Risk communication, community engagement and infodemic management in Ukraine’s emergency response: lifesaving interventions in crisis and beyond

Warsaw, Poland
14–16 November 2023
Meeting report
Abstract

The Risk communication, community engagement and infodemic management in Ukraine’s emergency response: lifesaving interventions in crisis and beyond meeting was held in Warsaw, Poland on 14–16 November 2023. Participants from national health authorities, civil society organizations, United Nation agencies and international partners shared, reflected upon, and documented the wealth of knowledge and experience gained during the Ukraine emergency response, as well as strategizing on the subsequent phases of the RCCE-IM response to the emergency.

Keywords

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<th>EMERGENCIES</th>
<th>HEALTH COMMUNICATION</th>
<th>INFODEMIC</th>
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<td>EMERGENCY PREPAREDNESS</td>
<td>COMMUNITY PARTICIPATION</td>
<td>SIGNAL DETECTION</td>
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This publication contains the report of the Risk communication, community engagement and infodemic management in Ukraine’s emergency response meeting in Warsaw, Poland, 14–16 November 2023 and does not necessarily represent the decisions or policies of WHO.
# Contents

**Abbreviations**  iv  
**Executive summary**  1  
**Background**  4  
  Meeting objectives  6  
  Meeting format and participants  6  
  Report structure  6  
**Meeting summary**  7  
  Setting the scene  8  
  Plenary session – Generating evidence: strategies to assess people’s perceptions and behaviours  11  
  Panel discussion – Matching health information and advice to community’s needs  15  
  Plenary session – Supporting people’s access to health services in an acute emergency  19  
  Plenary session – Supporting health protection in an emergency  22  
  Plenary session – Engaging communities and influencers  29  
  Panel discussion – Partner coordination for RCCE-IM in humanitarian emergencies  34  
**Way forward and final recommended actions**  36  
  Strategic actions in the continued Ukraine emergency response  37  
  Final recommended actions for RCCE-IM in humanitarian emergency response  40  
**References**  42  
**Annex 1. List of participants**  43  
**Annex 2. Meeting agenda**  46
**Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCI</td>
<td>behavioural and cultural insights</td>
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<td>CBRN</td>
<td>chemical, biological, radiological and nuclear</td>
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<td>COVID-19</td>
<td>coronavirus disease</td>
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<td>CSO</td>
<td>civil society organization</td>
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<td>ECDC</td>
<td>European Centre for Disease Control</td>
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<td>KI</td>
<td>potassium iodide</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>NUDZ</td>
<td>Národní ústav duševního zdraví [National Institute of Mental Health] (Czechia)</td>
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<td>RCCE-IM</td>
<td>risk communication, community engagement and infodemic management</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>URCS</td>
<td>Ukrainian Red Cross Society</td>
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“The most important part in risk communication is a human touch. When we try to develop or design some measures to respond to people in crisis, we need to think about their lives, about the real human beings who are on the other side and that we are trying to support them in their hour of need.” Katarzyna Drazek-Laskowska, Director of the International Cooperation Department at the Ministry of Health (MoH) of Poland

“Twenty-one months after the full-scale invasion of Ukraine first began, none of us could have foreseen the situation where hundreds of thousands of people were displaced due to war and sought safety elsewhere. Until the day Ukrainian people are safe and have access to essential services, risk communications, community engagement and infodemic management remain essential public health interventions ensuring the health and well-being of those who have been forced to flee.” Nino Berdzuli, WHO Representative in Poland and WHO’s Special Envoy for the Ukraine Emergency Response

“Since the war broke out, risk communication, community engagement and infodemic management have been core elements of our humanitarian response in Ukraine. It has been essential in targeting people with relevant public health advice in this evolving emergency. This event, to reflect on learnings over the past 21 months and to identify opportunities to do things differently in the future, will help us learn from one another about what has worked, what we wish to do differently and how we might address further challenges.” Jarno Habicht, WHO Representative in Ukraine

“Since the war in Ukraine started, we have all worked hard in our capacities to support the affected populations to cope with the consequences. We have collectively acquired an incredible wealth of experience in lifesaving RCCE-IM [risk communication, community engagement and infodemic management] interventions specific to humanitarian emergencies and conflict situations. Our experiences will define the pathway for the RCCE-IM response in the context of Ukraine’s war and guide other countries and people who might need this knowledge to respond to similar situations.” Cristiana Salvi, Regional Adviser on RCCE-IM, WHO Regional Office for Europe
Executive summary

When emergencies strike, risk communication, community engagement and infodemic management (RCCE-IM) is the bridge that connects people with health services and interventions. Whether the crisis is biological, climate-related or man-made, such as the war in Ukraine, offering health services is not enough — people need to make informed choices to access these services and protect their health. In order to accomplish this, they require timely and clear information from trusted sources on how to access or navigate disrupted or unknown health systems, advice on protective measures and how to maintain their health. This is where RCCE-IM can save lives as an essential public health intervention in humanitarian emergencies.

At time of writing, the humanitarian crisis following the Russian Federation’s full-scale invasion in Ukraine has put 14.6 million people in dire need of urgent humanitarian assistance. There are currently at least 3.7 million internally displaced people within the country and there are 6.4 million recorded refugees from Ukraine globally, of whom most are in Europe and 90% of which are women and children.

The emergency response in Ukraine has emphasized distinctive features of the RCCE-IM response in humanitarian emergencies. In such situations, the primary focus of the health response naturally shifts towards rescue and life-saving operations, followed by efforts to prevent communicable diseases and outbreaks.

Yet, when we align these priorities with the perceptions and needs of affected communities, a stark disparity emerges. Interactions with affected communities have revealed that while health concerns may not be their initial priority – understandably so, given their immediate worries about survival, shelter and livelihoods – the foremost health need for many affected individuals is not the risk of communicable diseases, but rather accessing affordable health-care systems and treatment, especially for their chronic conditions.

This realization has marked a significant shift in the RCCE-IM approach. During infectious disease outbreaks such as coronavirus disease, the focus is predominantly on engaging at-risk groups to increase acceptance and uptake of protective measures. In humanitarian crises, however, efforts shift towards supporting individuals in accessing and navigating disrupted or unfamiliar health-care systems as they relocate.

Following two years of conflict in Ukraine, various humanitarian actors across Ukraine and neighbouring regions have accumulated significant knowledge and expertise in responding to this humanitarian crisis. The Risk communication, community engagement and infodemic management in Ukraine’s emergency response: lifesaving interventions in crisis and beyond meeting took place on 14–16 November 2023, in Warsaw, Poland convening participants from national health authorities, civil society organizations, United Nations agencies and international partners. The objective was to collectively share, reflect upon, and document the wealth of knowledge and experience gained, as well as to strategize for the subsequent phases of the RCCE-IM response.

This report outlines the discussions and key insights from the meeting, aiming to inform and guide RCCE-IM interventions. It highlights best practices and provides longer-term recommended actions to promote recovery and enhance community resilience.
These can be grouped into five key points specific to humanitarian emergencies:

1. Providing health information is a core public health intervention. During humanitarian emergencies, affected populations face immense challenges, including turmoil, uncertainty and anxiety. Amidst these challenges, competing needs and shortened attention spans, it is crucial to provide simple, clear, concise and timely health information, including in visual formats. This enables individuals to access and navigate disrupted or unfamiliar health-care systems and protect their health, as they relocate. This includes providing health information that is informed by evidence-based insights and is tailored to meet the needs of affected individuals in a language they understand; through communication channels they use; in the amount they are able to receive; and at a time that they are ready to act on it. Not only does this facilitate affected populations’ access to preventive and treatment services, but it also provides a sense of direction and empowerment, thereby enhancing their overall well-being.

2. Human interactions are at the core of effective RCCE-IM interventions. Humanitarian emergencies heighten the vulnerabilities of affected populations by forcing an unprecedented number of people to endure turmoil either in their familiar surroundings or away from their homes and their countries, abolishing the systems, practices and routines they trust and are accustomed to. Displaced or not, surrounded by uncertainties, and unfamiliar with the new situation of their emergency life, affected populations need a “human anchor” to trust, to believe and to open up to. This can be someone who can listen to their perceptions, help them understand their needs, and guide them to navigate the health system to access services and care, and protect their health. Harnessing the power and influence of trusted community members and stakeholders such as local civil society organizations (CSOs), cultural mediators, health-care and social workers, community volunteers and peers, including fellow citizens already residing in host countries, is essential to achieve this objective. Outreach and support from these community actors can be a game changer in encouraging individuals, especially the most vulnerable, to follow guidance and seek support.

3. Defining and measuring interventions for social impacts collaboratively with affected populations is crucial to address their unique needs and foster resilience. Active community participation into the design, delivery and measurement of interventions enables a thorough understanding and the addressing of the unique risks, concerns, needs, preferences, behaviours and circumstances of affected populations. As such, it helps in tailoring the response based on the type, timing and delivery of the health information they require, as well as identifying factors that facilitate or hinder access to health services. Ultimately, placing communities at the centre of interventions and service delivery, ensures these interventions and services are provided where, when and how they are most needed, while also fostering shared accountability for results, thus leading to more successful and efficient interventions. In addition, interventions centred around people can also contribute to building the social capital necessary for recovery and resilience.

4. Addressing the challenges of both relocated and local communities is crucial to ensure social cohesion. Inclusive policies, measures and communications targeting the needs of both relocated and host populations can mitigate potential negative sentiments, such as concerns about resource allocation and access to health services. This also involves managing potential false narratives about relocating communities to reduce the risk of stigma and discrimination. Approaches that involve both displaced persons and host communities in the development and implementation of interventions can foster trust, improve perceptions, cultivate empathy and bridge cultural divides. This collaborative effort contributes to peaceful coexistence and social
harmony. Providing accurate information about displacement, acknowledging the challenges while emphasizing shared benefits with honesty and empathy will not only bolster trust in the response efforts but foster social cohesion.

5. RCCE-IM must be mainstreamed across coordination mechanisms for better health outcomes. Humanitarian emergencies frequently result in various immediate consequences and needs, including those related to survival, shelter and protection. They also potentially result in increased risks from nuclear facilities, winterization, food- and water-borne contamination, respiratory diseases and cholera. All have effects on the health of individuals and the health of populations. By actively embedding RCCE-IM in preparedness and response mechanisms and coordinating and collaborating with relevant partners and stakeholders across sectors and societal segments, RCCE-IM interventions can address the interconnected health needs of affected populations more timely and effectively. This approach better contributes to overall health and social outcomes.

This report enables those with an interest in RCCE-IM, humanitarian emergency response and the war in Ukraine to benefit from an extensive knowledge and practical experience of governments, United Nations agencies and CSOs responding to Ukraine emergency.
Background

During emergencies, delivering services and interventions is not enough. People’s behaviours and the accessibility of humanitarian services and interventions are central to emergency control and, to accelerate recovery these services and interventions must be accessed. Risk communication, community engagement and infodemic management (RCCE-IM) bridges service delivery and access. This understanding has confirmed that RCCE-IM is a public health intervention as crucial to a successful emergency response as biomedical measures.

Each area with RCCE-IM focuses on a specific set of interventions. Risk communication targets proactive, accurate, relevant and real-time information and advice through multiple platforms based on people’s perceptions and health needs. Community engagement ensures affected communities co-design and co-deliver interventions. Infodemic management uses social listening to detect and address false narratives and information overabundance and voids. Together, RCCE-IM builds trust and enables and empowers individuals and communities to make informed decisions to protect their health from emergencies.

In the newly proposed approach to strengthen the global architecture for health emergency, preparedness, response and resilience (1), it is noted that “health emergencies begin and end in communities”. Any effective health emergency response must put communities at the centre of efforts to prepare for, prevent and respond to health emergencies. This is also at the core of the regional strategy and action plan Preparedness 2.0. Central to engaging affected communities in the co-creation of response interventions is to make interventions serve the needs of affected populations. Effective community protection depends on achieving key objectives, among which RCCE-IM guides priority actions and strengthens community resilience.

RCCE-IM should be embedded in the entire emergency cycle and incorporated into planning and decision-making processes with a whole-of-government and whole-of-society approach. Moreover, adequate and sustainably funded human and financial resources are required to strengthen RCCE-IM capacities.

As lessons from the coronavirus disease (COVID-19) response have shown, strong RCCE-IM interventions that engage people, such as promoting public health and social measures and vaccination, vastly contributed to disease control. Also, by supporting trust building between people and health authorities, RCCE-IM drives the acceptance and uptake of protective measures and, ultimately, saves lives.

RCCE-IM in Ukraine’s emergency response

In support of national health authorities, the WHO Regional Office for Europe has been involved in the coordination of the health response to Ukraine’s emergency since the beginning of the Russian Federation’s full-scale invasion of Ukraine on 24 February 2022.

The war in Ukraine has put millions of people in danger, exacerbated their health risks, and caused a large-scale population displacement both within and outside Ukraine. At the time of writing an estimated 3.7 million people are internally displaced within Ukraine and over 5.8 million people fleeing the war in Ukraine have registered for temporary protection in Europe (2). Cross-border movement continues as some people are leaving and some are returning to Ukraine. A United
Nations High Commissioner for Refugees (UNHCR) Intentions survey (3) shows that the majority of people want to return to their places of residence (67% of displaced people within Ukraine and 62% of refugees) with the main impediments being safety and security and access to basic services.

Disrupted health-care services and attacks on hospitals rendered the population more vulnerable in Ukraine. Because of multiple displacements and disruptions of vaccination, prevention, testing and care, the risk of spread of communicable diseases has increased. The mental health of people has also been significantly affected by displacement, loss, grief and the prolonged uncertainty resulting from the ongoing war. Rehabilitation services are becoming a priority in Ukraine going forward.

The countries that neighbour Ukraine, including Bulgaria, Czechia, Hungary, Poland, the Republic of Moldova, Romania, Slovakia and Slovenia activated their immediate response operations to support arriving refugees. Fleeing the war, refugees have found support and welcome in these countries and by host communities, but also encountered barriers to accessing health services and care. The reasons include absent medical history documents and financial, administrative and language difficulties. Refugees from Ukraine with existing health conditions have been particularly vulnerable. Consequently, the refugee-receiving countries may face extra burdens on their health-care systems in the long term. Therefore, sustainable solutions are needed to address these challenges and invest in community resilience as a part of better preparedness for future emergencies.

Since day one of the war, RCCE-IM has been among the core public health intervention of WHO response (Table 1). Many people found themselves at a new location within or outside of Ukraine, often in distress due to family separation or the experience of violence. People need clear information from trusted sources, guidance on maintaining their health and the ability to feel engaged in the co-design of response activities. Such activities improve the ability of displaced people to navigate and access health systems for treatment and prevention, but also give people a sense of orientation and belonging, thus increasing their well-being.

Table 1. WHO RCCE-IM priorities in Ukraine and neighbouring countries in 2023

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<thead>
<tr>
<th>RCCE-IM priorities in Ukraine</th>
<th>RCCE-IM priorities in refugee-receiving countries</th>
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<tbody>
<tr>
<td>Providing timely access to health information about health services during the war</td>
<td>Building trust and supporting social cohesion between the relevant government, host community, and refugees from Ukraine</td>
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<tr>
<td>Ensuring that clear, reliable and trustworthy health advice reaches displaced people and other people affected by the war</td>
<td>Connecting refugees to health services, including mental health</td>
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<tr>
<td>Engaging with local authorities and communities</td>
<td>Promoting acceptance and uptake of health protective measures, including vaccination</td>
</tr>
<tr>
<td>Preparing for potential health threats (e.g., CBRN, cholera, etc)</td>
<td>Engaging communities in decision-making processes concerning their health and co-designing interventions</td>
</tr>
<tr>
<td></td>
<td>Strengthening communities’ readiness and resilience</td>
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Notes: CBRN: chemical, biological, radiological and nuclear
Meeting objectives

The purpose of the meeting was to, firstly, document and reflect upon the RCCE-IM interventions implemented as a part of emergency response in Ukraine and refugee-receiving countries. With 2 years of Ukraine’s emergency response, Ukraine and countries that neighbour Ukraine have gained vast knowledge and practical experience in managing an emergency of this scale. Secondly, the meeting aimed at strategizing and planning activities in the longer term, focusing on fostering recovery and community resilience. Thirdly, lessons and practices from Ukraine’s emergency response captured through this meeting will inform the development of guidance on RCCE-IM interventions in humanitarian emergencies.

Meeting format and participants

The meeting took place in Warsaw, Poland, on 14–16 November 2023. The agenda included two and half days of plenary sessions, panel discussions and breakout rooms on a variety of topics. The last day of the meeting was dedicated to group work around two questions: 1) What are the RCCE-IM interventions in the continued response to Ukraine’s emergency in Ukraine and refugee-receiving countries?; and 2) What are the final recommended actions for RCCE-IM in humanitarian emergencies based on the learnings from Ukraine’s emergency response?

Over 40 people joined the meeting in person. The country delegations comprised of representatives from:

- the National health authorities from Bulgaria, Hungary, Poland, the Republic of Moldova, Romania, Slovakia, Slovenia and Ukraine;

- CSOs from Bulgaria, Czechia, Poland, the Republic of Moldova, Slovakia, Slovenia and Ukraine; and

- international partners such as the European Centre for Disease Control (ECDC), the United Nations Children’s Fund (UNICEF)’s Refugee Response Office in Poland, and the Ukrainian Red Cross Society (URCS).

In addition, RCCE-IM specialists from the WHO Regional Office for Europe and WHO country offices in the European Region attended the event.

Report structure

The report follows the structure of the meeting agenda. In different sections, the report captures presentations from speakers during plenary sessions, panel discussions and key insights after breakout room work.

The sections on evidence generation, access to health, health protection and community engagement have been built around four plenary sessions. The “Setting the scene” boxes contain WHO’s approach to deploying RCCE-IM in humanitarian emergencies that were presented by moderators at the beginning of each session. Key insights from breakout rooms on evidence generation, multi-hazard preparedness and social cohesion are highlighted in coloured boxes. Panel discussions on matching health information to community needs and partner coordination are
included as separate sections of the report.

The Way forward and final recommended actions section contains a summary of group work on the last day of the meeting and discussed actions in the continuing emergency response in Ukraine and neighbouring countries and key recommended actions for RCCE-IM in humanitarian emergencies.

The list of participants and the agenda can be found in Annex 1 and Annex 2, respectively.
Meeting summary

Setting the scene

Speakers:

- Heather Jue-Wong, Project Management Officer, WHO Regional Office for Europe
- Cristiana Salvi, Regional Adviser on RCCE-IM, WHO Regional Office for Europe

The first part of the Setting the scene session focused on a situation update and the WHO emergency response in Ukraine and refugee-receiving countries. In the second part, the crucial and central role RCCE-IM plays during emergency responses was presented. This session explored the differences between health and humanitarian emergencies, with a focused analysis of RCCE-IM within the context of the war in Ukraine and suggested next steps in Ukraine’s emergency response.

**WHO emergency response in Ukraine and refugee-receiving countries**

The Project Management Officer of the Ukraine emergency response underlined that with more than 3.7 million people displaced within Ukraine and over 5 million in Europe (2), the cross-border displacement continues from and to Ukraine. The war has had a significant impact on health systems in Ukraine, as attacks on health-care facilities have resulted in deaths, injuries and reduced access to medical services. There is also a risk for the transmission of communicable diseases due to population movement, multiple displacements, poorer living conditions and disruption of vaccination, prevention, testing and care. Continuity of care is needed as a priority
for screening, diagnosis, prevention, treatment and care, especially for HIV, tuberculosis and vaccine preventable diseases. The mental health of refugees has been significantly affected by displacement, loss, grief and prolonged uncertainty resulting from the war.

Current WHO response to Ukraine emergency. In Ukraine, operations continue in areas that have been retaken, in places where active conflict persists and in other impacted regions. This includes providing training in trauma and injury care; deploying mobile health units to address noncommunicable diseases and other acute health needs in conflict-affected areas; setting up prefabricated primary health-care units to ensure access to care in areas where existing facilities have been damaged or destroyed; preparing for seasonal health risks; conducting risk assessments; and providing infrastructure support. In countries receiving refugees, ongoing efforts include coordination with and supporting local health systems and services; providing technical support and supplies; extending health services to refugees through the Refugee Health Extension programme; resuming interagency partnerships; offering support and guidance for health workers on HIV and tuberculosis; and developing strategic and refugee response plans.

The way forward in Ukraine’s emergency response. Now in its third year, the war in Ukraine remains a priority for WHO, with a continued focus on ensuring access to emergency and routine health services, particularly mental health and psychosocial support. Other priorities include procuring medical supplies and equipment for health facilities; strengthening disease surveillance and case management; providing rehabilitation services for medical evacuees and returnees; and preventing and responding to sexual exploitation, abuse and harassment. In countries receiving refugees, WHO’s priorities include advocating for policies designed for refugees; coordinating with related stakeholders; conducting ongoing listening exercises to understand refugees’ needs, concerns, and barriers to health-care services; providing health information and service delivery support; facilitating the integration of Ukrainian health workers into local health systems; engaging health and cultural mediators; and advocating for longer-term support for refugees.

**RCCE-IM as a central pillar of emergency response**

The WHO Regional Office for Europe’s Regional Adviser on RCCE-IM underlined that delivering services and interventions in emergencies is not enough. People’s behaviours are central to emergency control and to accelerate recovery these services and interventions must be accessed. RCCE-IM bridges service delivery and access. This understanding has confirmed that RCCE-IM is a public health intervention as crucial to successful emergency response as biomedical measures.

Communities’ role in managing emergencies. Any effective health emergency response must put communities at the centre of efforts to prepare for, prevent and respond to health emergencies. Central to community protection, RCCE-IM should be embedded in the entire emergency cycle, with whole-of-government and whole-of-society approaches sustainably funded. As the COVID-19 response has shown, strong RCCE-IM interventions that engage people in public health, social measures and vaccination vastly contributed to disease control. By building trust between people and health authorities, RCCE-IM drives the acceptance and uptake of measures and, ultimately, saves lives.

Humanitarian emergency versus health emergency. Planning and designing RCCE-IM interventions in a humanitarian emergency differ in several aspects from a health emergency such as a pandemic or a disease outbreak. Specific features of health emergencies include a high interest in health, coordination steered by the health sector and a rapid health response, as well as evolving science on the health issue. People’s behaviours in such emergencies drive disease control. At
the same time, an overload of health-related mis- and dis-information may impair response efforts. Consequently, health information and advice must be released immediately even in times of uncertainty and evolving science. There is a high need for social listening and infodemic management.

In conflict settings or other humanitarian emergencies, health is usually not the primary concern of affected populations – the immediate priorities being often related to survival, shelter and livelihoods. Acute trauma and injury treatment are among immediate health needs with other health needs emerging at a later stage. Routine health-care services such as vaccination are not people’s top priority. The coordination of the humanitarian response is usually steered by other sectors and the immediate response is about rescue and life-saving operations. Behaviours in humanitarian emergencies mostly drive access to health services. When it comes to false narratives, a vast number of those are linked to conflict management and political issues rather than health.

RCCE-IM in Ukraine’s emergency response. Whether people are displaced within Ukraine or seeking safety in the neighbouring countries, the displaced population tend to seek health information and services in case of any urgent health need and for chronic conditions. Often, they are in need of a “one-stop-shop” detailing all available health service information and ways to access these services. While designing information products to address these needs, it is important to avoid information overload. Bombarding audiences with excessive information, especially when an emergency starts, can impede the effective reception of and action on critical health and protection messages.

From the onset of the full invasion in Ukraine, WHO focused on supporting communities with the provision of timely, reliable health information and advice, working with local communities and authorities and preparing for future health risks in the country. In refugee-receiving countries, interventions focused primarily on connecting refugees to health services, as well as promoting the acceptance and uptake of health protective measures; involving communities in decision-making processes; building trust; supporting social cohesion; and strengthening community resilience.
Plenary session – Generating evidence: strategies to assess people's perceptions and behaviours

Moderator: Stefan Voinea, Infodemic Management Officer, WHO Regional Office for Europe

Speakers:

- Corina Gamurari, Main Consultant, Information and Mass Media Communication Unit, MoH, Republic of Moldova
- Angela Costandache, Specialist, Foreign Assistance Department, MoH, Republic of Moldova
- Oksana-Valentyna Kurnyk, Project Coordinator, CSO Зустріч [meeting], Poland
- Agnieszka Sochon, Social and Behaviour Change Specialist, UNICEF, Poland
- Martha Scherzer, Consultant, Behavioural and Cultural Insights (BCI), WHO Regional Office for Europe

Setting the scene

The evidence generation process involves systematically collecting, analyzing and using information about the community’s knowledge, attitudes and practices. Effective risk communication starts with listening, to better understand people’s needs and concerns. Two types of listening can assist in gathering social listening insights namely:

- **Active listening** (e.g., in-depth interviews, focus groups discussions, surveys and community feedback); and
- **Passive listening** (e.g., social and traditional media monitoring, data from call centres and functioning community feedback mechanisms).
This plenary session focused on reviewing activities done to collect evidence on people’s perceptions, knowledge and behaviours in the Ukraine emergency. It was noted that during an emergency, changing people’s behaviours is difficult and that people have a harder time navigating the information space and dealing with false information. Understanding as much as possible about your target audience, not the general public, is essential to deliver relevant health information and advice.

**Tracking and responding to false information.** Speakers from the MoH of the Republic of Moldova shared their experience in establishing an infodemic management system to monitor, track and respond to false information. The ways to detect false information signals included daily media monitoring; online social listening; face-to-face communication with refugees and focus group discussions during visits to refugee accommodation centres; and collecting data from emergency support hotlines, including those for people with disabilities. Upon the identification of false information, the health authorities responded with a number of different actions.

- False information was debunked on the government website and official social media channels.
- The newly created messaging application channel “First source” was used to debunk any falsehoods detected online.
- The government held public press briefings with national authorities to address the priority of preventing false information through providing clear, transparent and verified information regarding the situation with refugees, public health measures and services available. This led to trust-building between national authorities and communities. The MoH of the Republic of Moldova collaborated with the mass media to counter the infodemic. The media received data on health-care services available, vaccination campaigns and information on disease control measures in place to use in their materials.
- The Centre for Strategic Communication and Combating Disinformation was established in July 2023, at the initiative of the President of the Republic of Moldova.

**Online and offline social listening.** The CSO Зустріч [meeting] in Poland, emphasized the role that CSOs have played in targeted listening and community feedback collection. CSOs have prioritized gathering up-to-date community insights to act upon in their daily operations. Also, they have helped with reaching vulnerable groups by conducting offline listening sessions with older people staying in refugee centres. The findings showed social media as the preferred channel to receive health information followed by printed materials in medical facilities or distributed by CSOs, national hotlines and offline meetings. The insights helped to implement mobile outreach activities in affected communities.

Another example of targeted social listening conducted by the CSO Зустріч [meeting] was a needs assessment among Ukrainian refugees in a smaller city of Myslenice (Malopolskie Voivodeship), outside of Krakow. The main findings highlighted the need for better coordination of initiatives and communication, Polish language courses for refugees and additional psychological support for children and adults. In some instances, refugees reported hesitation to disclose their problems because of the risk of losing their residence. The findings showed the great impact of hotlines and free consultation services. Hence, when planning the response activities, making those services available could help refugees navigate the health-care system in a new location.

**Collecting behavioural data.** A representative from UNICEF’s Refugee Response Office in Poland presented a case of how behavioural insights could inform actions to increase vaccination among
refugees from Ukraine. Together with the Institute of Mother and Child Foundation, UNICEF conducted a study among Ukrainian mothers to understand the main barriers to routine childhood vaccination in Poland. Information about access to health care, low levels of vaccine literacy and vaccine safety concerns were identified as key barriers to routine child immunization. Based on the findings, the team developed targeted interventions in pharmacies, social media, outdoors and public transport, reaching over one million Ukrainian refugees. Campaign materials led people to the online resource Спільно [together], which has information about how to vaccinate a child in Poland and a map of available services (4).

When developing messages, the team at UNICEF’s Refugee Response Office conducted message testing to understand what message would stimulate target behaviours (e.g., having the intention to get a child vaccinated, making an appointment and acknowledging the importance of vaccinating a child). Messages on trust, access or risk aversion were tested. The message reminding people of the risk and importance of vaccination when being more vulnerable due to a conflict situation showed high effectiveness in influencing all target behaviours.

The findings of qualitative BCI studies was presented by the speaker from the BCI Unit at the WHO Regional Office for Europe. The BCI studies focused on perceived health service needs, gaps, barriers and drivers of uptake of health services from a refugees’ perspective. Studies aimed at documenting refugee experiences with the host health system and any potential areas of stigma or discrimination among other critical issues. Respondents among Ukrainian refugees in Czechia, Poland, Romania, Slovakia and Slovenia were recruited through social media channels and organizations working directly with refugees. A Ukrainian research company conducted online in-depth interviews with refugees in each country with a follow-up 3 months later.

Some of the findings were similar across all countries. For example, language was reported as a barrier in all countries and dentistry was considered too expensive hence often delayed. The availability and people’s knowledge about the services have increased over time, and so has the amount of information. Also, the vulnerable – those with any kind of disability, pregnant women, new mothers, and older people – needed social and other targeted support and services.

Key takeaways

• Effective evidence generation to understand people’s needs and concerns requires a combination of active and passive listening using varied sources, ranging from social media to community focus groups and grassroots needs assessments. Collected insights need to be used timely to inform RCCE-IM and the broader emergency response.

• CSOs play a crucial role in evidence generation; they have access to communities and can conduct targeted listening with at risk population groups. Changing people’s health behaviours in humanitarian emergencies is challenging because health-related issues such as vaccination will not be a priority. Message testing can help refine and create effective communication for behaviour change.

• Using behavioural insights as appropriate can help people make better health decisions, but barriers need to be considered such as access to health care, low literacy or safety concerns.

• Social listening and data gathering need to take place from the early phases of the response. The approach needs to be adapted depending on access to communities, resources and capacities available.
Breakout room discussion: Evidence generation in a humanitarian emergency: tools, methodologies, capacities, and data utilization

In this session, participants were grouped into five teams and tasked to identify key opportunities and challenges, best practices in collaboration, and data sources and methods in evidence generation. The following points encapsulate the summary of discussions and the resulting recommendations.

- Cross-country collaboration is needed to gather data about refugees moving between countries.
- Creating a coordination unit that fosters collaboration with national and local authorities and other entities such as media and CSOs who can reach vulnerable populations, provides a more comprehensive understanding of people's needs. Streamlining data collection process helps avoid duplications.
- International organizations have expertise in carrying on data collection in emergency settings, and therefore, are good partners to engage with.
- Triangulating data received from diverse sources – both qualitative and quantitative, online and offline – helps generate more solid evidence.
- Surveys and rapid risk assessments are useful for getting insights quickly in an acute emergency, but sampling biases can lead to limited insights or an inadequate understanding of the evolving situation.
- Health clinics and state services for refugees (including hotlines) can be an excellent source of data for the response.
- Utilizing datasets containing non-health-related information such as public sentiment regarding refugees, refugee employment status, or safety and security concerns, can be helpful to inform RCCE-IM interventions.
- There is a need for a blueprint on how each government entity should collect data and evidence in an emergency situation.
Panel discussion – Matching health information and advice to community’s needs

Moderator: Cristiana Salvi, Regional Adviser on RCCE-IM, WHO Regional Office for Europe

Speakers:
- Joanna Głażewska, Deputy Director, Department of Public Health, MoH, Poland
- Vita Kolomiets, Head of Communications, MoH, Ukraine
- Andrei Eșanu, Head, Federation of Families for Peace, Republic of Moldova
- Olexander Babenko, Head of Health and Care Department, URCS

This panel discussion focused on how to effectively deliver health information amidst emergencies based on the experience during Ukraine’s emergency response. In humanitarian emergencies, the affected population grapples with various essential and competing needs like shelter, food and safety. Therefore, it becomes imperative to offer accurate health information precisely when individuals are ready to receive and take action based on it.

Timely delivery of health information. Speakers from both Ukraine and refugee-receiving countries agreed that health information on urgent health needs should be communicated to affected populations immediately from the onset of the conflict or the moment they arrive at the border. Mental health and psychosocial support, first aid to injured people and landmine safety stood out as critical topics covered early in the response in Ukraine. Both in Ukraine and refugee-receiving countries, people with chronic diseases were prioritized as a target audience for health information to support the continuity of their treatment. Such approach would decrease the risks.
of them having further health complications as chronic diseases tend to be overlooked during emergencies, with later repercussions on health systems. Health information for those on the move stressed the importance of taking their medicines with them. Information regarding access to health services and medicine was among the key messages delivered to people in refugee-receiving countries.

**Channels of health information.** The MoH of Ukraine used digital media outlets such as its website, official pages on Facebook and Instagram, Telegram channels and opinion leaders and influencers to deliver health information to affected communities. When the internet bandwidth was limited, the MoH of Ukraine also used SMS to deliver health information.

URCS utilized the power of human-to-human communication via 126 mobile units, around its 200 branches across Ukraine and through 1000 volunteers. They reached various communities by disseminating health information designed and prepared by the URCS headquarters. Visiting communities as much as possible and delivering information in person proved effective and helped to see what kind of information communities actually need and to adapt the response accordingly.

The MoH of Poland used printed materials such as leaflets and brochures providing short and simple health messages at the borders and in shelters.

**Source of health information.** The participants agreed that the source of health information should be determined based on the community’s trust level towards various authorities and organizations. In some situations, people’s level of trust in CSOs may be higher than in government institutions. Health information and advice can be developed by different stakeholders but it needs to be presented to people by messengers they trust.

**Community feedback.** Social listening of the affected communities and understanding their needs and challenges were key practices of the Moldovan CSO Federation of Families for Peace, to ensure that health information was in line with community needs.

Speakers from both Poland and Ukraine stressed that any information released to affected people should be very specific and simple due to the tumultuous circumstances people face during crises. The MoH of Ukraine shared the story of people in the village of Borodianka who were left without access to drinking water during the occupation of the Kyiv region. When they had had internet access, they had memorized messages from the MoH on how to treat rainwater to make it safe for drinking. This case underlined the importance of keeping information short and simple and making it available at critical times.

**Coordination of health information.** URCS stressed the need for centralized and systematic information management, but decentralized and personalized information dissemination to reach as many communities as possible.

The MoH of Poland highlighted the importance of fostering the exchange of information between organizations involved in the response frequently to ensure health information about services are accessible to refugee communities.

**Challenges and solutions.**

**Understanding health needs:** One of the challenges encountered during the response involved
communities not explicitly expressing their health needs in conversations with volunteers. Consequently, volunteers had to interpret and discern the health requirements or symptoms of diseases from discussions that were not primarily centred on health, as per the insights of the Federation of Families for Peace. In response, the CSO implemented a solution by establishing a two-way communication channel between volunteers engaging with refugee communities and health professionals. This facilitated the identification of people’s health needs based on their statements in non-health-related discussions.

**Competing priorities:** The Federation of Families for Peace also reported that people needed support with non-health matters such as shelter and clothes. Although not related to their area of expertise, the organization recognized the impact of satisfied essential needs on community well-being and supported communities in non-health-related matters as well. This contributed to creating trust and people opening up about their health problems when they talked about other topics.

**Dealing with mental health stigma.** It was also difficult to address stigma around mental health, the Moldovan CSO added. As a solution, the organization provided alternative names to mental health and psychosocial services. For example, “parents’ club” instead of a “group therapy”, which led more people to participate and talk about their mental health challenges. Addressing mental health issues was significantly more effective when timely discussions about mental health occur within the community, alongside the introduction of related services. This helped individuals to see the needs and problems related to mental health are normal and common in abnormal situations such as war and led to the uptake of individual consultations for those in need. This approach proved effective for both the MoH of Poland and the Moldovan CSO. Emphasizing anonymity, discretion and privacy emerged as pivotal concepts when managing stigmatized health topics.

**Communication in sensitive situations:** Relying on the assistance of health-care providers and volunteers for disseminating health information is essential. However, not all of these individuals possess the expertise or ability to effectively navigate and communicate in challenging or sensitive situations. Offering training and empowering relevant influencers with the necessary skills to handle challenging situations and deliver pertinent health information could be effective for the dissemination of health information, the MoH of Poland stressed.

Differing health systems and procedures. Speakers from both the Republic of Moldova and Poland highlighted a significant obstacle: different health and medical protocols between Ukraine and refugee-receiving countries, affecting the delivery of health information to refugees. Recognizing differences between health systems of neighbouring countries and explaining them to the refugees to help them access health services was suggested as a solution.

**Delivering information in uncertain times.** URCS emphasized the difficulty of operating and disseminating information in uncertain times and unforeseeable situations, especially when there is no phone or internet access. Taking decisions based on existing information and evidence and enabling volunteers and CSOs to have the capacity to address various needs of the affected communities could be considered to ensure their well-being.

**Key takeaways**

- During the first weeks of Ukraine’s emergency response, priority health topics to communicate were on providing first aid, landmine safety, access to medicine – especially for people with chronic diseases, psychosocial first aid and access to health services.
• The release of information should be timed according to both the urgency of the health need and the ability of target audiences to receive and act upon the information. For example, guidance on accessing health services, including for trauma or mental health, should be prioritized for displaced people at points of entry.

• Health information in an acute humanitarian emergency phase should be simple, short, easy to memorize, and tailored to the immediate needs as not to overburden people.

• Finding alternative language to communicate about topics that are stigmatized can increase the uptake of provided services and support.

• Involving opinion leaders, influencers and volunteers to disseminate health information helps to reach more audiences and ensure people receive information from trusted sources.

• Coordination and frequent information exchange among partners is crucial.

• Recognizing differences between the health systems of neighbouring countries and that of Ukraine and explaining them to the refugees will help them to navigate health services more efficiently.

• Addressing the language barrier is critical to support refugees in accessing health services.

• Human-to-human interaction is of utmost importance for the uptake of health information in the context of humanitarian emergency.
Plenary session – Supporting people’s access to health services in an acute emergency

Moderator: Olha Izhyk, Risk Communications Officer, WHO Regional Office for Europe

Speakers:

- Joanna Głażewska, Deputy Director, Department of Public Health, MoH, Poland
- Alja Polajžer, Center for the Communication, National Institute of Public Health, Slovenia
- Nadezhda Todorovska, Deputy Director General, Head of Social Welfare and Operational Activities Division, Bulgarian Red Cross
- Lucia Fulierova, Project Manager, Equita, Slovakia
- Daniela Madan, Consultant, WHO Country Office in Republic of Moldova

Setting the scene

Risk communication provides information on risks and protective measures to target audiences based on their perceptions and supports trust. It is a critical component of any emergency response. In humanitarian emergencies, risk communication links people to available health services, by ensuring access to health information, and providing targeted advice. Effective risk communication includes listening and understanding risk perceptions, acknowledging concerns and expressing empathy, speaking in uncertainty, being consistent, segmenting and targeting...
audiences, developing and testing messages, choosing the right channels and knowing how to use them.

It is essential to understand the real-time needs and concerns of the affected populations. In the first days of a humanitarian emergency, there may be concerns about shelter, search and rescue, safety and immediate health threats (trauma and injury). In the first weeks, access to health services, access to medicines, and health care for chronic diseases become needed.

This session focused on how risk communication can support people's access to health in an acute emergency. Early in the humanitarian emergency, the situation may be precarious and confusing, and people are often on the move to safety and in distress. This impacts their ability to receive information and exacerbates their health risks.

**Understanding needs and concerns.** Gathering information to understand communities’ needs and concerns emerged as a recurrent theme during the session. The speaker from Slovenia pointed out the importance of learning the audience's specific needs as the first step in the response. In collaboration with WHO, the Center for the Communication of National Institute of Public Health conducted focus group discussions with affected communities. However, as noted in the presentation, finding people willing to participate was somewhat difficult. People's willingness was impacted by fear of going viral online or saying something wrong that would impair their stay in the host country, among other reasons.

The representative from the MoH of Poland raised the importance of understanding the cultural context of the arriving refugee population. While this was less relevant in Ukraine’s emergency context due to similarities between Ukrainian and Polish cultures, this would be of greater importance should refugees arrive from other more remote countries.

The Bulgarian Red Cross mapped the health profiles of Ukrainian refugees arriving in Bulgaria to understand their urgent health needs. The mapping uncovered some of the differences in the provision of health services in Bulgaria compared to Ukraine. A lack of knowledge about additional charges for health-care insurance and hesitancy of general practitioners to take on refugees due to their frequent movements and a language barrier had contributed to challenges in accessing health care.

Similarly, the WHO Country Office in Republic of Moldova in support of the government’s efforts conducted a rapid needs assessment to understand health needs. The data was collected by conducting in-depth interviews and focus group discussions at refugee accommodation and community centres.

**Health information and advice.** The Government of Slovenia developed communication materials explaining how to access health services in the country, in addition to information about accommodation, the school system and a vaccination scheme. These materials were available to people from Ukraine upon entry to Slovenia. Material development considered the existing language barrier and the need for translated information. Translated information for people from Ukraine was made available on governmental and nongovernmental institution websites.

The Government of Slovenia provided training for health-care workers in non-verbal communication to assist in interaction with newly arrived people. Poland similarly noted how the language of health information should be tailored to audience needs and context.
The speaker from the Slovakian CSO Equita outlined the delivery of correct and consistent information as an essential component of communication with refugees. From a CSO perspective, the ability to recommend follow-up care and solutions for individual cases benefited building stronger connection with refugees and gaining their trust. Also, targeted materials on specific topics, for example, HIV testing and vaccination, helped refugees to find relevant advice.

**Dissemination and outreach.** Collaborating with partners directly connected with the refugee communities was essential for the MoH of Poland. This helped link people from Ukraine to Polish governmental websites with translated information relevant to them.

As noted by Poland, information sources and channels refugees use changed over time. Utilizations of diverse formats, such as digital and printed materials, proved effective for dissemination. Social media was key to reaching refugee communities in this emergency, as noted by the WHO Country Office in Republic of Moldova as many people arriving from Ukraine found their own accommodation or stayed with family and friends, therefore, not living in refugee centres.

The CSO Equita flagged the need to reach different age groups via different channels. For example, young people use some but not all social media platforms. Also, engaging influential community leaders was important as they already had trust in the community. While information translated for refugees by the government was important, additional support in explaining how the health system in the host country works was needed. The CSO’s experience in working with vulnerable populations before Ukraine’s emergency helped bring that experience into the response.

The WHO Country Office in Republic of Moldova shared a case of making public announcements through audio systems at the border early after the war started. As the emergency context changed, the WHO country office implemented other ways of delivering information and directly engaging with both refugees and host communities (e.g., a public event dedicated to the World Refugee Day, mental health fairs, etc.)

**Linking people to health services.** The Bulgarian Red Cross provided assistance in enhancing the capacities of health mediators who helped refugees to navigate the health system and communicated with other institutions. The health mediators knew Ukrainian and the host country’s language. Also, the CSO in Slovakia organized a Slovak language course for people from Ukraine to tackle the language barrier and make access to health care for refugees easier.

The Bulgarian Red Cross and the CSO Equita mentioned helplines for Ukrainian refugees as another way of linking people to services. The helpline set up by the CSO Equita in Slovakia aimed at individual case management. The helpline engaged Ukrainian-speaking operators and case management services when needed.

**Key takeaways**

- Understanding the needs and concerns of affected communities, as well as cultural context of their native country, to learn the audience's specific needs should be the first step in the response.

- When organizing listening activities with affected communities, mechanisms to protect personal information and data of responders should be in place: respondents should have clear understanding of the objective of the interview, and how the findings will be used.
• There is a need for reliable, culturally sensitive and contextually tailored approaches to ensure effective communication with affected communities.

• To mitigate language barriers, translated information, language courses for refugees and engaging health mediators were identified as effective practices.

• CSOs reported on the benefits of applying their previous experience of working with vulnerable populations to the Ukraine response. They highlighted their role as a bridge between authorities and communities as they are rooted in the society, have full knowledge of communities and their needs and behaviours, and enjoy high community trust,

• Helplines with operators that speak the language of refugees and provide tailored information and advice helped link refugees to the health services available.

Plenary session – Supporting health protection in an emergency

Moderator: Faris Mahmutovic, RCCE–IM Officer, WHO Country Office in Poland

Speakers:

• Szymon Cienki, Director, Office of the Chief Sanitary Inspector, Poland

• Yana Ishchenko, Communication Officer, Public Health and Emergency Response, MoH, Ukraine

• Nikola Zwartková, Head of Communications Department, National Institute of Mental Health, Czechia

• Sakun Gajurel, Risk Communications Officer, WHO Country Office in Ukraine
Setting the scene

Delivering timely health advice to people on what actions they should take to protect themselves reduces their health risks. RCCE-IM’s role is to provide timely and consistent health advice to increase acceptance and uptake of protective measures. In the long term, increased health literacy helps protect health and prevent disease outbreaks among communities.

In a humanitarian emergency, messages released by health authorities, other state actors and partners should be aligned. Different population groups may need different information and advice, hence requiring a targeted approach. Key principles for health advice include keeping language simple, easy to understand, relevant to the affected communities and actionable to drive behaviour change.

This session focused on presenting case studies to address some of the priority topics of the Ukraine emergency response. The topics included vaccination and communicable diseases, mental health, food and waterborne disease prevention, and health protection in case of chemical, biological, radiological and nuclear (CBRN) events.

Vaccination and vaccine-preventable diseases. Experience from Poland showed that social media was not fully effective in reaching refugees about vaccination. Moreover, vaccination and disease prevention were not among the priorities for arriving people. Recognizing the importance of addressing routine health needs and mitigating possible health risks, representatives from the Chief Sanitary Inspectorate organized their response actions at the border. They produced leaflets about communicable diseases (e.g., polio, measles, pertussis, etc.) in the Ukrainian language.

Food- and water-borne diseases. The MoH of Ukraine presented its case of the RCCE-IM response following the destruction of the Kakhovka dam in June 2023. The event left around 700,000 people in Ukraine without access to drinking water. The immediate actions of the Emergency Response Headquarters were to provide official operational information to the public and set up a hotline. The MoH of Ukraine issued priority health advice for people on first aid, access to medical services, food- and water-borne diseases and actions for people left without access to drinking water. The MoH of Ukraine prioritized short simple visual messages easy for people in crisis to memorize. For example, materials included steps on how to purify dirty water, actions in case of hypothermia, first aid in case of drowning and prevention against cholera.

The MoH of Ukraine used diverse channels for dissemination. The institution published information on the Ministry’s website and official social media channels, held press briefings with media and organized live broadcasts on social media platforms with MoH representatives. Furthermore, the MoH has supported the information work of the regional Centers for Disease Control and Prevention with communities at the Kakhovka dam disaster site. In total, more than 200,000 copies with health advice developed in partnership with the WHO Country Office in Ukraine were distributed in printed format. Although internet penetration in Ukraine is high, printed materials helped to reach people who were temporarily without internet access and in some instances relatives and the community would cascade information. More than 80,000 consultations took place with the affected communities on health risks and preventive measures against food- and water-borne diseases.

The MoH of Ukraine also responded to false information. For example, during the Kakhovka dam emergency, the ministry detected false information about a cholera outbreak in Ukraine.
In response, the ministry released an official statement in collaboration with the Centre for Combating Disinformation. They engaged medical experts to help communicate information about the disease and preventive measures to the public in the media. Also, sharing health materials on digital platforms was a regular practice. One of the posters featured a health worker disproving the cholera outbreak claim, adding that the health system would be ready to respond should the cases appear.

- Overall, as lessons taken from this disaster, the MoH of Ukraine shared outlined principles of effective risk communication during this type of emergency, including:
  - immediate information about the situation and specific advice to the public;
  - regular communication during the ongoing emergency about public health risks and access to health services;
  - information and advisory work with the affected communities on potential disease outbreaks and preventive measures;
  - information about assessed long-term risks for public health; and
  - monitoring and timely response to false information.

**Mental health.** Národní ústav duševního zdraví (NUDZ) [the National Institute of Mental Health] in Czechia supported activities to help people from Ukraine get mental health support. The research showed almost half of Ukrainians in Czechia had symptoms of depression or anxiety. Despite the high prevalence, only 3% of those received the help they needed. Some of the identified barriers included difficulty recognizing symptoms and what care people needed, difficulty finding information, confusion over entitlements, feelings of embarrassment over seeking professional help, and lack of time or financial means.

In response to the situation, NUDZ planned a campaign to motivate people to look after their mental health by increasing their knowledge about symptoms and skills in self-care and helping others in need. NUDZ mapped available psychosocial services (over 250 in total for Ukrainian speakers) in Czechia and created an interactive online dashboard. To popularize the usage of the dashboard, they targeted two audiences: service providers, and people receiving support and affected communities. The service providers received information about the map and a QR code or the link to the map for publishing on their websites. NUDZ distributed over 10 400 flyers and 100 posters at the Regional Employment Offices. At the same time, people receiving support were informed via community meetings, events and charity organizations. Information about the map was published in the media and on social media platforms, with Instagram showing higher engagement rates compared to Facebook or Telegram.

Several challenges NUDZ faced during the response included not being able to measure what interventions motivated people the most to seek care. Also, they faced a lack of experts with knowledge of the Ukrainian language and culture available to work on the activity. NUDZ’s brand was not well-known among the refugee community limiting their direct engagement. Posts published on social media by NUDZ did not receive much engagement from the Ukrainian refugees. The institute recognized more potential in targeting Ukrainians within their frequented networks that were popular and used by Ukrainians, and not assuming that networks popular among the host communities would be known among the refugees.
Overall, the key learning points for NUDZ from the implementation were to:

- connect with established brands and use sources already known among the target community;
- utilize word-of-the mouth more as it is the most effective mode to share information among refugees; and
- connect more with local groups and communities (e.g., regional service providers, psychotherapists, schools, etc.).

**CBRN preparedness.** The WHO Country Office in Ukraine presented its RCCE-IM activities as part of CBRN preparedness in the country. The possibilities of the use of CBRN weapons have been heightened since the beginning of the invasion.

Zaporizhzhia nuclear power plant currently located in the occupied territories of Ukraine poses a constant danger of a potential nuclear explosion or other events, radiological and nuclear burn, population displacement and a large-scale impact on communities. While the preparedness for a potential event at the nuclear plant is coordinated by the Government, the WHO Country Office in Ukraine contributed to preparedness activities, including on RCCE-IM. In support of the MoH of Ukraine, the WHO Country Office in Ukraine developed materials on nuclear and radiation protection, including on the proper use of potassium iodide (KI) tablets. Social listening findings showed instances of inappropriate use of KI tablets prompting the release of this health advice. Materials were shared on the MoH’s social media channels and reached large online audiences. In addition to two social media outreach campaigns, 350 000 pocket-size leaflets with essential information were printed and distributed.

The WHO Country Office in Ukraine noted that the management of public risk perception in Ukraine and neighbouring countries was one of the challenges in CBRN preparedness. It was important to avoid alarm or outcry while providing people with information on how to protect themselves in case of CBRN events. Another challenge was the overwhelming amount of information and advice from various, often unreliable sources, potentially minimizing the visibility and effect of essential advice: go inside, stay inside and stay informed. Keeping information short and simple was essential as people’s ability to process information drops significantly under stress. Risk communication specialists need to work with technical experts to avoid technical language and keep materials simple.

To evaluate the effectiveness of the deployed RCCE-IM interventions for preparedness, the WHO Country Office in Ukraine conducted two focus group discussions with 18 people staying in shelters from the Donetsk and Zaporizhzhia regions. The insights showed a prominent level of knowledge among participants about key steps to take in case of a nuclear or radiological incident and the proper use of KI pills. They also showed that people residing in shelters found printed materials to be a valuable source of information. Personal communication and direct engagement with communities were other important practices to deliver information to people.

During the discussion, a participant from Romania shared experience of panic in the country after hearing the news about a potential event at the Zaporizhzhia nuclear power plant in Ukraine. Romanians wanted to take KI pills. To address such a situation, the MoH of Romania held a briefing warning against stockpiling KI pills and reassuring people the stocks were available should the event occur. As stated by the participant from Romania, there was high trust in the government’s advice given the previous experience of them effectively responding to a gas explosion that saved people’s lives.
Key takeaways

• Health information release should be timed based on both health needs and perceptions, to increase the likelihood that receivers act on them.

• Even if health may not be the most immediate priority for people who are fleeing conflict, lifesaving health information on urgent issues, such as trauma and injury care, as well as treatment for noncommunicable diseases, including access to medicines and continuation of care, should be released at the onset of the emergency to mitigate health risks and connect people to health services.

• Both digital and printed materials can be relevant for targeted audiences, communicating through channels that are preferred by and accessible to the audiences when needed is important to timely reach them.

• In a high-risk situation such as a possible CBRN event, a major challenge is raising risk perception without alarming people. It is essential that national authorities prioritize the most important health advice to share with the public, keeping it clear and simple, and acknowledging the uncertainty.

• Engaging in outreach activities within spaces commonly frequented by refugees yielded more effective results compared to initiatives organized by CSOs in venues of their choosing. This is mainly because local CSOs that were previously established in the host countries and recognized within the host communities are often not well known among refugee populations.
**Breakout room discussion: Multi-hazard preparedness in conflicts – nuclear emergencies, winterization, respiratory diseases, food and water safety, and cholera**

In this session, participants were grouped into five teams and tasked with identifying crucial preparedness activities for specific hazards, namely nuclear emergencies, winterization, respiratory diseases, and the hazards of food- and water-borne diseases, and cholera. The following points summarize discussions and the resulting recommend actions.

Regarding nuclear emergencies, it was recommended to:

- increase the role of TV, radio and text messages as sources of information;
- compose short, simple messages and test with target audiences;
- begin communication immediately after identifying potential risks;
- alert but do not alarm to avoid inciting panic; and
- address false information as it may spread even faster in this type of emergency compared to others.

Regarding winterization, it was recommended to:

- identify target audiences, especially vulnerable populations (e.g., homeless people)
- prepare health materials and advice on priority topics in advance
- focus on delivering localized information to people about available spaces to warm up
- create a helpline to provide information related to cold weather conditions
- provide safety information on using heating devices
• communicate on how winter conditions may affect livelihood and health
• prepare health materials to communicate about seasonal diseases such as influenza.

Regarding respiratory diseases, it was recommended to:
• plan and prepare messages before the winter season begins;
• identify target audiences (e.g., vulnerable groups such as children, elderly, refugees, minority groups and health workers);
• target advice on preventive measures based on the risk (e.g., hand hygiene, avoiding crowded spaces, proper use of masks as needed) and vaccination;
• include messaging on the proper use of antibiotics;
• utilize special events as opportunities to disseminate information (e.g. European Antibiotic Week); and
• engage with CSOs to reach vulnerable communities.

Regarding food- and water-borne diseases, it was recommended to:
• develop an RCCE-IM plan for food and water-borne diseases before an outbreak
• deliver timely update to the population about the spread of the disease
• acknowledge the uncertainty of the situation that may evolve
• address false information immediately.

Regarding cholera, it was recommended to:
• identify the target audience, main information needs and relevant outreach channels;
• communicate preventive measures, food and water safety advice;
• develop and test messages in advance using both online and offline tools; and
• involve partners at community level (e.g., schools, churches, universities, community leaders, etc.) to deliver messages.
Plenary session – Engaging communities and influencers

Moderator: Irem Karakaya, RCCE-IM Consultant, WHO Regional Office for Europe

Speakers:
- Zhivka Getsova, Expert, Epidemiology, National Center for Parasitic and Infectious Diseases, Bulgaria
- Oksana-Valentyna Kurnyk, Project Coordinator, CSO Зустріч [meeting], Poland
- Nadiia Timoshenko, Public Health Programs Manager, Light of Hope, Ukraine
- Iryna Kaskova, Cultural Mediator, WHO Country Office in Romania
- John Joseph Cordey, Risk Communication and Community Engagement Officer, WHO Country Office in Romania

Setting the scene

Community Engagement embodies the collaborative process to co-design and co-deliver interventions with affected communities and community actors to empower them to be resilient to current and future health emergencies.

By leveraging the power of human relations and interactions, community engagement fosters trust, well-being, a sense of belonging, social cohesion and acceptance of protective behaviours. Establishing effective connections with communities via mediators and trusted influencers can significantly impact community well-being and behavioural change. These connections contribute to a better understanding of communities, including a deep knowledge of the local and cultural context and community needs. Mediator and trusted influencer proximity to communities helps to build respect and trust, creates a wider outreach to vulnerable populations and encourages a participative approach to decision-making.
The session highlights how engaging with communities, particularly vulnerable ones such as refugees and internally displaced people, is vital in accessing health information and services, and the uptake of health advice during emergency response. The effects of a crisis or an emergency tend to weigh more heavily on individuals and communities already facing underlying vulnerabilities. Amid emergencies, community voices can be unheard, leading to their needs being invisible in decision-making; hence, fostering community engagement is crucial for amplifying their needs and preventing neglect.

The session engaged experts from a government institution in Bulgaria, CSOs from Poland and Ukraine and the WHO Country Office in Romania, illustrating successful examples of community engagement both in Ukraine and refugee-receiving countries.

**Collaboration with trusted community actors.** The National Center for Parasitic and Infectious Diseases of Bulgaria presented the collaboration with various partners such as United Nations agencies, medical associations, media, CSOs, regional health inspectorates and regional health centres that contributed to Bulgaria’s aim of reaching the most vulnerable. Successful partnership with community influencers, health-care workers’ and health institutions facilitated refugees’ access to health services. Working together with CSOs to deliver health information to refugees was key due to their proximity to, and the trust gained in, communities. Making use of media, another trusted voice in the eyes of communities, the government of Bulgaria disseminated news in Ukrainian via a national TV station. Another effective example of community actor involvement was teachers’ engagement with Ukrainian students’ parents to promote student immunization.

**Influence and impact of cultural initiatives and mediation.** The Polish CSO Зустріч [meeting] used the power of culture by organizing numerous cultural initiatives, such as music, theatre and photography exhibitions for both Ukrainian and Polish people, to support social cohesion. Working with municipalities, influencers and other CSOs, the organization widened its reach to Ukrainian refugees on a number of essential topics, including seeking health care. They focused on vulnerable groups such as older people and children, the voices of whom were often overlooked. The CSO also provided a platform to connect host and refugee populations through activities such as fitness, art therapy and language classes. Among their focused efforts, the CSO prioritized enhancing existing systems to provide benefits to both refugees and host nationals, thereby promoting inclusivity and collaboration within the community.

The WHO Country Office in Romania and the MoH of Romania hired cultural mediators with Ukrainian, Russian and English language skills to learn the needs of refugees. They also hired Romanian-speaking people as county coordinators to facilitate access to health services for refugees. The county coordinators liaised with local authorities, medical providers and humanitarian organizations, following up on the needs identified by cultural mediators among refugees at county level. This coordination resulted in more than 600 mapped out refugee-inclusive health services which were made available on the UNHCR’s Service Advisor platform (5). Apart from making services visible to refugees, county coordinators also conducted meetings with family doctors and municipality representatives to discuss issues reported by refugees to cultural mediators and jointly present them to national authorities.

Human-to-human interaction was key in the response activities in Romania to ensure refugees’ access to health care. Cultural mediators with psychological or medical professional backgrounds and knowledge of both Ukrainian and Romanian health-care systems facilitated appointments, accompanied patients and provided psychosocial support through individual counselling, group
therapy, art therapy and activities. Cultural mediators linked people in need to health-care service providers helping to mitigate language barriers. They responded to differing needs and improved understanding of the Romanian health-care system. At times, individuals required personalized attention, assurance and support. Feeling acknowledged and understood holds immense significance, as it fosters trust and bolsters confidence.

Cultural mediators supported social listening with refugees from Ukraine in Romania by conducting a survey on their knowledge and experience in accessing health services. The identified challenges included accessing primary health care. The information was communicated to health-care providers and authorities who could inform follow-up actions.

**Reaching out to communities.** Since the start of the war, the Ukrainian CSO Light of Hope has shifted its routine health promotion activities to engagement-centred ones. The routine health promotion activities fell short of responding to people’s health needs as the war shifted people’s focus away from their health. On top of the overstretched health-care system, disrupted medicine supply chain, poor shelter and livelihood conditions, the rising number of internally displaced populations within the country and the growing number of medical professionals leaving the country aggravated health needs. The organization introduced mobile health teams that supported communities via various medical services and tackled misinformation. Communities were provided with information regarding scheduled vaccination and consultation dates through mobile health teams, utilizing social media in the areas that internet was available. In the areas with no internet access, communities were reached via printed materials.

Thanks to mobile health teams in the field, Light of Hope was able to put the communities’ various needs at the centre of their operation and adapt quickly if needs changed. In addition to health-care workers, the presence of social workers in the mobile teams helped effective communication with communities. Another good practice was making services available for both internally displaced populations and the host communities and promoting this.

**Key takeaways**

- RCCE-IM interventions need to harness the power of human connections and interactions. Vulnerable populations, such as refugees and the older people among them, require a "human anchor" to open, believe and accept protective behaviours.

- Enhancements to systems and services tailored to the collective needs of refugees, internally displaced populations and host communities have proven effective in nurturing social cohesion.

- Collaboration with different partners and community actors can expand outreach to affected communities, especially the most vulnerable.

- Cultural initiatives help contribute to social cohesion between host and affected communities.

- Direct interaction with communities and bringing health-care services closer to them helps to create trust, tackle misinformation and adapt interventions to community needs.

- Working with cultural mediators is a successful practice that facilitates access to health, fostering trust and bolstering confidence within the affected communities. Cultural mediators ideally should have psychological or medical professional backgrounds and knowledge of both refugee- and host-country health-care systems.
Breakout room discussion: Trust building between host communities and refugees/internally displaced people

In this session, participants were grouped into five teams and tasked with coming up with innovative practices from their experience; a lesson drawn from their experience in the context of Ukraine’s war response; and a suggestion on dealing with negative sentiments, collaboration between governments and CSOs and engaging health workers for positive behaviour change. The following points summarize discussions and the resulting recommended actions.

Regarding social cohesion, it was recommended to:

• increase funding for and frequency of communication around social cohesion;

• strengthen feedback mechanisms, conduct social listening to monitor negative sentiment, and the source of arising negative sentiments, and design activities in response to these social listening insights;

• conduct community-based activities including cultural exchange activities among youth, involving host populations and refugees to promote togetherness and including vulnerable populations and minority groups in social cohesion activities;

• engage influencers and trusted community leaders, including religious leaders, to deliver messages of inclusion from both host communities and refugee communities/internally displaced populations;

• launch media campaigns and documentaries, if possible, to highlight commonalities between host communities and refugees/internally displaced people;

• deliver training on cultural sensitivity, inclusion of the most vulnerable and empathy to those actors who are frequently in touch with refugees, such as teachers and health-care workers;
• train journalists on using destigmatizing language and inclusion stories, and consider awarding those publishing inclusive stories and articles to encourage positive coverage.

Regarding **government–CSO partnership for community engagement preparedness and response**, it was recommended to:

• form a strong coordination mechanism between all stakeholders involved (i.e., government, international organizations, local organizations), organize regular technical working group meetings and exchange of information, establish effective reporting mechanisms and foster linkages between various sectors for comprehensive solutions;

• map out relevant stakeholders based on their area of work – divide roles and tasks between all to avoid overlapping and ensure that all gaps are filled and all needs are addressed;

• increase collaborative rapport, joint initiatives and synergy between stakeholders (especially between international and local CSOs) to ensure that activities align effectively with the nuances of the local context; and

• prioritize preparedness activities (including meetings, workshops and simulations) in times of peace to develop a response strategy detailing the division of work between relevant parties.

Regarding the **engagement of health-care workers for behaviour change**, it was recommend to:

• leverage the expertise and credibility of Ukrainian health-care workers who have relocated to refugee-receiving countries – these professionals already command trust and respect within the Ukrainian community and can effectively disseminate key messages within their respective refugee communities;

• train health-care workers to recognize their potential influence over communities, be trust builders and role models, encourage positive behaviour change in health-related matters and communicate effectively;

• map health-care worker influencers and involve them in existing or planned communication, media and health campaigns;

• encourage health-care workers to use social media to reach and engage with existing health networks, student organizations and CSOs and to collaborate with other community actors who have a certain influence over communities; and

• highlight the influence of health-care workers on communities in curriculums, medical societies and roundtables.
Panel discussion – Partner coordination for RCCE-IM in humanitarian emergencies

Moderator: Cristiana Salvi, Regional Adviser on RCCE-IM, WHO Regional Office for Europe

Speakers:
- Joanna Głażewska, Deputy Director, Department of Public Health, MoH, Poland
- Sakun Gajurel, Risk Communications Officer, WHO Country Office in Ukraine
- Catalin Bercaru, Communication Officer, ECDC
- Lucia Fulierova, Project Manager, Equita, Slovakia

The panel discussion focused on the experience of partner coordination in response to Ukraine’s emergency. The moderator stressed the need for coordination to be inclusive and structured with roles and responsibilities clearly divided. Establishing technical working groups within larger coordination mechanisms could streamline coordination processes. Mapping partners, their expertise and resources was mentioned as an essential step in setting up partner coordination mechanisms. Effective leadership, making space for CSOs to participate and building bilateral relationships were noted as key to sustaining partnerships.

Various coordination forums were established in Poland as a part of the health response to Ukraine’s emergency. It was mentioned that “coordination of coordination” was needed to better
streamline processes, get partners to know each other and complement each other’s work rather than duplicate. Strong coordination is particularly important for cross-country situations such as refugee crises. Bringing everyone to the table as early as possible was identified as one of the lessons for Poland. The MoH of Poland naturally emerged as the first point of contact for health-related issues when refugees started arriving in the country.

As noted by ECDC, one of the considerations in partner coordination was the turnover of partners and agencies over time. At a very acute phase, the response happened organically with many entities participating, but that had reduced over time. RCCE-IM should be planned in coordination with health and non-health actors, for example, CSOs, who were the first point of contact for refugees. Getting to know partners and their priorities helped strengthen the coordination.

Bringing the perspective of a CSO, Equita from Slovakia shared an example of an effective partnership between multiple actors with different strengths resulting in a higher demand for hepatitis testing among refugees from Ukraine. For example, WHO provided tools and expertise, and Equita helped provide a physical space for testing at the health clinic. This resulted in over 450 tests completed up to date.

The WHO Country Office in Ukraine shared an example of coordinating the Technical Working Group on RCCE-IM with the MoH of Ukraine participating. Since the beginning of the response in Ukraine, this group served as a platform to understand needs, priorities and required action. The initiative helped align messages and share health materials with partners on different topics (e.g., vaccination, winterization, mental health and psychological first aid, CBRN, etc.). In this case, the materials could be rapidly released if needed, saving time.
Way forward and final recommended actions

The two-and-a-half-day meeting showed the power of peer-to-peer learning to inspire impactful RCCE-IM approaches, drawing from shared experiences within the emergency response in Ukraine and refugee-receiving countries. Participants from national health authorities, CSOs and international organizations stressed that listening to communities, creating effective risk communication products, building trust, and listening to and empowering communities are essential parts of any intervention for equitable health and well-being during humanitarian emergencies.

The plenary sessions, panel discussions and breakout room sessions presented practical and effective RCCE-IM interventions that hold the potential for adaptation and implementation both in the context of Ukraine’s war and beyond. The will and commitment of governments, CSOs, WHO and partners to support Ukrainian people affected by the almost two-year-long war, backed up by resolute implementation on the ground, remains a pivotal factor for reaching the most vulnerable communities in Ukraine and refugee-receiving countries.
Strategic actions in the continued Ukraine emergency response

Moderators:

• Cristiana Salvi, Regional Adviser on RCCE-IM, WHO Regional Office for Europe
• Anna Postovoitova, RCCE-IM Consultant, WHO Regional Office for Europe

In the final breakout session, participants were separated into groups with the objective of pinpointing strategic measures in the ongoing phase of emergency response in Ukraine and neighbouring countries to bolster community resilience. The following points provide the summary of discussions and the resulting recommendations.

In Ukraine

1. Design interventions on the reintegration of returnees and veterans: Develop and execute projects specifically designed to provide support for individuals returning to their habitual place of residence and for veterans facing challenges while reintegrating into civilian life, connecting them to health information and services.

2. Promote access to mental health and psychosocial support for people affected by the war. Prioritize RCCE-IM actions that aim to:
   • normalize seeking mental health support, specifically among veterans, their families and families who have lost loved ones;
   • facilitate people’s access to mental health and psychosocial support services;
   • equip families of who are assisting in the care and treatment of their loved ones facing mental health challenges with information on how to provide support for their recovery;
   • support families of who are assisting in the care and treatment of their loved ones with information and services on how to take care of their own mental health; and
   • support individuals coping with the loss of a loved one with mental health services and information.

3. Reduce stigma and discrimination against people with physical disabilities through targeted activities and programs: Plan activities that ensure protection, inclusion and respect of the rights of people with disabilities and increase their visibility by normalizing the image of people with disabilities in public spaces.

4. Establish preparedness activities for potential health hazards: Formulate RCCE-IM interventions to address risks like CBRN incidents, cholera outbreaks, food and water safety issues, and other health challenges prevalent in humanitarian crises.

Refugee-receiving countries

1. Advocate for active leadership in RCCE-IM coordination:
   • enhance and maintain government, CSO and interagency communication and coordination for aligned actions;
   • promote an RCCE-IM technical working group for consolidated actions, and creating and
aligning standard operating procedures for an inclusive, comprehensive and consistent response for current and future emergencies;

• secure financial and human resources to sustain RCCE-IM efforts and build RCCE-IM capacity;
• continuously monitor and document the incoming and outgoing refugee statistics, gather evidence, strategize for humanitarian action, and adapt the response plan accordingly; and
• review the response, refine solutions, advocate for legal and policy reforms and come up with lessons learned for future emergency preparedness and response.

2. Continuously communicate changes in access to health-care systems and available services, and tailor advice to both newly-arrived refugees and those staying long-term:

• create a centralized health information hub for streamlined access;
• disseminate content developed by multiple stakeholders to foster trust and maintain consistent messaging;
• focus on preventive services and building health literacy in communication to refugees and host communities;
• ensure changes and updates in the health system are communicated to the target population in a timely manner;
• increase cooperation with media to produce health content that informs refugees about changes in the health system and available health services;
• advocate for the dissemination of health information and advice in locations commonly frequented by refugees, such as schools and workplaces; and
• identify obstacles to accessing health information and advice and take steps to address them.

3. Prioritize social cohesion, inclusion and better communication between host and refugee communities:

• plan interpersonal skills activities for health workers working with refugees for effective communication and engagement with communities;
• tailor the information provided to foster social cohesion between refugees and host communities, while also facilitating the integration of refugees in the host country;
• plan collaborative events that unite host communities and refugee populations, fostering opportunities for interaction and mutual understanding;
• ensure inclusivity and integration by involving the Ukrainian expat community in events and activities aimed at supporting refugees to foster a sense of trust, belonging and solidarity among all members of the community;
• promote the establishment of community centres that serve as comprehensive hubs for refugees, offering multiple services in one location;
• support refugees with local cultural and legal information and introduce different practices in the host country;
• organize language courses and community-based activities aimed at facilitating language
acquisition for refugees, aiding in overcoming language barriers in the host country;

- provide the right resources, information and communication to host communities; and

- prioritize peer-to-peer communication via cultural mediators and personnel guiding patients that can facilitate access to health services and address language barriers.

4. Enhance social listening and infodemic management:

- conduct online and offline social listening, needs assessments and/or BCI studies on a regular basis to gather insights from the host and refugee communities on the behaviours and needs of refugees;

- capture information gaps, rumours, dis- and mis-information within refugee and host communities to detect potential risks for preparedness and address them promptly;

- collaborate with fact-checkers including CSOs to verify circulating narratives; and

- make sure accurate messages are timely distributed across official platforms.

5. Expand the reach and delivery of services to vulnerable groups within refugee and host communities through community stakeholders:

- identify CSOs that can be engaged to connect with vulnerable groups both in refugee and host communities now and in anticipation of potential refugee influxes;

- engage with local influencers, such as public authorities, health-care workers, community leaders and other trusted community actors to promote the uptake of health advice among vulnerable populations within refugee and host populations.
Final recommended actions for RCCE-IM in humanitarian emergency response

In this part of the breakout session, participants were also tasked with generating up to 10 recommended actions for designing an RCCE-IM response from the onset of a humanitarian emergency. The following points summarize the discussion and the resulting recommended actions.

1. Leadership and coordination:
   - establish and activate an RCCE-IM coordination structure in support of national health authorities and define a clear processes and responsibilities in response operations;
   - identify relevant partners to work together and leverage available RCCE-IM resources;
   - identify skilled and knowledgeable personnel trained in RCCE-IM to engage in the response; and
   - map relevant actors, partners and influencers.

2. Understanding at-risk population needs and concerns:
   - As soon as the security situation permits, reach affected population groups to understand their needs and concerns and continue social listening activities through first-line responders and workers in the field who have direct links to affected populations;
   - establish regular two-way communication mechanisms with affected communities (e.g., field visits, national and local hotlines, focus group discussions, face-to-face interviews, via groups on social media);
   - collect data from the communities in a coordinated, collaborative and shared manner between partners – focus on essential questions and immediate needs;
   - analyse data, synthesize key insights on priority health needs and communicate them with partners through coordination mechanisms; and
   - use collected insights in a timely manner to inform RCCE-IM and the broader emergency response.

3. Health information and advice:
   - prioritize key messages on priority topics relevant to people in an acute emergency situation (e.g., first medical aid, psychological first help, access to medicine for chronic diseases, shelter services etc.);
   - release health information and advice in the right amount and at the right time to make sure target audiences are ready to receive and act on it;
   - within the first weeks of an emergency prepare health advice on available health services, including on mental health support, and how to access them – plan to release more health advice as the situation evolves and health needs change;
   - develop short, simple, visual and to-the-point messages – focus on essential protective measures, taking into consideration the potential low attention span of people in distress;
• have materials that can be easily translated into different languages and adapted to different dissemination formats – digital or printed;
• conduct message testing with affected populations;
• prepare messages for those who want to help (e.g., volunteers, host communities who want to help) on how to engage with the affected population and communicate in a culturally sensitive way;
• communicate transparently on the evolving situation, particularly related to health risks and public concerns, even in times of uncertainty; and
• in line with the ongoing risk assessment, continue preparing relevant health information and advice for identified health hazards (e.g., CBRN events, food- and water-borne disease outbreaks due to damaged infrastructure, etc.).

4. Outreach and dissemination:
• identify target population groups and relevant communication channels to reach them;
• diversify communication channels and formats of delivery (offline via community meetings and one-on-one interactions, social media, other digital channels, printed materials, etc.) taking into consideration possible internet and mobile network disruption;
• prioritize human-to-human interaction, whenever possible;
• ensure communication channel accessibility and relevance to needs (e.g., a one-stop information website, helpline, etc.); and
• map and engage regularly with trusted community groups such as religious leaders, community mediators, local formal and informal leaders, health-care workers, social workers, volunteers, national CSOs and secondarily affected populations.

5. Infodemic management:
• establish monitoring mechanisms to track false information, websites and other sources spreading them – sieve through false information relevant to health; and
• fact-check, prebunk and debunk false information that may have a dangerous impact on people’s health.
References


All references were accessed on 22 March 2024.
Annex 1. List of participants

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**Stickybeak**
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Co-founder

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WHO Country Office in Ukraine
Sakun Gajurel
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Ivanna Pavliuk
Risk Communication and Community Engagement Consultant
### Annex 2. Meeting agenda

**DAY 1 – Lifesaving risk communication, community engagement and infodemic management (RCCE-IM) interventions in humanitarian emergencies**

<table>
<thead>
<tr>
<th>Times</th>
<th>Agenda item</th>
<th>Resource person</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30–09:00</td>
<td>Registration</td>
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<tr>
<td>09:00–09:30</td>
<td>Welcome and opening remarks</td>
<td>Katarzyna Drążek-Laskowska, Director of the Department of International Cooperation, Ministry of Health, Poland</td>
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<td>Nino Berdzuli, WHO Representative in Poland and Special Envoy for Ukraine’s emergency response</td>
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<td></td>
<td>Jarno Habicht, WHO Representative in Ukraine (recorded video)</td>
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<tr>
<td>09:30–09:45</td>
<td>Group photo</td>
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<tr>
<td>09:45–10:30</td>
<td>Setting the scene</td>
<td>Heather Jue-Wong, Project Management Officer, Ukraine’s emergency response, WHO Regional Office for Europe</td>
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<td></td>
<td>Cristiana Salvi, Regional Adviser on RCCE-IM</td>
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<tr>
<td>10:30–11:00</td>
<td>Coffee break</td>
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</tr>
<tr>
<td>11:00–12:30</td>
<td>Plenary session 1: Generating evidence: strategies to assess people’s perceptions and behaviours</td>
<td>Corina Gamurari, Main Consultant, Information and Mass Media Communication Unit, Ministry of Health, Republic of Moldova</td>
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<td>Angela Costandache, Specialist, Foreign Assistance Department, Ministry of Health, Republic of Moldova</td>
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<td>Martha Scherzer, Consultant, Behavioural and Cultural Insights, WHO Regional Office for Europe</td>
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<td>Agnieszka Sochon, Social and Behaviour Change Specialist, United Nations Children’s Fund (UNICEF) Poland</td>
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<td>Oksana-Valentyna Kurnyk, Project Coordinator, civil society organization Зустріч [meeting], Poland</td>
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<td>12:30–13:30</td>
<td>Lunch break</td>
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<tr>
<td>13:30–14:30</td>
<td>Breakout rooms 1: Evidence generation in a humanitarian emergency: tools, methodologies, capacities and data utilization</td>
<td>Stefan Voinea, Infodemic Management Officer, WHO Regional Office for Europe</td>
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<td>Reporting back to the plenary</td>
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</table>
Panel discussion 1: Matching health information and advice to community’s needs

- Joanna Głażewska, Deputy Director, Department of Public Health, Ministry of Health, Poland
- Vita Kolomiets, Head of Communications, Ministry of Health, Ukraine
- Olexander Babenko, Head of Health and Care Department, Ukrainian Red Cross Society
- Andrei Eșanu, Head, Federation of Families for Peace, Republic of Moldova

Moderator: Cristiana Salvi, Regional Adviser on RCCE-IM, WHO Regional Office for Europe

Coffee-break

Plenary session 2: Supporting people’s access to health services in an acute emergency

- Joanna Głażewska, Deputy Director, Department of Public Health, Ministry of Health, Poland
- Yana Ishchenko, Communication Officer, Public Health and Emergency Response, Ministry of Health, Ukraine
- Alja Polajžer, Center for the Communication, National Institute of Public Health, Slovenia
- Daniela Madan, Consultant, WHO Country Office in Republic of Moldova
- Lucia Fulierova, Project Manager, Equita, Slovakia

Moderator: Olha Izhyk, Risk Communications Officer, WHO Regional Office for Europe

Close of day one: summary of key points and housekeeping announcements

WHO Regional Office for Europe

Dinner

DAY 2 – Planning and coordination of RCCE-IM in humanitarian emergencies

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<thead>
<tr>
<th>Time</th>
<th>Agenda item</th>
<th>Resource person</th>
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<tr>
<td>09:00–09:30</td>
<td>Plenary session 3: Supporting health protection on priority topics</td>
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<td>• Szymon Cienki, Director, Office of the Chief Sanitary Inspector, Poland</td>
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<td>• Nikola Zwrtková, Head of Communications Department, National Institute of Mental Health, Czechia</td>
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<td>• Sakun Gajurel, Risk Communications Officer, WHO Country Office in Ukraine</td>
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<td>• Nadezhda Todorovska, Deputy Director General, Head of Social Welfare and Operational Activities Division, Bulgarian Red Cross</td>
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<td>11:00–11:30</td>
<td>Guest speaker: Message testing in crises</td>
<td>Presenter: David Talbot, Co-founder Stickybeak, Director Talbot Mills Research</td>
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<tr>
<td>11:30–12:30</td>
<td>Breakout rooms 2: Multi-hazard preparedness in conflicts: nuclear emergencies, winterization, respiratory diseases, food and water safety, cholera Reporting back to the plenary</td>
<td>Moderator: Olha Izhyk, Risk Communications Officer, WHO Regional Office for Europe</td>
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<tr>
<td>12:30–13:30</td>
<td>Lunch break</td>
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<tr>
<td>13:30–15:00</td>
<td>Plenary session 4: Engaging communities and influencers</td>
<td>Moderator: Irem Karakaya, Consultant, RCCE-IM, WHO Regional Office for Europe</td>
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<td></td>
<td>• Zhivka Getsova, Expert, Epidemiology, National Center for Parasitic and Infectious Diseases, Bulgaria</td>
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<td>• Iryna Kaskova, Cultural Mediator, WHO Country Office in Romania</td>
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<td>• John Joseph Cordey, Risk Communication and Community Engagement Officer, WHO Country Office in Romania</td>
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<td></td>
<td>• Nadiia Timoshenko, Consultant, Light of Hope, Ukraine</td>
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<td>• Oksana-Valentyna Kurnyk, Project Coordinator, civil society organization Зустріч [meeting], Poland</td>
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<td>15:00–15:30</td>
<td>Coffee-break</td>
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<td>15:30–16:30</td>
<td>Breakout room 3: Social cohesion: trust building between host communities and refugees/internally displaced people Reporting back to the plenary</td>
<td>Moderator: Irem Karakaya, Consultant, RCCE-IM, WHO Regional Office for Europe</td>
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<tr>
<td>16:30–17:30</td>
<td>Panel discussion 2: Partner coordination for RCCE-IM in humanitarian emergencies</td>
<td>Moderator: Cristiana Salvi, Regional Adviser on RCCE-IM, WHO Regional Office for Europe</td>
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<td></td>
<td>• Joanna Głażewska, Deputy Director, Department of Public Health, Ministry of Health, Poland</td>
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<td>• Cornelia Cirlescu, Counsellor for the External Relations and International Affairs Unit, Ministry of Health, Romania</td>
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<td>• Sakun Gajurel, Risk Communications Officer, WHO Country Office in Ukraine</td>
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<td>• Catalin Bercaru, Communication Officer, European Centre for Disease Prevention and Control</td>
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<td>• Lucia Fulierova, Project Manager, Equita, Slovakia</td>
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<td>17:30–17:45</td>
<td>Close of day two: summary of key points and housekeeping announcements</td>
<td>WHO Regional Office for Europe</td>
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<td>19:00–20:30</td>
<td>Dinner</td>
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# DAY 3 – Lessons learned, recommendations and the way forward

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda item</th>
<th>Resource person</th>
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<tbody>
<tr>
<td>09:00–09:30</td>
<td>Summary of the two days: RCCE-IM best practices and interventions</td>
<td>Presenter: Anna Postovoitova, Consultant, RCCE-IM, WHO Regional Office for Europe</td>
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<tr>
<td>09:30–11:30</td>
<td>Breakout rooms 4: Lessons learned and way forward</td>
<td>Moderator: WHO Regional Office for Europe</td>
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<tr>
<td></td>
<td>• Identifying key learnings from Ukraine’s emergency response</td>
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<td>• Defining specific interventions for humanitarian response vs health emergency response</td>
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<td>• Standard operating procedures</td>
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<td>• Discussing opportunities to sustain RCCE-IM capacities in crisis and beyond</td>
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<td>• Composing final recommendations for RCCE-IM in humanitarian emergencies</td>
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<td>11:30–12:45</td>
<td>Group presentations to the plenary and final recommendations</td>
<td>Moderator: WHO Regional Office for Europe</td>
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<td>12:45–13:00</td>
<td>Closing remarks</td>
<td>WHO Regional Office for Europe</td>
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<td>13:00–14:00</td>
<td>Lunch</td>
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The WHO Regional Office for Europe

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.

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