraine is not as high as that for a citizen of Slovakia even though the consultation
often takes a lot longer and is more complex, with the need for translation, a lack of documentation and complex medical issues.

Further noted were difficulties in providing information to both health-care professionals in host countries and refugees on how the system works for people from Ukraine. Slovakia turned to IT solutions with the use of a website in Ukrainian and Slovak. Hungary utilizes social workers for children and interpreters that are linked with the paediatric hospital to provide translation and a continuum of care. Hungary is also currently developing information packages for social and health-care services (described in presentation 22 (Annex III)).

A further key point from the session concerns the health insurance system in Slovakia – refugees may join and change between any of the several insurance providers, but changes are seldom reported to the original insurer, making accurate data collection problematic. About 30% of refugees registered with a health insurance company utilize health care.

In summary, essential health service provision is currently secured in all of the refugee-hosting services, although health-systems, especially PHC systems, are under immense strain, and faced with lack of interpreters and a lack of documentation. The challenge for the future remains as how to provide a continuum of care, which is resilient to absorb shocks, scalable, adaptable to cultural and language needs and provides at least a minimum standard of quality care for all, including vulnerable groups, and addresses determinants of health to ensure no one is left behind.

3.5. Parallel session 3: Communicable diseases

Presenters of this session noted that at the beginning of the refugee crisis it was difficult to estimate the scope of the issue in regard to communicable diseases. In population displacement settings, risks for the spread of communicable diseases are particularly high and the high turnover of people with refugee status makes it difficult to know the risk profile of the refugee population at any given time. Poor and overcrowded living conditions, disruption of vaccination services and disease prevention measures, are risk factors in this setting for communicable diseases including multi-drug resistant tuberculosis (MDR-TB), HIV and vaccine-preventable diseases. However close cooperation between neighbouring countries and Ukraine was in place and early warning and surveillance data were available within just days of the crisis outset.

A challenge in the communicable disease prevention response included defining and granting access to free necessary health care for Ukrainian refugees in hosting countries. But legal frameworks, for example in Poland, have been quickly developed to support free-of-charge routine vaccination.

The International Health Regulation (2005) (IHR)-National Focal Point working group reported its findings of a recent IHR survey conducted in Austria, Czechia, Hungary, Poland, Slovakia and Ukraine, indicating that within these five Member States, two have conducted a public health situation analysis, two have employed an internal reporting process from the regions to
ministerial and public health institutes, and one had been regularly submitting COVID-19/epidemiological reports with a section on refugee health.

Communicable diseases against which routine and mandatory vaccinations are given to children, may not have been identified as an epidemiological threat during the first few months of the response even if Ukrainian children were not all fully vaccinated on arrival. While there are differences in the national routine vaccination schedules between Ukraine and hosting countries, most hosting countries vaccinated children according to their own national vaccination schedules, and if in doubt about the prior vaccinations, age-relevant vaccinations have been administered. High coverage of vaccination has been achieved among the Ukrainian population from the beginning of the crisis, and no major outbreak of any vaccine-preventable disease has been found.

Speakers noted that in Poland, vaccinations for adults, except for COVID-19 vaccinations and post-exposure vaccinations (rabies, tetanus and diphtheria) are not free of charge. Poland ensured that in case of outbreaks or increased number of cases of e.g., pertussis, hepatitis A and poliomyelitis, vaccinations will be administered.

Retaining vaccination records was also noted as a challenge for the refugee population and Poland is introducing vaccination cards to address this issue. Currently, the main factors hindering the monitoring of vaccination in Poland for Ukrainian citizens is the high turnover of people with refugee status, and the use private health care, which may not always report infectious diseases.

Continuity of care in Poland seems to have been well addressed and promises to continue. This care addresses not only the risk of acute outbreaks but also lifelong conditions such as HIV, which may bring additional long-term challenges, especially for ensuring access to the same WHO recommended treatment regimens, that may be available in Ukraine but not in all EU countries.

A special focus in this session was tuberculosis, specifically MDR-TB, to which Slovakia recently dedicated a workshop. Access to MDR-TB medicines remains difficult in host countries: the relatively small number of MDR-TB patients and subsequent small quantities of medicines needed as well as their high prices make procurement problematic. Indeed, manufacturers and suppliers of most WHO re-qualified medicines are not interested to respond to tender, neither to register their products in the EU (i.e. Rifapentine). The directorate-general of the European Commission, Health Emergency Preparedness and Response Authority have launched a tender for a call for proposals (closing date end May 2023) for a country/group of countries to host stockpiles of medicines, including antibiotics and medicines for MDR-TB as a solution for speeding up procurement of MDR-TB medicine.

Polish representatives also presented several simplifications and adjustments in the TB service delivery model away from mandatory hospitalization to outpatient, home-based and video-supported treatment, as well as information materials for patients in Ukrainian and Polish, and active screening of high-risk patients. This might be of particular importance to refugees who could decide on short noticed to move to other locations.
Looking forward, the presenter suggested stronger information exchange modalities between countries and ensuring, as far as possible, data interoperability, augmenting the ability at field level for active community-based surveillance and involving the IHR national focal point networks to exchange information on population movement and the potential risks. Equally, laboratory preparedness and capacity-strengthening in order to process additional samples for the detection of high threat pathogens was also noted as a requirement. Finally, better mechanisms of linking people to treatment and care across countries and addressing access to WHO recommended treatment regimens for both MDR-TB and HIV are also necessary.

3.6. Parallel session 4: MHPSS

During this session, speakers highlighted the vital importance of addressing MHPSS needs from the outset of the emergency response. Indeed, presenters and panellists of previous sessions had mentioned mental health numerous times and already identified MHPSS as a key intervention area, where considerable additional investment and capacity strengthening is a matter of paramount importance and urgency. Similar challenges and issues were noted for MHPSS as for health-care in general, namely the shortage of MHPSS staff, especially of trained child and adolescent mental health-care specialists; the stress placed on already strained systems in host communities; language barriers; and particularly stressed were the issues of stigma and information dissemination – including where and how to access MHPSS services – and the importance of the cultural adaptability of services, especially to address and mitigate the impact of stigma regarding the seeking and use of MHPSS services (described in section 28 and 29 (see Annex III)).

Given the pressure on health and social systems in host countries, as well as obstacles with language, stigma and information dissemination, the idea of task sharing and the training of non-specialists to be able to provide psychosocial support was presented, noting that community mental health is not only for specialists. Task sharing and training of non-specialists enables evidence-based psychosocial support at community level – for example by refugees to refugees. The importance of collaboration with CSOs and NGOs to address and provide a wide range of MHPSS services is well documented. Speakers noted that, as with other health and social services, the participation of Ukrainian refugees in various service provision modalities across different settings, including schools, community centres and hospitals is an important factor to increase social cohesion with the host community.

Governments’ increased recognition of the importance of integrating MHPSS into emergency preparedness, response and recovery has intensified the collaboration between WHO country offices and national authorities in Czechia, Estonia, Poland, Romania and Slovakia. The WHO Country Office in Poland, the Ministry of Health of Poland and the Ministry of Health of Ukraine, for example, jointly agreed on a pathway to access psychotropic medication for refugees from Ukraine, with all refugees able to continue their psychiatric treatment in Poland. Prescriptions issued by a psychiatrist or other doctors are required to obtain medication from a pharmacy, but prescriptions issued in Ukraine are also valid in Poland.
Other points mentioned in the session included that a systems approach is critical to address a wide range of population-diverse MHPSS needs – focusing on one area would not bring a sustainable system change. Evidence-based and well-tested MHPSS tools exist and are recommended for adaptation to local context and use. Building on existing structures and integrating MHPSS programmes into existing services ensure sustainability and contribute to addressing stigma.

Strengthening MHPSS service delivery capacities, to ensure access and sustainability of support during a protracted crises while expanding evidence-based, culturally adapted and needs-oriented MHPSS programmes to support transition and integration is key, as they contribute towards maintaining and systematically improving mental health and psychosocial well-being of all affected, while strengthening crisis-resilient national service delivery systems.

The moderator concluded the session by reminding everyone that emergencies, despite their tragedies, represent a unique opportunity to give attention to and build back better mental health systems in affected countries.

3.7. Plenary session 6: NCDs

Participants of this session reflected on the question “How well are we doing on NCDs and emergencies?” Experts from Hungary, the Republic of Moldova and Slovakia all noted that the refugee crisis has further exposed weaknesses in their systems for NCD prevention and management, and WHO experts noted the gaps in tools and packages for support. Interruptions in supplies of medicines/devices as observed in the current crisis can have catastrophic and life-threatening consequences – leading to acute exacerbations, hospitalizations, more costly care, disability or even death. As mentioned in the HIS session, the lack of systematic data collection and documentation in refugee care generally is also lacking in NCD care (described in presentation 32 (see Annex III)).

The rate of NCDs, and notably cardiovascular disease morbidity, of the Ukrainian population does not significantly differ from that of the Slovakian population. It was noted that around 10% of refugees are elderly and thus most prone to cardiovascular diseases. Elderly patients, both refugees and those from host countries, are often treated non-systematically mainly in emergency departments due to lack of capacity in PHC and while some conditions may have a high cure/treatment rate if timely quality care is provided others have limited time window for care, and it may be difficult to provide the full scale of treatment and rehabilitation within the host country (described in presentation 33 (see Annex III)). Challenges, especially in paediatric care, include the frequent immediate need for in-patient specialist care and the lack of available beds. In this regard, Hungary has initiated hospital capacity coordination at national level, which stems from the COVID-19 pandemic. Hungary also introduced a hotline to aid refugees, which included providing information for those living with NCDs, and registration forms in three languages as well as information about further non-medical support structures.

Host countries also reported on the shortage of specialists, which created long waiting lists for all that act as a barrier to accessing the specialist care frequently required for NCDs. To try and
address this issue, Slovakia has created and trained emergency teams (physicians, nurses, medical students and other health-care professionals) to treat NCDs. Language barriers to accessing NCD care in Slovakia have been addressed through the training of professional health interpreters. It was also noted that while specialist treatment capabilities are available in most host countries, the costs are much higher than for NCD treatment through PHC services.

Suggestions for further cross-country action in NCD management include the coordination of medical specialist care, uniform patient documentation templates and information on patient transit. WHO and Global Health Cluster partners have developed a high priority humanitarian package of essential health services to be maintained during the emergencies (7), which is based on the universal health coverage compendium (8). It is important that host countries define the comprehensive country specific costed packages of integrated, quality essential health services available within their health systems in “normal” times and during health emergencies. These packages should include NCD emergency referral pathways, indications where to refer to, triage tools, and the minimum requirement of supplies and human resources. The existing WHO package of essential noncommunicable disease interventions for primary health care (the PEN tool) (9) should be disseminated.

3.8. Plenary session 7: The health workforce

In this session, specialists from Czechia, Poland, the Republic of Moldova and Slovakia reported on their countries’ steps to help support Ukrainian health professionals to work in their national health systems, recognizing the benefits for both refugee and host communities. The main points of discussions considered the qualifications required by host countries to support Ukrainians to work close to their chosen profession and to support their career development. It was mentioned as a caveat that long-term recruitment should not be justified, given the shortages of health-care workers in Ukraine, especially nurses.

Differences in curricula between the training of doctors in Ukraine and host countries have led to some countries only allowing refugees to be employed as residents or assistants. In the republic of Moldova, however, where the language barrier is not an issue, and many of the Ukrainian health qualifications are recognized, recruiting Ukrainian health-care workers has been a quick process. As the other countries are part of the EU, this recruitment process is more complicated, but Ukrainian health professionals are being assisted with language classes, whereby a minimum level of B1 (intermediate level) in the respective language must be achieved. Attempts are being made to shorten the period needed to obtain the necessary licences.

Several hundred Ukrainian medical professionals in Czechia, Poland and Slovakia are already receiving special language training courses and courses on working within national health systems. Czechia is also planning to set up a career centre for foreign medical doctors, dentists and pharmacists who intend to work in the country. In Poland, the Ministry of Health has been closely cooperating with WHO in supporting medical personnel from Ukraine by running a hotline providing information concerning the requirements and documents necessary towards obtaining consent to work. Furthermore, WHO, in cooperation with the Medical Centre for
Postgraduate Education (a unit under the supervision of the Minister of Health), currently organizes and carries out the course “Organization of Health Care in Poland” for people who plan to work in Poland (described in presentations 34–36 (see Annex III)).

A new initiative in Poland targets medical professionals, particularly paediatricians, who are currently employed outside the medical system, to re-enter their medical profession. Paediatric specialist training for current postgraduates has also be substantially shortened so that they can enter the health workforce sooner – thus, about 30 paediatricians will start working in the next 18 months.

Ukrainian health workers may require other social support beyond language training, including mental health support, and legal and socioeconomic support. Since many refugees are women with children, childcare also has to be secured.

In summary, refugee-hosting countries value Ukrainian health-care professionals and through various means are promoting adaptation and recruitment processes.

4. Plenary session 8: Conclusions and the way forward

As the conflict continues, health-care provision may become a critical challenge that requires the further cooperation between the international community and refugee-hosting countries, and vitally, between the host countries themselves. The two-day Consultation in Bratislava, Slovakia, which gathered over 120 participants, including ministers and policy-makers, refugees, academic and civil society representatives, and EU and UN agencies, provided an overview of the Ukrainian refugee response in the attending refugee-hosting countries, lead to discussion on the strengths and weaknesses of the health system emergency response, and reflection on the way forward.

A multisectoral and cross-country approach requires collaboration among various stakeholders from health, social, education and other sectors, and while the agenda mainly included sessions on the way forward regarding core health and health system issues, it also provided time for networking and promoting dialogue between participants from health and social sectors and government representatives.

Suggestions for a subregional and cross-country way forward include the creation of a common platform (similar to the Bucharest Forum (10)), which should mobilize inter-country action on the refugee response, promote investment in collaborative agreements concerning the current crisis, and initiate emergency preparedness activities. With the support of the WHO Regional Office for Europe, interested health specialists from the participant countries shall meet to determine the terms of reference of the platform and define the thematic areas to be addressed. As suggested during this Consultation, these are likely to include:

- sharing experiences on CSO accreditation for service delivery and community outreach, and coordination with civil society, working groups of the Refugee Coordination forums and other key stakeholders involved in refugee response;
- exploring funding opportunities and means of coordinated financing;
• creating subregional twinning projects with action plans for learning based on the strategic WHO frameworks (10); and
• conducting joint internal and external evaluations, and discussing refugee health-care worker accreditation requirements.

The WHO Regional Office for Europe proposes applying a whole of society, cross-sectoral approach to the response, linking social and other services to health services in all refugee-hosting countries and will support its Member States by:

• developing tools for enhancing community engagement and capacity for risk communication, community engagement and infodemic management training, and contributing to the revision of existing tools, such as the WHO tool for assessing and strengthening the health system capacity for crises preparedness, response, recovery and resilience building (11), as well as standard operating procedures and guidelines for good practice;
• establishing a living inventory of the practical refugee responses of Member States; and
• convening regular technical meetings (with a focus on essential health services and leadership), as well as supporting national and institutional communication.

Several specific topic related recommended actions concerning governance, essential health services, HIS and the health workforce were mentioned during the consultation and are listed in Annex IV.

With a new vision and clear understanding of what should be done, the challenge remains to implement these commitments and discussion points. Participants reiterated that it is now imperative to put words and agreements into action and focus on taking this work forward. Member States welcomed the guidance and leadership of WHO across all country, Regional and global offices to support stakeholders in moving forward their common vision and to help to transform theory into practice.

Finally: start planning for the next crisis!
References


1 All weblinks were accessed on 13 July 2023.
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### 17 APRIL 2023

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<thead>
<tr>
<th>Time</th>
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<tr>
<td>18:00–19:00</td>
<td>Registration opens</td>
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<tr>
<td>19:00</td>
<td>Welcome reception (dinner) hosted by the Ministry of Health of Slovakia and the WHO Country Office in Slovakia</td>
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### DAY 1: 18 APRIL 2023

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<tr>
<td>08:00–08:30</td>
<td>Arrival and registration</td>
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<td></td>
<td>Event Moderator: Professor Jozef Šuvada, WHO Executive Board Member</td>
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<tr>
<td>08:30–08:45</td>
<td>Opening session</td>
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<td></td>
<td>Welcome and Opening Statement</td>
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<td></td>
<td>Dr Michal Palkovič</td>
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<td></td>
<td>State Secretary, on behalf of Mr Eduard Heger, Minister of Health of the Slovak Republic</td>
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<td></td>
<td>Dr Gerald Rockenschaub</td>
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<td></td>
<td>Regional Emergency Director on behalf of Dr Hans Henri P. Kluge, WHO Region Office for Europe</td>
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<td></td>
<td>Mr Myroslav Kastran</td>
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<td>Ukrainian Ambassador in Slovakia</td>
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<td>08:45–08:50</td>
<td>Message from Ukrainian refugee representative</td>
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<tr>
<td></td>
<td>Ms Viktoria Mariniuk</td>
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<td>Ukrainian refugee representative; Programme Manager, League for Mental Health</td>
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<tr>
<td>08:50–09:50</td>
<td>Plenary session 1: Moderated ministerial forum</td>
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<tr>
<td></td>
<td>Ministers from Czechia, Hungary, Poland, Republic of Moldova, Romania and Slovakia</td>
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<tr>
<td></td>
<td>General overview of the Ukrainian refugee response in respective Member States</td>
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<td></td>
<td>10-minute interventions per country</td>
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<td></td>
<td>Moderator: Dr Gerald Rockenschaub</td>
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<td></td>
<td>Regional Emergency Director, WHO Regional Office for Europe</td>
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<td>Panelists:</td>
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<td></td>
<td>Mr Jakub Dvořáček</td>
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<td></td>
<td>Deputy Minister of Health, Ministry of Health of the Czech Republic</td>
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<td></td>
<td>Dr Ala Nemerenco</td>
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<td></td>
<td>Minister of Health, Ministry of Health of the Republic of Moldova</td>
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<td></td>
<td>Mr Adam Niedzielski</td>
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<td></td>
<td>Minister of Health, Ministry of Poland (recorded video)</td>
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<td></td>
<td>Dr Michal Palkovic</td>
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<td></td>
<td>State Secretary, Ministry of the Slovak Republic</td>
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<tr>
<td>09:50–10:20</td>
<td>Coffee break</td>
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<td>Group photo</td>
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<td>Press conference</td>
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<tr>
<td>10:20–11:40</td>
<td><strong>Plenary session 1: Moderated ministerial forum (contd.)</strong></td>
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<tr>
<td></td>
<td>Overview of the Ukrainian refugee response from WHO, European Union (EU) institutions and United Nation agencies perspectives</td>
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<td></td>
<td><strong>50 minute presentation + 30 minute discussion</strong></td>
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<td><strong>Final remarks and closing of the Ministerial forum</strong></td>
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<td>11:40–12:25</td>
<td><strong>Plenary session 2: Learning from other countries</strong></td>
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<td></td>
<td><strong>Canada – Whole of government approach and use of data for an evidence-based response</strong></td>
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<td><strong>Examples from Sweden and beyond – Good practices in promoting refugee and migrant health.</strong></td>
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<td><strong>Germany – Presenting the models of care and innovative solutions to overcome language barriers</strong></td>
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<tr>
<td>12:25–13:25</td>
<td><strong>Lunch break</strong></td>
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<tr>
<td>13:25–14:30</td>
<td><strong>Plenary session 3: What is required by a national health sector to enable a good emergency response?</strong></td>
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<td><strong>What are the international standards and WHO guidelines and tools?</strong></td>
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<tr>
<td>14:30–16:00</td>
<td><strong>Plenary session 4: Health leadership and coordination, governance, and financing of the humanitarian emergency response</strong>&lt;br&gt;Keynote (5 minutes) followed by panel discussion&lt;br&gt;Up to six panellists from Member States to discuss challenges, lessons learned and the way forward with emphasis on potential cooperation/collaboration with other neighbouring countries</td>
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<tr>
<td>16:00–16:20</td>
<td><strong>Coffee break</strong></td>
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<td>Time</td>
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<td>16:20–17:50</td>
<td>Parallel session 1: Health information and evidence/data-based decision-making in emergencies</td>
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<th>Time</th>
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<th>Moderator</th>
<th>Keynote</th>
<th>Panelists</th>
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<tbody>
<tr>
<td>16:20–17:50</td>
<td>Parallel session 2: Role of NGOs and civil society organizations in the refugee emergency response</td>
<td>Mr Leonardo Palumbo</td>
<td>Mr Leonardo Palumbo</td>
<td>Ms Georgiana Andreea Afumateanu, National Emergency Response Coordinator, WHO Country Office, Romania</td>
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<td></td>
<td>Keynote (10 minutes) followed by panel discussion</td>
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<td>Mr Michal Chelstowski, Head of Medical Division, NGO Humanosh, Poland</td>
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<td>Ms Vira Orel, Chief Executive Officer, Medimost, Poland</td>
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**DAY 2: 19 APRIL 2023**

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<tr>
<th>Time</th>
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<tr>
<td>08:30–10:00</td>
<td>Plenary session 5: Essential health services</td>
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<td>Keynotes (up to 10 minutes) followed by panel discussion</td>
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<td></td>
<td>Short overview on essential health services in emergencies focusing on primary health care where Member States discuss relevant challenges, lessons learned and the way forward with emphasis on potential cooperation/collaboration with other neighbouring countries</td>
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<td>Session includes emergency health care, vaccination, child health, access to medicine, sexual and reproductive health, gender-based violence</td>
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<td>60 minute intervention + 25 minute discussion</td>
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<td>19:30</td>
<td>Dinner and networking</td>
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</table>

**Moderator:** Ms Katarzyna Drążek-Laskowska  
Director, Bureau International Co-operation, Plenipotentiary of the Minister of Health of Poland for patients from Ukraine, Ministry of Health of Poland

**Keynote speakers (3 minutes each):**

- **Dr Adelheid Marschang**  
  Senior Emergency Officer, Health Emergencies Interventions, WHO headquarters

- **Dr Ardita Tahirukaj**  
  Technical Officer, Health Emergencies Programme, WHO Regional Office for Europe

**Panelists: Experts from Member States**

- **Mr Rafat Bulanowski**  
  Department of Health Care, Ministry of Health, Poland (online)

- **Dr Branislav Chrenka**  
  Slovak Society of Primary Pediatric Care, Slovakia

- **Dr Erika Kovács**  
  Strategic and Quality Management Director of the National Pal Heim Paediatric Hospital, Hungary

- **Mr Ion Prisacaru**  
  Secretary of State, Ministry of Health of the Republic of Moldova

- **Dr Tatiana Speváková**  
  Coordinator, Clinic in Rovnainakova District, Bratislava, Slovakia

- **Dr Tomas Szalay**  
  Head, Health Department of Bratislava Self-Governing Region, Slovakia

- **Ing. Jozef Uhrin**  
  Director of the Strategies at Health Insurance Company, Slovakia
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Description</th>
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</table>
| 10:00–11:00 | Parallel session 3: Communicable diseases  
Keynote (10 minutes) followed by panel discussion  
Overview of Member States’ challenges, lessons learned and the way forward for addressing communicable diseases in refugee and host populations in refugee-hosting countries  
40 minute intervention + 20 minute discussion |

**Discussants:**

- **Dr Saidkasim Sakhipov**  
  United Nations Population Fund Emergency Coordinator, Republic of Moldova
- **Dr Flavio Salio**  
  Emergency Medical Teams Network Leader, WHO headquarters (online)
- **Dr Oleg Storozhenko**, Technical Officer, Health Emergencies Programme, WHO Regional Office for Europe (online)

**Moderator:** **Dr Stela Bivol**  
Unit Lead, Joint Infectious Diseases, WHO Regional Office for Europe

**Keynotes/presentations:**

- **Ms Tifenn Humbert**  
  Technical Officer, Strategic Procurement and Supply, WHO Regional Office for Europe (online)
- **Dr Mark Muscat**  
  Technical Officer, Vaccine-preventable Diseases and Immunization, WHO Regional Office for Europe
- **Dr Teresa Zakaria**  
  Technical Officer, Health Emergencies Interventions; Officer in Charge, Fragile, Conflict and Vulnerable Settings, WHO headquarters

**Panelists – Experts from Member States:**

- **Professor Alexandra Brazinova**  
  Public Health Authority and Comenius University, Slovakia
- **Professor Pavol Jarcuska**  
  Chief of Slovak Infectious Diseases Society, Košice University Hospital, Slovakia (online)
- **Dr Alena Koščálová**  
  Infectious Diseases Department, University Hospital Bratislava, Slovakia
- **Ms Joanna Kujawa**  
  Department of Public Health, Ministry of Health, Poland (online)
- **Ms Alexandra Kušnyérová**  
  National International Health Regulation WHO Focal Point, Public Health Authority of the Slovakia
- **Dr Dmytro Skirhiko**  
  Infectious Disease Doctor, Czech AIDS Society, Czechia
- **Professor Ivan Solovič**  
  Director, National Institute for Tuberculosis, Lung Diseases and Thoracic Surgery, Vysne Hagy, Slovakia
### 10:00–11:00
**Parallel session 4: Mental health and psychosocial support**

**Keynote (10 minutes) followed by panel discussion**

Up to six panelists from Member States to discuss challenges, lessons learned and the way forward with emphasis on potential cooperation/collaboration with other neighbouring countries.

40 minute interventions + 20 minute discussion

**Moderator:** Dr Ledia Lazeri  
Regional Advisor (Mental Health), Country Policies and Systems, WHO Regional Office for Europe

**Keynote:**  
Dr Fahmy Hanna  
Technical Officer, Mental Health and Substance Abuse, WHO headquarters (online)

**Panelists – Experts from Member States:**

- **Dr Elena Kopcová**  
  Director General, TENENET, Slovakia
- **Mr Marek Stańczuk**  
  Department of Public Health, Ministry of Health, Poland (online)
- **Ms Ivana Svobodova**  
  Secretary of the Government Council for Mental Health, Ministry of Health of Czechia
- **Dr Andrej Vršanský**  
  Chief Executive Officer, League for Mental Health, Slovakia

**Discussants:**  
Mental health and psychosocial support Working Group Leads

### 11:00–11:20
**Coffee break**

### 11:20–12:20
**Plenary session 6: Noncommunicable diseases (NCDs)**

**Keynote (10 minutes) followed by panel discussion**

Overview of Member States' challenges, lessons learned and the way forward for addressing NCDs in refugee and host populations in refugee-hosting countries.

40 minute intervention + 20 minute discussion

**Moderator:** Dr Jill Farrington  
Regional Medical Officer (cardiovascular disease and diabetes), NCDs, WHO Regional Office for Europe

**Keynote:**  
Dr Gauden Galea  
Strategic Advisor to the Regional Director on NCDs and Innovation, WHO Regional Office for Europe (online)

**Panelists – Experts from Member States:**

- **Dr Maria Jackuliková**  
  St. Elizabeth University, Slovakia
- **Dr Alexandru Voloc**  
  Technical Officer (communicable diseases and NCDs), WHO Country Office, Republic of Moldova
- **Dr Erika Kovacs**  
  Strategic and Quality Management Director of the National Pal Heim Paediatric Hospital, Hungary
- **Dr Michaela Kostičová**  
  Comenius University Bratislava, Slovakia
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<tr>
<th>Time</th>
<th>Session Details</th>
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<tr>
<td>12:20–13:20</td>
<td>Lunch break</td>
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<tr>
<td>13:20–14:20</td>
<td>Plenary session 7: The health workforce</td>
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<td>Keynote (10 minutes) followed by panel discussion</td>
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<td>Up to six panellists from Member States to discuss challenges, lessons learned and the</td>
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<td>way forward with emphasis on potential cooperation/collaboration with other surrounding</td>
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<td>40 minute intervention + 20 minute discussion</td>
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<td>Moderator: Dr Paloma Cuchí</td>
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<td>WHO Representative and Head of Country Office in Poland</td>
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<td>Keynote: Ms Margrieta Langins</td>
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<td></td>
<td>Policy Advisor, Nursing and Midwifery, WHO Regional Office for Europe (online)</td>
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<td>Panelists – Experts from Member States:</td>
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<tr>
<td></td>
<td>Ms Soňa Hrdličková</td>
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<td></td>
<td>Deputy Director for Education, Institute for Postgraduate Medical Education, Czechia</td>
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<td>Professor Monika Jankechova</td>
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<td></td>
<td>Head, Department of Health Education, Ministry of Health of the Slovak Republic</td>
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<td></td>
<td>Ms Małgorzata Zadorożna</td>
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<td></td>
<td>Department of Medical Personnel Development, Ministry of Health, Poland (online)</td>
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<td></td>
<td>Dr Vadym Zavatskyi</td>
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<td></td>
<td>Data Management and Reporting Officer, WHO Country Office, Romania</td>
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<td>14:20–15:40</td>
<td>Plenary session 8: Presentation of the conclusions from sessions and recommendations for the way forward</td>
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<td>Followed by open floor questions and answers with all participants</td>
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<td>Presentations from plenary sessions and parallel sessions</td>
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<td></td>
<td>50 minute presentation + 30 minute discussion</td>
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<td>Moderator: Professor Jozef Šuvada</td>
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<td>Ms Katarzyna Drążek-Laskowska</td>
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<td>Minister of Health Plenipotentiary for the transfer of Ukrainian patients to EU and EEA, Ministry of Health, Poland</td>
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<tr>
<td>15:40–16:00</td>
<td>Wrap up, next steps and closing remarks</td>
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<td>bringing together, lessons learned and key messages for the 76th World Health Assembly 2023</td>
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<td>Dr Michal Palković</td>
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<td>State Secretary, Ministry of Health of the Slovak Republic</td>
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<td></td>
<td>Dr Gerald Rockenschaub</td>
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<td>Regional Emergency Director, WHO Regional Office for Europe</td>
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</table>
Annex III. List of PowerPoint presentations

Plenary session 1: Moderated ministerial forum

1. European Centre for Disease Prevention and Control (ECDC) support to countries in meeting the health needs of people fleeing the war against Ukraine. Andrea Ammon, Director of the ECDC.
2. WHO’s response. Heather Papowitz, Incident Manager Ukraine Response, WHO Regional Office for Europe.

Plenary session 2: Learning from other countries

3. Case examples from Germany as a refugee hosting country. Dr Elke Jakubowski, WHO consultant, Germany.
4. Good practices in promoting refugee and migrant health – Examples from Sweden and beyond, Soorej Jose Puthoopparambil, Senior lecturer (Global health and Migration), Uppsala University, Sweden.
5. Community Based Care for Refugees, “Canadian perspective”, Kevin Pottie, Professor and Clinician-Investigator at the Department of Family Medicine and School of Epidemiology, Public Health and Preventive Medicine, and Ian McWhinney Chair of Family Medicine Studies, Professor, Department of Family Medicine, Western University, Canada.
6. Knowledge mobilization strategies to increase the awareness, use, and engagement of the COVID-19 Recommendations Map, Ashley Motilall, Knowledge Mobilization Coordinator Cochrane Canada, McMaster University, Canada.

Plenary Session 3: What is required by a national health sector to enable a good emergency response?


Plenary Session 4: Health leadership and coordination, governance and financing of the humanitarian emergency response

9. Health leadership in Romania. Mihaela Necula, Counsellor, General Department of Medical Assistance, Ministry of Health.
11. Humanitarian emergency response in the Czech Republic, Dr Jakub Dvořáček, Deputy Minister of Health, Ministry of Health of the Czech Republic.

Parallel session 1: Health information and evidence/data-based decision-making in emergencies

13. Population based study to assess perceived health status, health needs and access to essential health services: Lessons learnt and best practices shared between Ukrainian refugee-hosting countries in the European region. Dr Jana Kollarova and Dr Dietzova, Public Health Authority, Kosice, and Dr Isabelle Devaux, WHO Country Office in Slovakia.
14. Collection and integration of data on refugee and migrant health in the WHO European Region – Challenges and Opportunities. Soorej Jose Puthoopparambil, Associate Professor, WHO Collaborating Centre, Uppsala University, Sweden.

**Parallel session 2: Role of NGOs and civil society organizations in the refugee emergency response**
17. The role of NGOs. Lucia Roussier, Executive Director, Equita, Slovakia.

**Plenary session 5: Essential health services**
20. Essential health services for Ukrainian refugees in Poland. Mr Rafat Bulanowski, Department of Health Care, Ministry of Health, Poland (online)
21. Primary care clinic in Rovniankova, Slovakia. Dr Tatiana Specakova, Coordinator Clinic in Rovnainakova District, Bratislava.
22. The tasks of Heim Pál National Pediatric Institute to help the Ukrainian refugee children, Hungary. Erika Kovács, Strategic and Quality Management Director of the National Pal Heim Paediatric Hospital, Hungary.

**Parallel session 3: Communicable Diseases**
23. Communicable Diseases in Emergencies, Key Considerations. Dr Teresa Zakaria, Technical Officer, Health Emergencies Interventions; Officer in Charge, Fragile, Conflict and Vulnerable Settings, WHO headquarters.
24. Vaccination in Ukrainian Refugees. Ms Joanna Kujawa, Department of Public Health, Ministry of Health, Poland.
27. Access to TB medicines in the WHO European Region. Tifenn Humbert, Technical Officer, Strategic Procurement and Supply, WHO Regional Office for Europe.

**Parallel session 4: MHPSS**
28. Lessons learnt and best practices shared between Ukrainian refugee-hosting countries in the European region: Actions, best practices and lessons learnt in Hungary, with special focus on the mental health care of the refugees. Dr Róbert, Department Leader at Országos Kórházi Főigazgatóság/ National Directorate-General for Hospitals, Department for Primary Care Planning and Development.
29. Six common pitfalls while designing or implementing mental health and psychosocial support programmes for refugees and forcibly displaced populations. Dr Fahmy Hanna, Technical Officer, Mental Health and Substance Abuse, WHO headquarters.
30. MHPSS community centres. Dr Elena Kopcová, TENENET, Bratislava, Slovakia.

**Plenary session 6: NCDs**
32. Non-Communicable Diseases in Emergencies: Lessons learned from the first line, Slovakia. Dr. Maria Jackuliková, St. Elizabeth University, Slovakia and Dr Michaela Kostícová, Comenius University Bratislava, Slovakia.
33. Cardiovascular health care for Ukrainian refugees - can we cope? Róbert Hatala, Chief Cardiologist, National Institute of Cardiovascular Diseases, Slovakia.
Plenary session 7: health workforce

34. Lessons learnt and best practice sharing between refugee-hosting countries in the context of the Ukraine crisis. Soňa Hrdličková, Deputy Director for Education, Institute for Postgraduate Medical Education, Czech Republic.

35. Lessons learnt and best practice sharing between refugee-hosting countries in the context of Ukraine crisis, Margrieta Langins, Policy Adviser, Nursing and Midwifery, WHO Regional Office for Europe (online) and Tomas Zapata, Health workforce and Service Delivery Regional Adviser, Slovakia.

36. System of issuing permission to work in medical professions in Poland on simplified terms for personnel from third countries, Małgorzata Zadorożna, Department of Medical Personnel Development, Ministry of Health, Poland.
Annex IV. Recommended actions and suggestions

Participants presented throughout the Consultation the challenges experienced and solutions found in national responses to the refugee crisis and have formulated several possible specific collaborations and actions for health sector partners in view of this likely protracted crisis. Selected proposals are listed below:

<table>
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<tr>
<th><strong>Health leadership and coordination, governance and financing of the humanitarian emergency response</strong></th>
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<tr>
<td>• Institutionalize <strong>sector-wide collaboration</strong>.</td>
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<td>• Provide the <strong>legal basis</strong> for policies concerning:</td>
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<td>• Identify next steps for long-term (at least three years) <strong>strategic planning</strong></td>
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<td>• Review <strong>preparedness for all-hazard and multifaceted</strong> events, ensuring capacity and contingencies to address risks such as epidemics and pandemics and emerging diseases that may occur concomitantly with natural or other disasters, and scale up accordingly.</td>
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<tr>
<th><strong>Health information and evidence data-based decision-making in emergencies</strong></th>
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<tr>
<td>• Improve <strong>knowledge management</strong> with enhanced <strong>disaggregated data collection</strong> from various sources, as well as data sharing and interoperability through comprehensive and interconnected data systems. Provisions for <strong>cross-country health data transfer</strong> should be specified and implemented.</td>
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<tr>
<th><strong>Integrated essential health service delivery</strong></th>
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<tr>
<td>• Establish <strong>people-centred service delivery</strong> systems and ensure provision of integrated and quality essential health services such as emergency and acute care, prevention, diagnosis and treatment for noncommunicable diseases, communicable diseases, and mental health and psychosocial and social support (MHPSS), as well as nutrition, sexual and reproductive health and community outreach, based on principles of primary health care and universal health coverage and inclusive of essential public health functions and addressing priority determinants of health.</td>
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</table>
• Map vulnerabilities, vulnerable groups and minorities in both Ukraine and host countries and ensure risk communication and community engagement reach all parts of society.
• Regularly assess and monitor need and health-care services utilization by vulnerable groups including refugees in order to address the service requirements corresponding to people’s needs and cultural preferences and to avoid treatment interruptions, through multiple approaches including mobile teams, community outreach and referral pathways.
• Analyse barriers to identify priority factors that limit utilization of health and social services and address its causes (cultural, language, etc).
• Develop and implement a standard comprehensive package of services to be available within the health system generally and in health emergencies to ensure continuity of essential health services during emergencies, including specifications for refugee health and the participation of social workers in service delivery.
• Develop further programmes based on MHPSS situation analysis and regular needs assessments, and raise awareness of MHPSS among both the host community and refugees.
• Tailor psychosocial activities to support and improve the well-being of individuals and communities affected by crises.
• Strengthen both non-specialized and specialized MHPSS services in cooperation with national authorities and enable access to primary health and social care systems.
• Update, adapt, disseminate and apply existing tools including WHO universal health coverage resources (1), the Inter-Agency Working Group on Reproductive Health in Crises’ Minimal Initial Service Package for sexual and reproductive health (2), MHPSS tools and risk communication and community engagement tools (3,4).
• Develop tools to facilitate partnerships with national and refugee civil societies, such as in task sharing, referral pathway tracking, and the training of non-specialists to be able to provide evidence-based psychosocial support at the community level including refugee lead support services, and provide guidance on multisectoral collaboration for the monitoring of communicable disease risk factors, vulnerabilities, and capacities.

Health workforce

• Integrate Ukrainian health and social workers according to specific accreditation requirements and support inclusion with supplementary professional training and specific language tuition.
• Analyse and evaluate what skill-mix models exist for different population and patient groups, and with which outcome(s), as a first step to understand what might work in what context and for which population group.
• Provide capacity-building activities such as training, supervision, workshops and webinars for the engaged workforce to strengthen the response, address burnout and support adaptation of services to developing needs.

• Where appropriate, engage community groups to implement interventions (such as training by community members, or creating support groups, etc).

References


The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

**Member States**

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czechia  
Denmark  
Estonia  
Finland  
France  
Georgia  
Germany  
Greece  
Hungary  
Iceland  
Ireland  
Israel  
Italy  
Kazakhstan  
Kyrgyzstan  
Latvia  
Lithuania  
Luxembourg  
Malta  
Monaco  
Montenegro  
Netherlands (Kingdom of the)  
North Macedonia  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
Tajikistan  
Türkiye  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan

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