World Health Organization
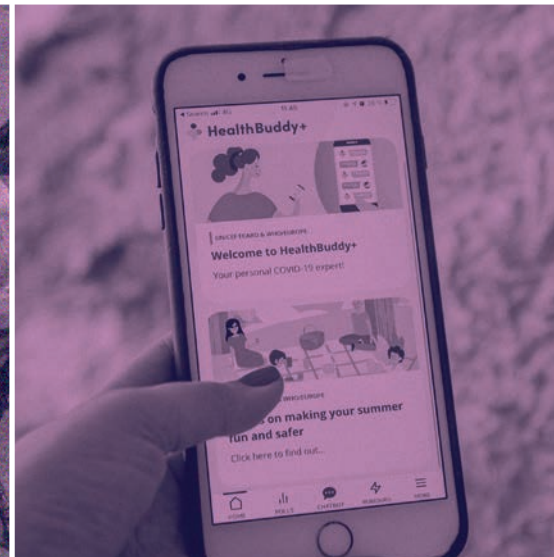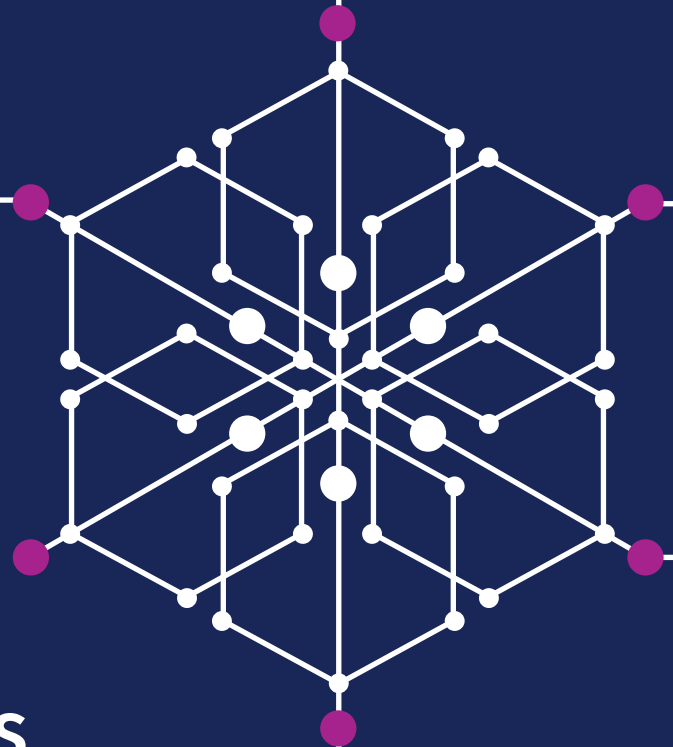
European Region

Risk communication and community engagement:
a compendium of case studies in times of COVID-19

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Contents

Foreword

This collection of case studies on risk communication and community engagement (RCCE) from 18 different country/ area level public health partners in the WHO European Region provides evidence of numerous results achieved and lessons learned since the start of the COVID-19 pandemic. RCCE has not traditionally been an area where evidence of challenges and solutions was documented. With this compendium, we wanted to collect and share this evidence to support decision-making in this area of work.

In early 2020, as WHO was building its teams to respond to what became the COVID-19 pandemic, we positioned RCCE as a core cross-cutting function. This meant that RCCE experts at country/area, regional and global levels worked closely with their biomedical colleagues across all aspects of the response: from case finding, testing and contract tracing to prevention measures, self-care, home-care, treatment and roll out of COVID-19 vaccines. Hard-earned experience from earlier health emergencies, such as outbreaks of Ebola, measles, Middle East Respiratory Syndrome (MERS) and H1N1 pandemic influenza, taught us that communities are central to emergency control, and effective RCCE is a prerequisite for all these interventions to succeed – and ineffective RCCE can doom them to failure. Much of the best work done by WHO in the European Region during the COVID-19 pandemic has been a result of mainstreaming RCCE across the entire emergency cycle.

There are many conclusions to draw from the assembled evidence and experience – and these are neatly brought together in the "Lessons learned" section. Nevertheless, we would like to highlight five key learnings here:

• RCCE has never been so vital as a public health intervention and never so high on government agendas as during the COVID-19 pandemic. Its role in health emergency preparedness and response will never be the same as before the pandemic.

• Designing effective RCCE interventions is a highly skilled technical area and can determine the success of the entire health emergency response. Doing it well requires a methodical, evidence-led approach along with technical knowledge of RCCE and public health. It is a core cross-cutting capacity within the emergency cycle needed to facilitate the success of various different interventions. For example, effective RCCE supports compliance by communities and individuals with recommended prevention measures, or their cooperation with testing and contact tracing.

• The investments that WHO and its country/area level partners in the European Region made in RCCE capacity-building in the years before the pandemic have paid dividends since 2020. In this compendium, you can find examples of those country/area level partners using their RCCE capacities to reach vulnerable groups, counter misinformation, maintain high levels of public trust and, ultimately, empower communities to protect themselves from the pandemic.

• There is still more to do in further strengthening country/area-level RCCE capacities and continuing to improve the impact of RCCE interventions. Many country/area level partners have built strong RCCE capacities, but the picture across the Region is highly variable. Not all country/area level partners have invested in building a team of skilled RCCE professionals or developing the systems and partnerships needed for high-quality RCCE.

• The amount of data and other evidence collected on the reach and impact of RCCE during this pandemic is unprecedented. But there are still gaps in the data and many areas where the evidence-led approach to RCCE could be further improved.

This compendium is the result of many dozens of interviews with frontline RCCE practitioners at local, country/area level and international level. Interviewees have included staff of civil society organizations, religious leaders and academics as well as officials in public health authorities, WHO and other United Nations agencies.

During a health emergency, protecting the population and mitigating the health threat are always the top priority. However, each emergency response is an opportunity to learn and improve. Our exercise in documenting the activities that were conducted on RCCE and the impact this had during the COVID-19 pandemic has identified much we can learn from. There is plenty of good practice we can share more widely, and there are some important lessons on where we need to further improve our RCCE capacities and systems ahead of the next pandemic. Our challenge now is to act on those lessons.

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Acknowledgements

The case study done in Israeli is based on a joint interview with Dr Daniel Roth and Rachel Lieberman of Mosaica and Jumanah Essa-Hadad of Bar-Ilan University in November 2021. The text was also reviewed by Leonardo Palumbo and Elsa Laino of the Regional Office's RCCE team.

The case study conducted in Armenia is based on interviews with Zhanna Perzadayeva, Communication Officer at the WHO Country Office in Kazakhstan and Yerkezhan Kadessova, a Kazakh youth activist with Global Shapers, who also works in information technology. Material from Armenia came from the online meeting with the European Youth Parliament and Armenian Progressive Youth organized by the WHO Country Office in Armenia in February 2022. Ben Duncan conducted the interviews and drafted the case study. It was reviewed by Zhanna Perzadayeva and Martha Scherzer, also of the WHO Regional Office.

The case studies on Armenia and Russian Federation were based on interviews with Ms Anzhela Kzhdryan, RCCE Officer at the WHO Country Office in Armenia and Ms Olga Manukhina, Communication Focal Point at the WHO Country Office in the Russian Federation.

The text was also reviewed by the interviewees.

The case study on contact tracing in the Western Balkans is based on interviews with: Michala Hegermann-Lindencrone of the Epidemiology Pillar, and Kimberly Rambaud and Altug Akin of the RCCE Pillar of WHO Regional Office for Europe's response to COVID-19, as well as an interview with Dr Pranvera Kaçaniku Gunga from a partner organisation in Kosovo[1]. All interviews took place in May 2022. Written input was provided by Simon van Woerden of the RCCE Pillar who, together with Kimberly Rambaud, co-authored the interim guidance on RCCE for COVID-19 contact tracing. The author also drew on information and materials provided by Claire Blackmore, who was part of the Epidemiology Pillar in 2020–2021. The text was also reviewed by the interviewees.

The case studies done in Kyrgyzstan are based on interviews with Dr Okoliyski, Mr Spasov, and with Ms Bashtovenko and her team. Ben Duncan conducted the interviews and drafted the case study. The text was reviewed by Stefan Voinea, Kimberly Rambaud and Simon van Woerden, who together managed the HealthBuddy+ initiative as part of the Infodemic Management Project in the Communication Pillar of the Regional Office's COVID-19 Incident Management Support Team.

The case study from France is based on an interview with Dr Zoë Heritage, UPRIE, SpF. Additional material came from Dr Isabelle Bonmarin and Ms Oriane Nassany (UPRIE, SpF) and Ms Emmanuelle Hamel (Unit for Elderly and Vulnerable Populations, SpF), data from surveys conducted by SpF, and a presentation at the Asia–Europe Foundation Risk Communication Conference, which was held online in October 2021.

The case studies from Sweden and Ukraine are based on a joint interview with Sarah Earnshaw-Blomquist of PHAS and Anna Johansson of Stockholm County in September 2021, a joint interview with Dr Alona Mazhnaia and Dr Aron Kassahun Aregay of the WHO Country Office in Ukraine in September 2021, materials and written input subsequently provided by the teams. The text was reviewed by Martha Scherzer of the Behavioural and Cultural Insights unit and Catharina Reynen-De Kat of the Vaccine-Preventable Diseases and Immunization unit at the Regional Office.

The case study conducted in the Scotland (United Kingdom) is based on an interview in October 2021 with Professor Nick Hopkins, of the University of Dundee and member of the Scottish Government COVID-19 Advisory Group, and written input and review from the Advisory Group.

The case study on Roma community boards in North Macedonia was developed with the input of Borjan Pavlovski of the Association for Emancipation, Solidarity and Equality of Women (ESE) and Board members Dzengis Berisha, Nezhlan Ismailovska and Dr Ruzha Kostovska.

The case study from Romania was developed largely on the basis of an interview in September 2021 with Daniel Rădulescu, who was President of the National Agency for Roma until the end of June 2020. Additional input and review was provided by Andreea Cassandra Butu and Teodora Andreea Popescu of the WHO Country Office in Romania. Inputs to the text were provided by Vera Dimitrievska, a consultant to the WHO Country Office in North Macedonia, Katrine Habersaat, Elsa Laino, Leonardo Palumbo and Martha Scherzer of the WHO Regional Office.

Abbreviations

BD	Brčko District of Bosnia and Herzegovina
BI	behavioural insight
BNT	Bulgarian National Television
CSO	civil society organization
ECARO	Europe and Central Asia Regional Office (UNICEF)
ECDC	European Centre for Disease Prevention and Control
EOC	emergency operations centre
ESE	Association for Emancipation, Solidarity and Equality of Women (North Macedonia)
EU	European Union
FAQs	frequently asked questions
FBIH	Federation of Bosnia and Herzegovina
HSE	Health Service Executive (Ireland)
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
IMST	Incident Management Support Team
JEE	Joint External Evaluation of IHR Core Capacities
MoCA	Ministry of Civil Affairs (Bosnia and Herzegovina)
NAR	National Agency for Roma (Romania)
PHAS	Public Health Agency of Sweden
RCCE	risk communication and community engagement
RCE	Resource Centre for the Elderly (Kyrgyzstan)
SAGE	Scientific Advisory Group on Emergencies (United Kingdom)
SAMHI	State Agency on Mandatory Health Insurance (Azerbaijan)
SARS	severe acute respiratory syndrome
SpF	Santé publique France
TABIB	Administration of the Regional Medical Divisions (Azerbaijan)
THL	Finnish Institute for Health and Welfare
UNICEF	United Nations Children's Fund
UPRIE	Unit for Prevention of Infectious and Environmental Risks (France)

Introduction

Two decades of RCCE capacity-building in the WHO European Region

WHO held its first-ever technical conference on risk communication in Singapore in 2004, in the aftermath of the severe acute respiratory syndrome (SARS) outbreak of 2003, and issued its first guidance on risk communication in 2005 *(1,2)*. From 2005 to 2008, WHO at international level supported country/area level partners in developing preparedness plans for pandemic influenza, which it recommended include a chapter on risk communication and community engagement (RCCE). From 2009 onwards, "emergency risk communication" was defined by WHO as one of the core disease prevention and control capabilities under the 2005 update to the International Health Regulations (IHR). This meant that all WHO Member States are obliged to report to WHO annually about their "emergency risk communication" capacity. Since 2022, WHO has redefined this IHR core capacity as "risk communication and community engagement".

In its *Action plan to improve public health preparedness and response in the WHO European Region 2018–2023*, the WHO Regional Office for Europe noted that over the preceding years: "…risk communication capacity in compliance with IHR requirements has been scaled up. Yet, the coordination among agencies during the response, to ensure sustained human and financial resources and engagement with communities, needs to be improved" *(3)*.

During 2013–2017, the Regional Office scaled up risk communication capacity in the European Region – providing training in 29 countries and one area in central and eastern Europe and central Asia. Between March 2017 and February 2018, the Regional Office piloted a breakthrough emergency risk communication five-step capacity-building package in 13 countries and Kosovo[1] with financial support from the Federal Ministry of Health of Germany. This led to:

- the global launch of a finalized version of the five-step package in 2018 *(4)*;

- further WHO capacity-building support to priority countries/area, enrolling 19 countries and Kosovo[1] by the end of 2019;

- implementation of the SocialNet 2018 and 2019 trainings in Bishkek, Kyrgyzstan and Belgrade, Serbia – focusing on social and behavioural aspects of outbreak response *(5)*.

While significant progress was made in reinforcing RCCE capacities across the European Region in the years immediately before the start of the COVID-19 pandemic, many country/area level partners started from a low base. Not all the capacity gaps and limitations identified during the rollout of the five-step package were fully remedied and some significant challenges remain. These include: shortages of skilled staff; limited expertise in listening to and engaging with communities; challenges in addressing rumours and misinformation; and lack of long-term sustainable structures, systems, skills and funding for RCCE *(6)*.

During the pandemic, the Regional Office has ramped up its RCCE capacity-building support to new levels. As well as organizing over 40 RCCE regional and country/area-level capacity-building workshops (mostly online) and offering in-country/area technical support, the Regional Office has developed a new online RCCE capacity-building platform – taking stock of the lessons learned during the pandemic. This soon to be launched interactive online platform will support the countries and area in developing RCCE plans, and is structured around the four core capacities leading to trust (Box 1). The platform is also a repository of practical guidance, tools and ideas on effective RCCE interventions.

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[1] All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council Resolution 1244 (1999).

Box 1. Four core capacities for effective RCCE
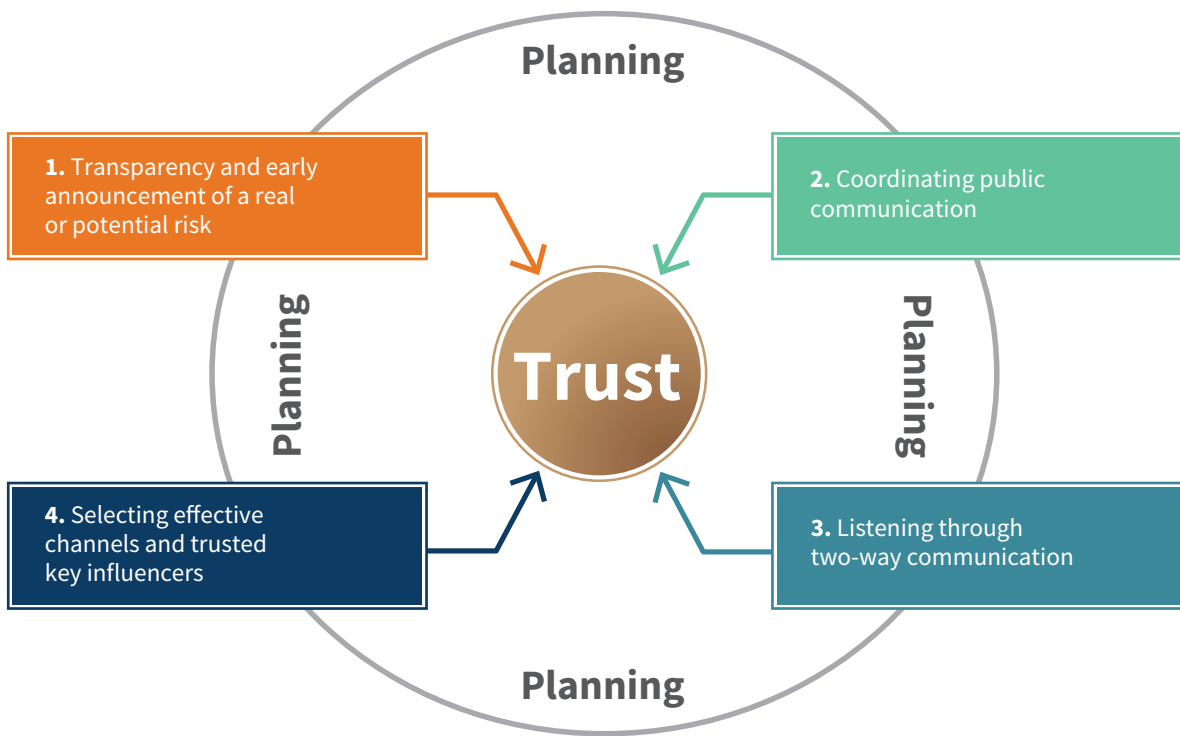
Source: WHO Regional Office for Europe *(4)*.

Document outline

This compendium of case studies has been written to document RCCE good practice in the WHO European Region during the COVID-19 pandemic. It details the factors that enabled these good practices to happen, some of the impacts they had, and the challenges or limitations encountered. It is based on dozens of semi-structured interviews with health officials, frontline RCCE practitioners, civil society activists and academics involved in responding to the pandemic. The interview tool used by the lead author and researcher, Ben Duncan, can be found as an annex to the compendium.

The compendium starts with a set of overarching RCCE lessons from the pandemic. Lessons learned from the case studies fed into this section, but so too did the wider experiences during the pandemic of the RCCE team and discussions with RCCE experts in the areas of academia and research.

At the beginning of each case study you can find "At a glance" information on:

- what the case study is about
- why it is important
- which on the four core capacities for RCCE it focuses on:

1. Transparency and early announcement
2. Coordinating public communication
3. Listening through two-way communication
4. Selecting effective channels and trusted key influencers.

Several of the case studies also feature important topics beyond the four core capacities. These are:

A. RCCE preparedness

B. RCCE in support of preventive measures

C. Infodemic management/detection of rumours

D. Use of social science data and expert opinion to inform RCCE

E. Inclusive governance

F. Vulnerable groups

At the end of each case study is a box highlighting the Regional Office's analysis of the key lessons that can be drawn from it.

Further information

If you are interested in reading more about the role of the WHO Regional Office for Europe in responding to the COVID-19 pandemic, please visit the following webpage:

https://www.who.int/europe/emergencies/situations/covid-19

For more information on WHO's activities in strengthening the health emergency preparedness and response capacities at country/area level in the European Region please visit:

https://www.who.int/europe/emergencies/our-work-in-emergencies

References

1. Outbreak communication: best practices for communicating with the public during an outbreak: report of the WHO Expert Consultation on Outbreak Communications held in Singapore, 21–23 September 2004. Geneva: World Health Organization; 2005 (https://apps.who.int/iris/handle/10665/69138, accessed 26 April 2022).

2. WHO outbreak communication guidelines. Geneva: World Health Organization; 2005 (https://www.who.int/publications/i/item/who-outbreak-communication-guidelines, accessed 26 April 2022).

3. Action plan to improve public health preparedness and response in the WHO European Region 2018–2023. Copenhagen: WHO Regional Office for Europe; 2018 (https://www.who.int/europe/publications/i/item/9789289053914, accessed 28 June 2022).

4. Emergency risk communication five-step capacity-building package. Copenhagen: WHO Regional Office for Europe; 2018 (https://www.who.int/europe/publications/i/item/WHO-EURO-2018-2993-42751-59637, accessed 28 June 2022).

5. SocialNet2019 – Community engagement training – White Paper and SocialNet experience 2019. Copenhagen: WHO Regional Office for Europe; 2020 (https://www.who.int/europe/publications/m/item/socialnet2019---community-engagement-training---white-paper-and-socialnet-experience-(2020), accessed 28 June 2022).

6. Salvi C, Frost M, Coulliard C, Enderlein U, Nitzan D. Emergency risk communication – early lessons learned during the pilot phase of a five-step capacity-building package. Public Health Panorama. 2018;4(1):1–146 (https://www.euro.who.int/__data/assets/pdf_file/0009/364869/php-4-1-1207-emergency-risk-eng.pdf, accessed 26 April 2022).

Overview of case studies by theme

The case studies in this compendium are grouped thematically. The first eight case studies give examples of good practice relating to the four core capacities for effective RCCE identified by the WHO Regional Office for Europe (Box 1):

1. Transparency and early announcement
2. Coordinating public communication
3. Listening through two-way communication
4. Selecting effective channels and trusted key influencers.

They start with two case studies (Bosnia and Herzegovina, and Georgia) that look at transparency and early announcement, as well as the impact of pandemic preparedness activities. The following six case studies feature two examples of good practice for core capacity 3, three for core capacity 4 – but only one (Finland) relating to core capacity two. This is a reflection of two realities: 1) that cross-government coordination is one of the most difficult core capacities to implement; and 2) where this coordination happens, it is usually led by senior officials who often lack the time to talk about this politically sensitive work.

Other case studies look at some of the key issues and challenges that emerged during the COVID-19 pandemic, and how these were addressed. In the European Region, this pandemic saw unprecedented efforts to gather and analyse social science evidence and apply it to RCCE strategies and actions. Since this innovation was encouraged and supported by the Regional Office – particularly in the area of behavioural insight (BI) surveys – there are three case studies looking at good practice in the use of BI surveys (France, Sweden, Ukraine) and one focusing on the use of expert opinion (United Kingdom, Scotland) to guide RCCE strategy and actions. There are also three case studies on the themes of RCCE in support of preventive measures (Armenia, Russian Federation, Western Balkans), infodemic management (Bulgaria, Kyrgyzstan) and inclusive governance/vulnerable groups (case studies from Israel and Kazakhstan, and a short update from Armenia).

Table 1 presents an overview of the case studies by theme, while Table 2 lists the case studies by country.

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Table 1 presents an overview of the case studies by theme, while Table 2 lists the case studies by country/territory.

Table 1. Overview of case studies by theme

	ARM	AZE	BIH	BUL	FIN	FRA	GEO	IRL	ISR	KAZ	KGZ	MKD	ROM	RUS	SWE	UKR	WBA		Page numbers
CC 1 [+] A			▨		■		▨												BIH GEO
CC 2					▨														FIN
CC 3		▨		■				▨			■								AZE IRL
CC 4	▨								▨			■	■						ISR KAZ (update from ARM)
[+] B	▨													▨			▨		ARM RUS WBA
[+] C				▨							▨								BUL KGZ
[+] D BI surveys						▨									▨	▨	▨		FRA SWE UKR
												▨	▨		▨	▨	▨		United Kingdom
[+] E												▨	▨						MKD ROM
[+] F									■	■		▨							

Key

▨	Main topic under which case study is listed
■	Other main topic or area featured in case study

CC 1   Transparency and early announcement
CC 2   Coordinating public communication
CC 3   Listening through two-way communication
CC 4   Selecting effective channels and trusted key influencers

[+] A.   RCCE preparedness

[+] B.   RCCE in support of preventive measures

[+] C.   Infodemic management/detection of rumours

[+] D.   Use of social science data and expert opinion to inform RCCE

[+] E.   Inclusive governance

[+] F.   Vulnerable groups

ARM = Armenia; AZE = Azerbaijan; BIH = Bosnia and Herzegovina; BUL = Bulgaria; FIN = Finland; FRA = France; GEO = Georgia; IRL = Ireland; ISR = Israel; KAZ = Kazakhstan; KGZ = Kyrgyzstan; MKD = North Macedonia; ROM = Romania; RUS = Russian Federation; SWE = Sweden; UKR = Ukraine; WBA = Western Balkans.

Table 2. List of case studies by country

Country	Page
Armenia	54
Azerbaijan	34
Bosnia and Herzegovina	19
Bulgaria	68
Finland	30
France	77
Georgia	25
Ireland	39
Israel	44
Kazakhstan	49
Kyrgyzstan	68
North Macedonia	91
Romania	91
Russian Federation	54
Sweden	77
Ukraine	77
United Kingdom (Scotland)	85

In addition to case studies from Member States there is also a case study from the Western Balkans (WBA) that feautures Kosovo[1]. This appears on page 61.
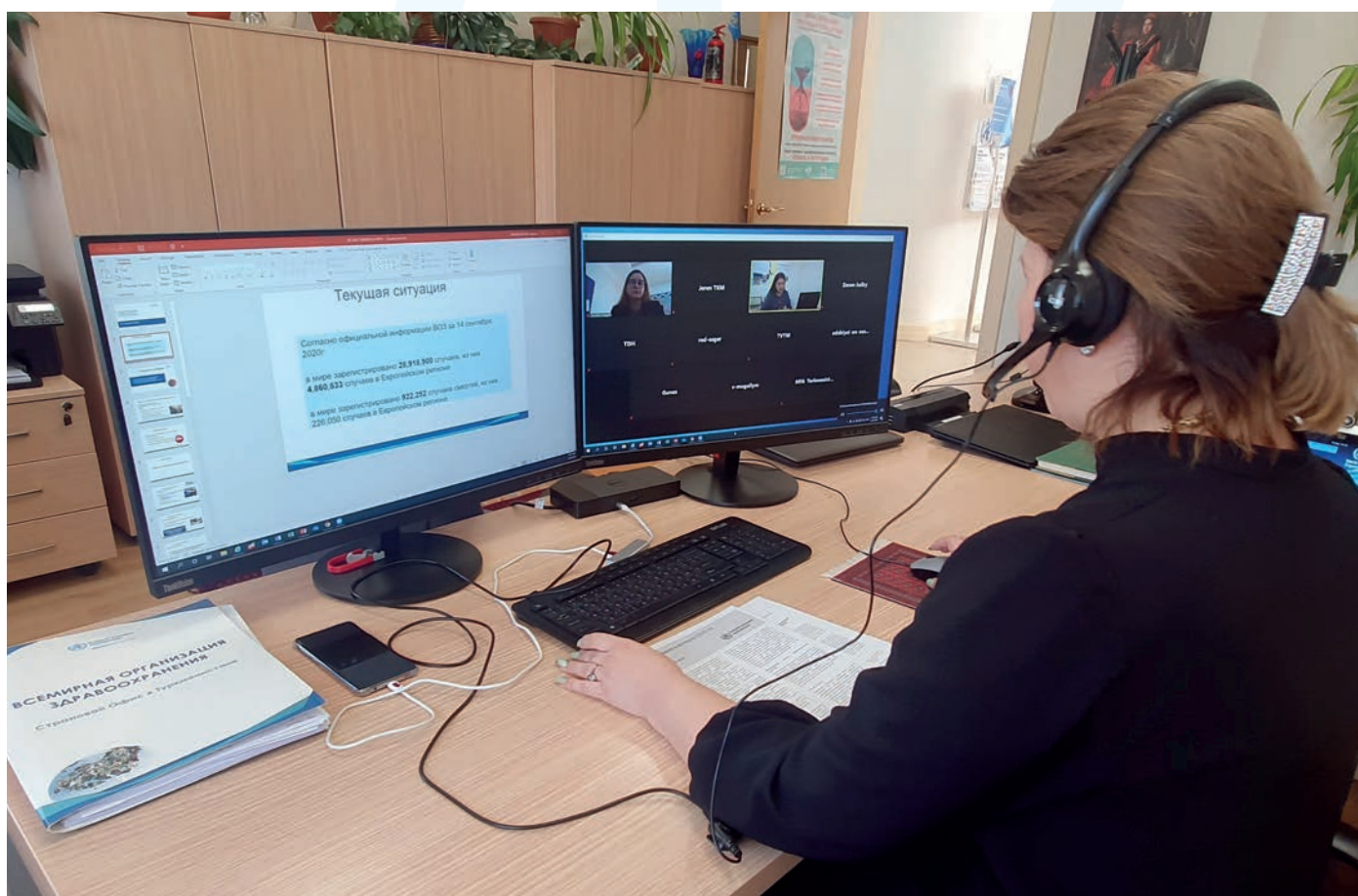
1   All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

Lessons learned on RCCE from the COVID-19 pandemic

Many of the lessons set out below have been identified as issues by WHO and national authorities in previous health emergencies. However, these lessons have been highlighted as never before since 2020 during the COVID-19 pandemic. These lessons are drawn both from the case studies in this compendium and from the wider experiences during the pandemic of the RCCE team at the WHO Regional Office for Europe and discussions with RCCE experts from across the European Region.

Lessons for health authorities and partners

1. RCCE is a public health intervention at the heart of emergency response

Experience during the pandemic

The COVID-19 pandemic has highlighted RCCE as a core public health intervention contributing to emergency response. Already during the first months of the response, when there was no vaccine and little in the way of treatment available, RCCE was a key measure available to authorities to persuade at-risk and affected communities to protect themselves. RCCE interventions continued to be hugely important to encourage people to get vaccinated when vaccines did become available, and also to maintain other preventive behaviours such as use of masks or physical distancing. Not only were RCCE actions at the core of behaviour change outcomes, they were also needed to achieve results across all the main areas of the response – from testing, contact tracing and isolation, to treatment and protective measures including vaccination. For all these measures support from the public is crucial for their success.

Recommended actions

Health authorities must recognize RCCE as a core public health intervention at the heart of their decision-making for emergency preparedness and response. This means making sure their interventions are not only sound from a risk-assessment perspective, but that they are also culturally and socially appropriate. When setting priorities and allocating resources, RCCE should be regarded as a cross-cutting function enabling the success of nearly all other pillars across the response. Disease prevention and control activities, such as preventive measures or testing, case finding and isolation, need to be accompanied by an RCCE plan. In a similar way, health authorities should recognize that introducing a new vaccine during a pandemic will always require a significant RCCE effort.

2. RCCE capacities need to be embedded in all phases of the emergency cycle and sustainably funded

Experience during the pandemic

In the WHO European Region, country/area level partners that engaged in RCCE preparedness planning and capacity-building before the pandemic found this gave them a solid basis for developing their response to COVID-19. They were better equipped to increase acceptance and uptake of protective measures, including vaccination. At the core of preparedness are strong capacities and sustainable funding. However, far too many country/area level partners went into the COVID-19 pandemic with RCCE functions that were under-funded, lacked dedicated skilled staff or were under-recognized within the national health emergency preparedness and response system. Country/area level public health organisations and their international partners – including WHO – made great efforts to remedy this during the pandemic. Staff were often repurposed and trained on the job. A cohort of hundreds of staff in government, international and community organizations have gained practical experience of RCCE. However, many of these newly trained and experienced RCCE staff are surge capacity and their skills and experience risk being lost to the health sector once their temporary contracts end. Moreover, the current availability of funds and political-level support for investing in RCCE may not last beyond the emergency.

Risk communication and community engagement for health emergencies: learning lessons from COVID-19 in the Western Balkans May 2022 in Tirana, Albania. © WHO

Recommended actions

Health authorities have a once-in-a-generation opportunity to significantly strengthen their RCCE capacities and fulfil their obligations under the International Health Regulations (which recognize RCCE as a core emergency response capacity). RCCE needs to be placed higher on the international agenda and that of country/area level partners in the whole emergency cycle – from prevention and preparedness to response and recovery. The additional funding and staff allocated to RCCE since 2020 should be sustained and further increased beyond the end of the COVID-19 pandemic, with an understanding of the central role that RCCE plays in emergency response. A core team of skilled RCCE experts should be in place during the preparedness phase ahead of the next health emergency. This team should be fully engaged in developing and testing country/area and local level preparedness plans against health emergencies of all types; it should be "activated" during the response and supplemented with surge capacity as needed; and it should transition to recovery and lessons learned to make RCCE interventions sustainable.

3. RCCE is an expert technical area that needs an evidence-led approach

Experience during the pandemic

During the pandemic it became clear, as never before, that RCCE is a complex and challenging technical area which aims to 1) build and maintain trust between authorities and affected or at-risk communities; and 2) empower individuals and communities to take informed decisions to protect their health. Neither of these have been easy to achieve or sustain during a long pandemic characterized by high levels of uncertainty, a pathogen that has mutated several times, and an "infodemic" of rumours and misinformation that has often undermined trust. Designing effective RCCE interventions that address these challenges has required a strategic, evidence-informed approach which incorporates data and insights from social listening and evidence from research and academia. One set of barriers is the inherent difficulty of rapidly assessing the impact of RCCE and the relative absence of both validated research methods and researchers able to drive rapid studies on RCCE impact and effectiveness.

Recommended actions

Health authorities must recognize RCCE as an expert technical area where strategies and actions are supported by evidence. Key data informing RCCE decision-making include: 1) data on perceptions and behaviours, and 2) data on cost-effectiveness of interventions. These data can be obtained through different methods including: online and offline social listening, applied quantitative and qualitative studies, desk review of published and unpublished study results, advisory expert groups, lessons learned exercises, and return on investment studies. Health authorities should partner with universities and research organizations to increase the quality and quantity of applied research on both social listening insights and impacts of RCCE, and incorporate this data into systems of measurement, evaluation and learning to develop the evidence base on where, when and how to apply RCCE interventions.

4. Communicating uncertainty is central to trust

Experience during the pandemic

The COVID-19 pandemic has confirmed the importance of keeping risk communication timely and transparent. While this might be resource-intensive during a fast-moving health emergency such as the pandemic, when it happens timely and transparent communication has been effective in building and maintaining public trust *(1)*. What has been more challenging, though, has been communicating fast changing information that contains significant levels of unknowns, such as the evolving nature of the threat from new virus variants and emerging knowledge about vaccines, masks and other prevention measures. Uncertainty consistently characterizes disease outbreaks, particularly those of unknown origin. What was most difficult was to reconcile: 1) being timely and transparent about the latest scientific information and guidance; and 2) maintaining credibility.

Recommended actions

To avoid being criticized for inconsistency as information and guidance are updated, health spokespersons need to set expectations that public health advice will likely change throughout the event as more is known. The public and journalists want certainties; they tend to perceive things in black and the white, leaving aside the grey of uncertainty. This means that acknowledging uncertainty might not be enough; it needs to be prominently and repeatedly proclaimed, and explained at every step of communication. Helping people understand that the situation and recommended actions may change over time as science evolves increases trust. Linked to this, health spokespersons should consistently and swiftly communicate new guidance as new evidence emerges.

5. Communication coordination across government and society reduces confusion and builds trust

Experience during the pandemic

Two big challenges during the COVID-19 pandemic have been the ever-changing nature of the threat and the science around it, coupled with an over-abundance of information – some of it reliable, some of it less so. The cacophony of noise about COVID-19 has sometimes made it difficult for important science-based messaging from health authorities to be heard by the public. When different parts of government or different actors within the health sector or society give out health information and advice in an uncoordinated way, this adds to the noise and confusion, damages trust and decreases the likelihood of acceptance and uptake of protective measures.

Recommended actions

Most country/area level partners already have systems in place for multi-sectoral coordination during pandemics and other health emergencies, such as RCCE working groups or subcommittees under the country/area emergency response committee. Response leaders should ensure these systems are used to regularly and effectively coordinate communication across sectors and levels of administration in emergencies. This regular coordination should be extended to key partners in society, as far as possible, including civil society and the private sector. Within their socioeconomic and cultural-political context, the countries and area should aim for a "whole-of-government" and "whole-of-society" approach to RCCE. This will help to increase consistency, optimize interventions and maximize outreach.

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6. Two-way communication and social listening are essential for effective response

Experience during the pandemic

Many country and area partners have provided services enabling individual citizens to ask questions about COVID-19 and receive a reply to their concerns. These have included telephone hotlines, online question answering chatbots, face-to-face community dialogues and door-to-door visits, and social media. Whichever method has been deployed, these services have been widely used and have contributed to building trust. Their existence benefits both health authorities and individuals. Health authorities can better understand the perceptions and needs of the communities they serve and show that they are open and responsive. People can access those in charge of the response and receive accurate information in answer to their questions. During the COVID-19 pandemic, hotlines have often been re-purposed from existing call centres as a way to understand public concerns and meet demand for accurate and reliable health information and advice. Social media has been a major channel of communication in most parts of WHO European Region as it can reach a wide audience quickly and relatively cheaply. Comments on and reactions to posts from the health authorities have enabled them to practice social listening and conduct two-way communication with the people they serve.

Recommended actions

All health authorities should provide two-way communication services to communities affected by or at risk from health emergencies. This should be a core part of their RCCE capacity available for deployment in future emergencies. The methods employed for two-way communication should be appropriate to the emergency situation and to a country/area's socioeconomic and cultural context. This may well include using hotlines as a way to directly link affected people to responders, and social media accounts, particularly to target population groups using this channel. Whatever form of two-way communication is deployed, the health authority should allocate enough skilled capacity (for instance medical students) to both routinely monitor the type of questions being asked and the opinions expressed, and provide rapid feedback. This also enables them to rapidly address misperceptions and misinformation. Data and analysis from these social listening activities should be regularly reported to the pandemic response team and used to inform their decisions.

7. RCCE interventions need to be informed by social listening and behavioural insight data

Experience during the pandemic

The quantity and quality of data collection on populations' knowledge, behaviours, perceptions, attitudes and beliefs during the COVID-19 pandemic has been unprecedented. Many health authorities and partners have gathered data through qualitative and quantitative research or feedback from two-way communication services such as social media, call centres or online chatbots, and analysed them. In many instances, these data have been a game changer as they have guided RCCE strategies and interventions targeting the right population groups and addressing the right needs. Often however, health authorities have found it difficult to use collected data to drive the response. One of the barriers to this may be a shortage of expert staff able to analyse and interpret the data rapidly, put them in context and produce options for action based on them.

Recommended actions

Health authorities should continue to collect social listening and behavioural insight data to inform their response. They should make sure their RCCE interventions are based on information that is rapidly translated into action. Data should be drawn from a wider body of evidence, including results from online and offline social listening, operational research, and peer-reviewed and grey literature. This should be done systematically to be able to detect changes in knowledge, behaviours, perceptions, attitudes and beliefs based on both the evolution of the emergency and the applied interventions. To enable this to happen during emergencies, appropriate systems and skills need to be built during the preparedness phase. This can be achieved through capacity-building, establishment of digital platforms, engagement of community actors, and partnerships with universities and social science researchers.

8. Communities need to be at the core of emergency preparedness and response

Experience during the pandemic

The COVID-19 pandemic has shown beyond any doubt that communities and individuals are central to successfully controlling an emergency. Being able to engage communities and empower them to protect themselves has become a crucial capacity for every health authority. During the pandemic, many health authorities have partnered with civil society organizations (CSOs), community mediators and influencers to: 1) understand communities; 2) amplify and tailor RCCE interventions and messages; and 3) engage with specific target groups. These community stakeholders have included faith-based organizations, health workers, youth groups, local journalists and others. In many instances, they have successfully acted as a bridge between the health authorities and communities leveraging the trust they have already built, as well as their knowledge of and outreach to the community. This has been particularly important with some under-served or vulnerable communities. CSOs, mediators and community influencers can be a source of advice on the barriers to uptake of a specific measure, and how to overcome those barriers; and they can support health authorities to design RCCE interventions tailored to diverse population groups.

Recommended actions

Health authorities need to prioritize investing in their capacity to empower communities. This includes mapping the leaders, influencers and CSOs active in the different communities they need to engage with, and analysing who may be the most trusted and effective mediators or bridges into the communities. It also includes supporting and working with community actors to build the structures, the systems and the skills to engage communities and co-design interventions. To enable them to do this, health authorities must have skilled staff, resources and systems in place to work with community actors. The development of a framework for continuous dialogue with communities throughout the full emergency cycle is crucial for improving inclusive governance. For a better response, it is key that such a framework is in place before an emergency, during the preparedness and readiness phase. By working together, connections between health authorities and members of the community are established that can be activated when an emergency happens.

9. One-to-one communication between health workers and patients remains of key importance

Experience during the pandemic

Experience and insights gained during the COVID-19 pandemic showed that across the European Region health workers are among the most trusted sources of health information and advice. This is consistent with results of numerous studies from before the pandemic. One-to-one conversations between health workers and patients can often be instrumental in getting patients to accept guidance, practice protective behaviours or seek medical treatment. Health workers' behaviours – such as getting vaccinated – can also set a good example for many people. Many country/area level partners recognized, applauded and relied on the key role health workers can play in engaging with patients, particularly around the roll-out of COVID-19 vaccines. However, across the Region, more needs to be done to systematically embed their engagement into emergency preparedness and response, build trust between public health authorities and health workers, and ensure that they are equipped with the skills and information they need to engage patients.

Recommended actions

Following the 2009–2010 H1N1 influenza pandemic, the major role of health workers in influencing patients' decision-making on health was recognized as a critical feature of pandemic preparedness and response *(2)*. This lesson is even more valid in light of experience during the COVID-19 pandemic. Efforts should be scaled up to motivate, support and involve health workers systematically across the full emergency cycle on community engagement, including one-to-one engagement with patients, in settings where this is appropriate.

10. Managing rumours and misinformation saves lives

Experience during the pandemic

While the concept of an infodemic existing alongside health emergencies has long historical roots, the COVID-19 pandemic has produced conditions akin to a "perfect storm" of conspiracy theory and misinformation – all made highly visible on social media platforms. Misinformation and disinformation – both online and offline – have been eroding trust in authorities, undermining health choices and putting both health and lives at risk. Health systems around the world have been reporting many thousands of preventable deaths among people who had been offered the COVID-19 vaccine but refused it. There is evidence that for some people misinformation is lethal.

Recommended actions

Strong infodemic management should be part of a comprehensive RCCE response that detects and addresses misinformation and rumours early, thus helping to maintain public trust, to offer actionable public health advice and to link people to accessible high-quality health services. Infodemic management needs a systemic approach that involves diverse stakeholders working together to build trust. Health authorities, international organizations, CSOs, fact checkers and academia need to work together in country/area and regional infodemic management networks. To prevent infodemics, there should be a long-term focus on pre-emptive techniques that improve health literacy, digital literacy and critical thinking so as to increase the population's resilience against false information.

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Lessons learned for WHO

1. Show leadership on RCCE and fully embed it in the emergency cycle

Experience during the pandemic

The COVID-19 pandemic has highlighted RCCE as a core public health intervention contributing to emergency response. From the very start, WHO positioned RCCE as a core cross-cutting function in its incident management support teams at the three levels of the Organization (country/area, regional and global). It became clear as never before to WHO that RCCE was an enabling factor to the success of nearly all other pillars of the response. This was also recognized by country/area level partners in the Region, as seen in the unprecedented level of requests to WHO for capacity-building and technical support on RCCE. Not only did these partners express their interest in strengthening their capacities for the current response, but they requested guidance and support to be able to build back better in this core pillar of the emergency cycle.

Recommended actions

The role of RCCE in international health emergency preparedness and response will never be the same as before the pandemic. WHO needs to show leadership by further intensifying investment in its own RCCE capacity, and to both support and advocate for its country and area partners to do the same. RCCE needs to be placed higher on the health emergency agenda, investment in it expanded to meet country/area demand for support, and the number of highly skilled RCCE experts increased at the three levels of the Organization. WHO has an unprecedented opportunity to argue for the scale-up of RCCE capacities; an investment case for RCCE will give the Regional Office and other parts of WHO strong tools to advocate for commitment to and funding for RCCE.

2. Establish and build RCCE capacity at country/area level and localize interventions

Experience during the pandemic

Having strong capacity on the ground has been key to WHO in providing effective RCCE support during the pandemic. Country/area-based experts already know the local culture and context and have established relations with health authorities and partners, which is critical for shaping timely and effective RCCE interventions.

Having country/area-based RCCE experts in place ahead of an emergency is an essential feature of emergency preparedness. The pandemic has shown the limitations of relying on surge capacity. At many points, restrictions on international travel made it impossible to send international RCCE experts to support the countries and area. Repurposing local staff working in related areas, such as external communication or health promotion, as RCCE experts during the pandemic was not fully effective, as they generally lacked specific technical skills, experience and familiarity with emergency response.

Localization of RCCE interventions was often challenged by the lack of capacity for rapid translation of messages and materials (e.g. talking points, social media tiles and others) into local languages. This reduced opportunities to have a voice in the local media, or influence the public communication of the country and area partners and stakeholders, as all these have a strong preference for receiving input in local languages. Barriers to rapid localization of WHO RCCE messages and materials include the complex terminology often used for them, which can be difficult to adapt and translate; and lack of funding for and/or access to specialized translators who are both familiar with WHO's terminology and available at short notice to produce rapid translations.

Recommended actions

WHO and its partners need to invest in strengthening the RCCE capacities and capabilities of health authorities, WHO country and other offices, partners and stakeholders (e.g. health workers, journalists, CSOs, public health professionals, etc.). As part of this, WHO should increase the number of its RCCE hub and country/area level staff and train them, develop a comprehensive curriculum covering all RCCE capabilities, and provide RCCE courses, including full scale simulations, for key response players.

As part of building country/area level capacities and systems, WHO – at the three levels of the Organization – should create a network of specialized translators who

are familiar with the terminology used in RCCE messages and are available to produce translations and message localization at short notice. Message localization should be further enabled by simplifying the terminology used, taking translation needs into account at the time of message development and establishing systems for local message testing. This should be accompanied by an expansion of the number of RCCE experts in country/area offices who can address all the needs of localization – taking into consideration the local cultural, political and socioeconomic context.

3. Recognize that RCCE is evidence based and requires a rigorous technical approach

Experience during the pandemic

It became clear, as never before, that RCCE is not the same as external communication or health promotion. It is a technical area as complex and challenging as biomedical functions such as epidemiology and virology. As such, it requires a strategic, evidence-informed approach which, when possible, incorporates data and insights from the worlds of research and academia.

Recommended actions

WHO should fully recognize RCCE as a technical area, as the biomedical functions are, which needs to be implemented by highly specialized experts. In this context, WHO should foster evidence-informed RCCE by: 1) calculating the return on investment from investing in RCCE; 2) establishing a multidisciplinary technical advisory group on RCCE, supporting peer-to-peer learning and exchange of best practice among RCCE practitioners; 3) collaborating with academic institutions and in the longer term aiming to establish a WHO collaborating centre on RCCE.

4. Enable WHO spokespersons to communicate uncertainty

Experience during the pandemic

COVID-19 has reminded us that disease outbreaks, and especially those with a novel pathogen, are characterized by uncertainty. What has been particularly challenging for WHO spokespersons during the COVID-19 pandemic has been communicating the changing nature of this emergency. On some occasions, the fact that WHO updated elements of its guidance on COVID-19 as new knowledge emerged (e.g. on mask use) led to criticism of WHO of being inconsistent. It has often been very challenging during the pandemic for spokespersons to reconcile: 1) being timely and transparent about the latest scientific information and guidance; and 2) maintaining credibility.

Recommended actions

The COVID-19 pandemic has exacerbated the key feature of risk communication in emergencies, that is communicating fast changing information and guidance in the face of significant levels of unknowns.

Good practice in communicating uncertainty should be a more prominent part of the training offered to WHO spokespersons. As well as pre-emergency media training, coaching and support should be available to WHO spokespersons during the course of any emergency. This training and coaching should include an overall understanding of how to build, maintain or restore trust as information and guidance are updated during an emergency. Linked to this, spokespersons should consistently and swiftly communicate new guidance as new evidence emerges.

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5. Celebrate, maintain and further strengthen WHO's positioning in RCCE and key partnerships

Experience during the pandemic

WHO's role in RCCE has been increasingly acknowledged during the pandemic and it has been recognized as an authoritative partner by governments and other organizations. WHO's partnerships with the United Nations Children's Fund (UNICEF) and the International Federation of Red Cross and Red Crescent Societies (IFRC) have been crucial and effective during the pandemic. In the WHO European Region, coordination with these actors, together with the European Commission and the European Centre for Disease Prevention and Control (ECDC), has been of key importance in providing coordinated operational support to country and area level public health partners. This has included Region-wide projects such as an interagency task force to accelerate delivery of RCCE action plans targeting certain priority country and area level partners and the joint WHO Regional Office for Europe and UNICEF Europe and Central Asia Regional Office (ECARO) campaigns and HealthBuddy+ chatbot.

Recommended actions

WHO should further strengthen its role in RCCE as a peer of organizations that have long-term experience in this field, and maintain key partnerships in the area of RCCE across the whole health emergency cycle. In the European Region these partnerships are mainly with ECDC, the European Commission, and the regional offices of IFRC and UNICEF. They have helped to avoid duplications, optimize resources and maximize impacts. It has been demonstrated, for example, that when WHO and UNICEF have partnered to support Member States, government buy-in has increased.

6. Invest in WHO's capacity to produce RCCE multimedia content

Experience during the pandemic

The COVID-19 pandemic has shown the need to amplify WHO stories with materials that bolster messaging in more engaging ways. This includes using multimedia content such as photographs, human-facing stories, video and infographics that can tell the story in a compelling way to different audiences. WHO has been increasing use of multimedia during the pandemic response; however, more can be done to show the practical impact of its work on the ground using these tools, and how this makes a difference to public health and to the lives of the people it serves.

Recommended actions

WHO should continue to build on and further improve its risk communication successes over the past two years – making its stories more compelling, innovative and timely, and thus more impactful on the range of target audiences. To do this, WHO needs to invest in its capacity to produce timely, engaging and good quality multimedia materials that support its risk communication work in emergencies. This includes upskilling all core RCCE staff, including in country/area-level offices so they are able to rapidly produce impactful stories through the use of photographs and video and establishing networks of high-quality production teams who can be hired to produce these materials in locations across the Region when needed.

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7. Sustain WHO's tools, systems and capacities on social listening and behavioural insights

Experience during the pandemic

The quantity and quality of data collection on behaviours, perceptions and beliefs has been unprecedented during the COVID-19 pandemic. WHO has initiated behavioural insight surveys and established integrated online and offline social listening systems. Nonetheless, it took WHO and Member States some time to get the necessary systems up and running. It then took most health authorities even longer to learn how to use this data to improve response actions.

Recommended actions

WHO should maintain and further strengthen use of its behavioural insight data gathering tools and systems – such as quantitative surveys, qualitative consultations, social listening, and infodemic management systems (e.g. HealthBuddy+) – and sustain engagement of CSOs beyond the end of the current pandemic and into the "preparedness" phase. It should also strengthen rapid analysis, interpretation and use of data to inform the response. This will mean these tools and systems are ready for immediate deployment in the next emergency, and that there is a pool of experts who know how to interpret and use the data. WHO should aim for greater synergies and integration between social listening, behavioural insights and RCCE.

8. Sustain and further strengthen WHO's bottom-up approach to community engagement

Experience during the pandemic

At all three levels of the Organization, WHO has made significant efforts to increase the recognition of communities as being at the centre of emergency response and to engage proactively with community stakeholders on the ground. It has also run pilot projects in all WHO regions, directly financing national and local-level CSOs to empower communities to protect themselves against COVID-19 with a new bottom-up approach. These projects have delivered important results, inspired a more positive perception of WHO in communities, and encouraged many public health authorities to engage more actively and extensively with CSOs.

Recommended actions

WHO should capitalize on the bottom-up operational approach piloted during the COVID-19 response. This entails a dual-tracked effort of working with governments to enhance inclusive governance, and directly with CSOs (including through financial support) to empower them to be part of the solution. Bridging health authorities with communities through CSO empowerment has proven effective not only in supporting the response, but also in establishing structures, systems and skills at community level for the future. This can include targeting investment and technical expertise at developing a framework for measurement, evaluation and learning for community engagement activities.

9. Sustain WHO's role in the area of infodemic management

Experience during the pandemic

Early in the COVID-19 pandemic WHO identified the emergence of an unprecedented "infodemic" alongside it; defined as "excess information, including false or misleading information [as well as significant information voids], in digital and physical environments during an acute public health event" (3).

The scale of the infodemic required a response of equal scope, which was a new challenge for WHO, other international organizations and country / area level partners globally. WHO and partners have raised awareness of how an infodemic erodes trust in health authorities, undermines their response to the pandemic, and puts health and lives at risk. While doing that, WHO developed strategies and tools to manage the response to the infodemic and build future structures, systems and skills – under the label of infodemic management. Demands for support from country and area level partners intensified as their understanding of the importance of infodemic management in RCCE interventions grew, along with acknowledgment of the need to build their capacities.

Recommended actions

WHO should continue to invest in and steer infodemic management as part of its RCCE emergency response and leverage this opportunity to build capacities. This would support country / area level public health partners in building their own infodemic management capacities and capabilities, as well as fostering technological, educational and community-based solutions to managing the infodemic. In developing its infodemic management strategies and activities WHO should take a multidisciplinary and integrated approach that includes strong links between infodemic management and RCCE, digital health, social listening and behavioural insights, and the engagement of other WHO and external stakeholders and partners.

10. Ensure that internal procedures are "fit for purpose" during emergencies

Experience during the pandemic

Many of WHO's internal procedures and ways of working have been developed based on the model of WHO as an international standard-setting body that works with countries and area level public health partners. Though these procedures and systems serve WHO's programmatic work well, they are not always well adapted to responding to a fast-paced emergency event such as a pandemic.

During the COVID-19 pandemic, RCCE practitioners experienced that long clearance procedures sometimes prevented WHO from communicating in a timely way about new developments or emerging issues of concern to the public and media. They experienced that getting the ethical clearances and financial approvals to run studies to inform RCCE decision-making took many months; and that centralized clearance of new guidance would hamper timely release. They also found that due diligence and legal rules were sometimes a barrier to developing partnerships with stakeholders such as CSOs and private entities.

Recommended actions

WHO should review all its internal procedures and ways of working to better adapt them to emergency response. It needs to look in particular at whether procedures can be made faster and lighter for clearance of risk communication messages, materials and guidance; contracting and grant management during emergencies; and for due diligence and legal rules applying to non-state actors. Innovating the way WHO works, making it timely and building strong partnerships must be an ongoing priority throughout the emergency cycle.

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How RCCE preparedness helped ensure timely and transparent communication in Bosnia and Herzegovina

At a glance

What the case study is about

This case study looks at how RCCE preparedness helped Bosnia and Herzegovina's health systems to respond to the COVID-19 pandemic with timely and transparent communication.

Why it is important

WHO and international experts have long advised on the importance of emergency preparedness in all IHR core capacities. This case study looks at the importance of RCCE preparedness and how it reinforced the capacity of the Federation of Bosnia and Herzegovina and the Republic of Srpska to conduct timely and transparent risk communication during the COVID-19 pandemic.

Main RCCE core capacity* featured
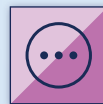
1. Transparency and early announcement

Other RCCE core capacities* and areas featured

3. Listening through two-way communication

4. Selecting effective channels and trusted key influencers

A. RCCE preparedness

C. Infodemic management/detection of rumours

* See Box 1.

Context of Bosnia and Herzegovina

Bosnia and Herzegovina is a country in the western Balkans region of Europe. It has a population of around 3.3 million and is relatively low income in comparison to nearby European Union (EU) countries.[1] Like other smaller, relatively low resource countries in the European Region its health authorities have had few resources available to invest in RCCE capacity. This challenge of limited resources is compounded by the country's complex administrative structure. RCCE coordination requires involvement of many different players.

Bosnia and Herzegovina is a state consisting of two entities: the Federation of Bosnia and Herzegovina (FBIH), which is administratively further devolved into 10 separate cantons; the Republika Srpska; and also the autonomous Brčko District of Bosnia and Herzegovina (BD). Health care organization, finance and delivery fall under the purview of the FBIH, Republika Srpska and BD, and are regulated by the Ministry of Health of the FBIH, the Ministry of Health and Social Welfare of the Republika Srpska and the Department of Health and Other Services of Brčko District. At the state (Bosnia and Herzegovina) level, the Ministry of Civil Affairs (MoCA) is mandated

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with "carrying out tasks and discharging duties which are within the competence of BiH and relate to defining basic principles, coordinating activities and harmonising plans of the Entity authorities and defining a strategy at the international level in the field of health and social care" (Law on Ministries and Other Bodies of Administration of Bosnia and Herzegovina, 2003, Article 15).

One further detail to note is that the governments of the 10 cantons that make up the FBIH play a major role in public health. Each canton has its own ministry of health, its own public health institute and its own emergency operations centre. The cantons have therefore also played a significant role in the response to COVID-19 in the FBIH.

RCCE preparedness in Bosnia and Herzegovina

The most tailored initiative from the WHO Regional Office for Europe in the pre-pandemic period was the risk communication capacity-building workshop organized in Sarajevo in 2018, with key public health authorities from Bosnia and Herzegovina. In particular, the health ministries of the Republika Srpska, BD and the FBIH, and FBIH's cantons. This combined risk communication skills development with capacity mapping, plan development and discussions of how the communication resources of the MoCA, FBIH, Republika Srpska, the cantons, BD and partners such as WHO might best be used to manage RCCE in a pandemic. In early 2019, the Regional Office organized a country-wide training for field epidemiologists from the FBIH and Republika Srpska, and representatives from the MoCA, that included training on RCCE. In December that year WHO also invited communication staff from the FBIH and Republika Srpska, with representatives from the MoCA, to SocialNet *(1)*, an expert RCCE training and crisis simulation exercise held in Belgrade, Serbia, by WHO and partners.

RCCE preparedness in the FBIH

Following the 2018 workshop, the Ministry of Health of the FBIH worked intensively with the two Regional Office experts who had facilitated the workshop to develop an emergency risk communication plan. The main public health law of the FBIH enables the Ministry to establish an emergency operations centre (EOC) if it identifies a serious threat to public health. This can be done in the pre-emergency phase, before the situation has been declared an emergency. "Our idea was to develop a crisis communication plan for the EOC during the pre-emergency phase," says Zlatan Peršić who was the Public Relations Officer in the Ministry and one of the architects of the plan. The plan followed WHO's model of four core competencies. "We finalized it in 2019 with great input

and support from WHO," said Mr Peršić, referring to the Regional Office's *Emergency risk communication five-step capacity-building package (2)* and the one-to-one technical assistance he received from WHO experts.

RCCE preparedness in the Republika Srpska

The Ministry of Health and Social Welfare of the Republika Srpska developed an all-hazards Risk Communication Plan for Public Health after the 2018 workshop. In January 2020, this was adapted into a specific RCCE plan for COVID-19. "It was of great benefit that we had a plan prepared in advance and it was a good basis for the [COVID-19] plan," said Jelena Vujic, Head of the Ministry's Department for Public Relations. "Especially in the first month of the pandemic, we based many activities on the *Emergency risk communication five-step capacity-building package* created by the WHO Regional Office for Europe," *(2)* she said. "As much as circumstances allowed it, I relied on the knowledge and tools provided within the trainings organized by WHO." The initial plan created in January included draft press releases and media statements for key developments such as the first case of COVID-19 in the Republika Srpska and the first death caused by COVID-19.

Fig. 1.

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RCCE response to COVID-19

As stated earlier, the RCCE response to COVID-19 in Bosnia and Herzegovina has mostly been led by the health ministries of the FBIH and the Republika Srpska. Other ministries within the FBIH and Republika Srpska, such as the civil defence authorities of both, have also had a role in the response, as has the Council of Ministers of Bosnia and Herzegovina – which means these different bodies have also communicated about COVID-19. The RCCE response in Brčko District (population approximately 82 000) was led by its Ministry of Health.

The MoCA was in charge of receiving inputs from WHO, ECDC and the United States Centers for Disease Control and Prevention, and of international reporting; it also played the main role in the procurement of COVID-19 vaccines and vaccine-related materials through COVAX, EU4HEALTH and donations.

RCCE response in the FBIH

In January 2020, the FBIH-level EOC was activated. It brought together key staff from the FBIH's Ministry of Health and Public Health Institute. This created a pool of six media spokespersons: the Minister of Health; the Assistant Minister for Public Health; the Director-General of the Public Health Institute; the Head Epidemiologist of the Institute; and the public relations officers from the Ministry and the Institute. The EOC's RCCE function was given further staffing and support (e.g. use of a press room) from the Press Office of the FBIH government. All of this was very much needed, as by March of 2020 the FBIH EOC was holding up to two press conferences per day, seven days a week.

When the first lockdown started, the FBIH EOC's daily press conferences continued but without any journalists present. Instead, the press conferences were broadcast live on FBIH television. "Journalists sent in their questions by email and we answered them on live TV," says Mr Peršić. "It worked great."

Facebook and Instagram accounts were created for the EOC and soon these were achieving a very high reach in the FBIH. According to Mr Peršić, the popularity of the FBIH EOC's social media accounts and the positive relationships it developed with the traditional media (television, radio, newspapers etc.) helped in two-way communication and social listening.

The FBIH EOC's risk communication team reached out to key influencers in their society including religious leaders. They engaged respected leaders in vaccine promotion, including the Grand Mufti of the Islamic Community in Bosnia and Herzegovina and a cardinal from the Roman Catholic Church. Another innovation was that the communication team engaged with students at Sarajevo Academy of Fine Arts to develop materials on COVID-19 prevention. "They gave us a lot of material and we were able to promote it over Instagram," says Mr Peršić. "It was peer-to-peer communication and it was very nice."

Role of the cantons in the response

The 10 cantons that make up the FBIH have wide ranging powers and responsibilities for public health. Each has its own ministry of health, its own public health institute and, when emergencies happen, its own EOC. When the FBIH Ministry of Health activated the federal EOC it asked the cantons to activate their own health sector EOCs. Once this happened, the canton-level EOCs started holding regular press conferences. Although these were aimed primarily at cantonal media, announcements from the largest cantons such as Mostar, Tuzla and Sarajevo (the capital city) were reported across the FBIH.

"With the many press conferences going on there was great transparency of information," says Mr Peršić. However, it also made coordination of public communication challenging.

RCCE response in the Republika Srpska

Ms Vujic recalls that "shortly after WHO declared the … pandemic [in early 2020], it was necessary to expand the team because the demands for intensive communication and public engagement were enormous". The Ministry of Health and Social Welfare requested support from the Public Relations Bureau of the Government of the Republika Srpska. In response, the Bureau provided ongoing technical support and sent a public-relations specialist to work full time in the Section for Public Relations in the Ministry.

During the first phase of the emergency, in March–May 2020, press conferences were held every morning, seven days a week, and broadcasted live on Republika Srpska Radio Television and the video service of the Public Relations Bureau. Later, press conferences were held only when there were new developments to announce, such as at different stages in the COVID-19 vaccines roll-out in 2021.

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The Ministry has its own Facebook page, which is a fast channel for communicating both with the media and the public. As the emergency evolved, it became the Ministry's main channel for communicating about COVID-19. On a daily basis, the RCCE team created social media cards and other materials on COVID-19 and how to prevent it for the Ministry's Facebook and Instagram accounts and for its website. Linked to the Ministry's official website, Ms Vujic adds, the team created "a special internet platform … for citizens who want to leave messages of support for health professionals". Monitoring of social media was the main tool for social listening by the RCCE team in the Ministry. It gave rapid, and often useful, insights into communities' reactions to different public health measures.

The Ministry held a series of meetings with publishers, editors and journalists from the traditional media. These meetings included advice to media professionals on responsible reporting about COVID-19 and recommended actions on appropriate terminology.

With support from WHO and international partners, the Ministry developed a series of eight short informative videos on COVID-19. According to Ms Vujic, these "illustrate the work of health professionals and the standards that are respected in the diagnosis and treatment of patients". The videos were widely viewed via the Ministry's social media channels, as well as on numerous television channels in the Republika Srpska.

The Ministry engaged with health workers to get them to promote COVID-19 safe behaviours to the public. It also engaged "trustworthy groups/individuals, such as medical students and the Society of Psychologists," says Ms Vujic. This latter group established a telephone hotline for COVID-19 information and support, providing a 24-hour service for citizens in need. Other groups engaged by the Ministry included the Red Cross and local authorities. Ms Vujic notes the importance of this engagement with communities and stakeholders: "at one point [this was our] essential tool for maintaining people's interest in and engagement with the importance of health measures …".

WHO support

As recounted above, the WHO Regional Office for Europe supported RCCE preparedness work across all of Bosnia and Herzegovina in the years before the pandemic. During the pandemic, the WHO Country Office translated and localized WHO materials on COVID-19 prevention (see Fig. 1 and Fig. 2), and later-on, COVID-19 vaccines. The RCCE teams in the Republika Srpska, the FBIH and its cantons made use of these when developing their own materials. Social media cards from WHO about COVID-19 were widely used on the health authorities' social media channels. Also, in both the FBIH and Republika Srpska, WHO and international partners supported the production of short videos about COVID-19.

Impact

This section provides data and perspectives from the key interviewees within Bosnia and Herzegovina's public health authorities regarding their RCCE activities.

Perspective from the FBIH

Our transparency and availability to the media was excellent. For example, we set up a special website dedicated to COVID, and accounts for the Emergency Operations Centre on Facebook and Instagram. The reach we achieved with the Facebook account was really astonishing. Some news items achieved a reach of over 800 000 viewers, which is a lot in an entity of just 2 million people. Our Facebook account dedicated to COVID gets more "Likes" and "followers" than the official one in our much bigger neighbour Croatia, which has twice as many people.

In the team in the central Emergency Operation Centre we had a group of staff who were trained communicators who had experienced the 2009 [H1N1] pandemic. They worked very well and were very committed.

Extracts from an interview by the author with Mr Peršić.

Perspective from the Republika Srpska

From 5 March 2020 [to September 2021], the Ministry of Health and Social Welfare of the Republika Srpska organized 76 press conferences at the Government Press Centre, issued 88 press releases, and took part in more than 40 events, which received wide media coverage. From 5 March 2020 to the end of the year, a total of 1120 items were published on the Ministry's Facebook page. More than 5000 people visited this page each day. Currently 9146 people follow the Ministry's Facebook page. A series of videos illustrating the work of health professionals in combatting COVID-19 has proved popular on this page. Each video has been watched by about 30 000 people.

Extract from a written interview by the author with Ms Vujic.

Further information

Ministry of Civil Affairs – national ministry with role in health
https://www.vijeceministara.gov.ba

Website of the Federation of Bosnia and Herzegovina
http://www.fbihvlada.gov.ba

Website of the Republika Srpska
https://www.vladars.net/sr-sp-cyrl/Pages/default.aspx

Website of the District of Brçko
https://www.skupstinabd.ba/ba/

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Civil society organization engagement workshop in Republika Srpska Bosnia and Herzegovina, March 2022. © WHO

Lessons learned

- Bosnia and Herzegovina based its response to the pandemic on preparedness through the Regional Office's *Emergency risk communication five-step capacity-building package.*

- The public health authorities largely succeeded in putting in place the essential capacities recommended in the five-steps package.

- Finding surge capacity to rapidly expand the RCCE function was essential. This was done largely by redeploying staff from other parts of government administrations.

- Social media proved to be a vital channel for information dissemination, two-way communication and listening. The RCCE teams in Bosnia and Herzegovina made good use of this channel both for listening and message dissemination.

- The pandemic fostered innovation and outreach to new partners. The authorities had some notable successes on this, such as:

    - collaboration with religious leaders and art students in the FBIH;

    - collaboration with the Society of Psychologists and the website for citizens to express their appreciation of health-care workers in the Republika Srpska.

How Georgia's NCDC ramped up its RCCE capacity once the pandemic started

At a glance

What the case study is about

In summer 2019, a WHO-led assessment found that Georgia's RCCE capacity was a key area for improvement. When the pandemic began in early 2020, the country's National Centre for Disease Control and Public Health (NCDC) had to rapidly ramp up its RCCE capacity.

Why it is important

Many countries in the WHO European Region and around the world did not dedicate enough staff or funding to RCCE in the years leading up to the start of the pandemic in 2020. This case study documents how, after being trained in RCCE preparedness ahead of the pandemic, Georgia's NCDC was able to rapidly develop a strong RCCE capacity when the pandemic started. It also documents how a national health authority, Georgia's NCDC, maintained the trust of affected and at-risk populations with timely and transparent communication.

Main RCCE core capacity* featured

1. Transparency and early announcement
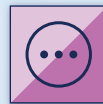
Other RCCE core capacities* and areas featured

3. Listening through two-way communication

4. Selecting effective channels and trusted key influencers

A. RCCE preparedness

* See Box 1.

Context of Georgia

Georgia is an upper-middle income country of just over 3.7 million people located in the South Caucasus region of Europe.

Based in Tbilisi, the capital of Georgia, the NCDC is a government technical agency responsible for protecting and improving health. It comes under the policy leadership and political responsibility of the Ministry of Internally Displaced Persons from Occupied Territories, Labour, Health and Social Affairs.

The NCDC has a core staff of around 440. Its remit covers promoting healthy lifestyles and combatting noncommunicable diseases such as cancer, heart disease and diabetes, as well as prevention and control of infectious diseases.

This case study recounts experiences from the Public Health Emergency Preparedness and Response Division of NCDC. It is primarily based on an interview conducted with the Head of the Division, Dr Ana Kasradze on 17 September 2021.

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Emergency preparedness

In recent years, Georgia has worked closely with WHO and international partners to strengthen its emergency preparedness. In 2018 and 2019 Georgia conducted emergency simulation exercises to test various aspects of its preparedness. In June 2019, Georgia hosted a WHO-led team of international experts for a joint external evaluation (JEE) of its "core capacities" under the IHR. This was a week-long review between the international experts and their Georgian counterparts of all aspects of Georgia's capacity to respond to a health emergency. While Georgia had made good progress in core disease control areas such as surveillance and laboratory capacity, the 2019 JEE found its capacity in the area of RCCE still needed to be strengthened *(1)*.

The health authorities in Georgia had already identified RCCE as one of their weakest capacities in their annual self-assessment reports under the IHR. In 2018 and 2019, Georgia had started strengthening this capacity by working with the WHO Regional Office for Europe to pilot its five-step approach to RCCE capacity-building *(2)*. This included WHO and other international partners holding RCCE trainings in Georgia.

However, in early 2020 when the pandemic started, the communication staff at the NCDC consisted of a two-person press office and a group of approximately 13 health promotion staff. This latter group worked on healthy lifestyles and noncommunicable diseases, though some of them had been trained on risk communication by WHO.

Dr Kasradze recognized that "What built our risk communication capacity was the start of the pandemic in 2020. Our lead press officer and I had been to some risk communication trainings. But it was not until the pandemic that NCDC really understood the need for a very strong risk communication capacity".

Ramping up RCCE at the start of the pandemic

The key adaptations that the NCDC made to strengthen its RCCE capacity at the start of the pandemic in 2020 were to:

• re-purpose 11 health promotion experts who had been working on healthy lifestyles as COVID-19 RCCE experts;

• expand its roster of media spokespersons to include a wider group of senior officials.

From March 2020 onwards, the NCDC suddenly had to face a steep learning curve on risk communication. The government organized press conferences about the COVID-19 situation in Georgia almost every day. The Minister of Health, or more often the first Deputy Ministers of Health, attended these along with a spokesperson for the NCDC. At the start of the pandemic, the NCDC Director-General and Deputy Director-General took the role of media spokespersons. Quite quickly, though, the NCDC widened its pool of media spokespeople to include Dr Kasradze and another director-level colleague responsible for communicable diseases. Dr Kasradze had been trained in the theory of risk communication by WHO but, up until then, she had had little experience giving media interviews.

NCDC develops an RCCE strategy and reinforces its core capacities

Within a few weeks, the NCDC developed a risk communication strategy and expanded its team dealing with this response area. Expanding the team also meant that the NCDC could deliver the four essential capacities identified through WHO's RCCE capacity-building package (see Box 1).

Actions and initiatives addressing core capacities

1. Transparency and early announcement; and 3. Listening through two-way communication

With the RCCE team's support, the NCDC was soon producing and updating frequently asked questions (FAQs) documents on COVID-19 and short videos explaining COVID-19 risks, symptoms and prevention. It started organizing regular Facebook Live sessions, where people could ask questions directly to different senior experts from the NCDC.

"Before COVID-19, the NCDC did not concentrate much on social media. We didn't really look at how many followers NCDC's accounts had, what content got a good reaction and what people wanted more of," says Dr Kasradze. "Since COVID we have a different attitude. We realize how important communication is."

By monitoring its social media statistics and developing a better understanding of the type of content its audiences appreciate, the NCDC has significantly increased its followers. The communication team monitors followers' comments on NCDC posts to identify "hot topics" and emerging rumours. This feeds in to deciding which topics to address in the NCDC's weekly Facebook Live session.

"Myths have been a popular topic in Georgia, starting with the one about 5G [mobile telephone signals causing COVID-19] and myths about the vaccine," says Dr Kasradze. Most of the myths picked up in Georgia are the same as those found across the European Region and the world (e.g. the myth that vaccines can cause infertility).

2. Coordinating public communication

Georgia has a system of ministerial, senior official level and technical level working groups to ensure a "whole of government" response to emergencies. These have been used to coordinate communication between different government agencies and ministries where needed. For example, they enable coordination between the NCDC and the Ministry of Education on issues around reopening of schools.

4. Selecting effective channels and trusted key influencers

The NCDC has had some contacts with the Red Cross during the COVID-19 vaccine roll-out campaign. The Red Cross is listed in Georgia's national emergency plan as the focal point for coordination between government and civil society.

Ahead of the arrival of COVID-19 vaccines in Georgia, the NCDC created a dedicated website for the vaccine roll-out. It also held media seminars and filmed video material for use by television channels. In addition, it organized social media campaigns to promote vaccine up-take and counter misinformation.

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WHO support for RCCE in Georgia

WHO support to Georgia's Ministry of Internally Displaced Persons from Occupied Territories, Labour, Health and Social Affairs and the NCDC has included:

- strategic advice and technical support on RCCE during the COVID-19 pandemic, including localization of WHO messages and materials for the Georgian context;

- support for the recruitment of a team of communication experts based in the NCDC to work on the vaccine roll-out; these locally recruited staff include experts in online marketing, social media and traditional mass media;

- RCCE capacity-building training and technical support for health officials before the pandemic using the Regional Office's five-step package.

In 2021, WHO recruited an international RCCE expert based in Tbilisi to support Armenia, Azerbaijan and Georgia with strategic planning and inter-partner coordination and to provide closer linkage with the RCCE team based in the Regional Office in Copenhagen. Funding for the reinforcement of RCCE capacity in Georgia will continue in 2022.

Impact

One of the primary objectives of RCCE is to build and maintain trust between the health authorities and communities at risk. Results from surveys carried out in Georgia, with support from the Regional Office, show that over the past year or so the NCDC and the Ministry of Internally Displaced Persons from Occupied Territories, Labour, Health and Social Affairs have continued to enjoy a reasonably high level of trust from the people of Georgia.[1]

The survey results are consistent with feedback from journalists and from the NCDC's followers online. Dr Kasradze believes the NCDC has established itself as a trusted and reliable source of information on COVID-19. "I have the feeling that not only our public, but also the media trusts the NCDC. We put a lot of work into ensuring whatever information we issue is reliable, so they trust it. I think that's also very good for us."

Looking to the future

"COVID-19 has showed us why it is vital for the NCDC to have a very strong risk communication capacity," says Dr Kasradze. "We have identified the need, so we need to retain the capacity. After all, the next pandemic could come sooner than any of us thinks."

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1   In four surveys carried out between September 2020 and August 2021 representative samples of around 1000 people were asked: "How much do you trust information about COVID-19 from the following sources?". They were asked to quantify their trust on a seven point scale, with one being "very little trust" and seven being "great deal of trust". The scores for the NCDC and the Ministry remained largely constant at between 5.1 and 5.3. Source: Behavioural insight surveys supported by WHO on behalf of Georgia's Ministry of Health [unpublished data].

Further information

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Lessons learned

- RCCE is a core function in emergency response. The best way to sustain RCCE preparedness and response to health emergencies is to build long-term expert capacity integrated into the entire emergency cycle. However, even where RCCE preparedness work is not fully implemented in the pre-emergency phase, the experience of Georgia shows it can still lay the foundation for an effective response.

- A relatively large team of RCCE skilled staff is needed to enable proactive and transparent communication across multiple platforms and channels. For example, being timely and transparent during the acute phase of an emergency means having RCCE staff available during extended hours, seven days a week. A pool of RCCE staff working shifts is the best way to achieve this.

- The experience of Georgia at the start of the COVID-19 pandemic shows that redeploying or repurposing and training health communication and health promotion staff working on lifestyle-related diseases and other longer-term public health challenges can be an effective short-term way to find surge capacity for RCCE during an emergency.

- While some staff are able to learn elements of RCCE on the job during an emergency, it is better to have pre-identified surge staff who are given RCCE training during the pre-emergency phase.

- Proactive, transparent risk communication by Georgia's NCDC, following the model of the Regional Office's RCCE capacity-building package, helped to maintain the trust of the public and journalists.

- In particular, pre-identified and trained spokespersons and pre-established social media platforms and capacity are critical to address the media and the surge of public demand for information that happens at the start of an emergency.

A legal duty to communicate with a whole-of-government approach: communication coordination in Finland

At a glance

What the case study is about

This case study describes Finland's whole-of-government system of emergency response and what this meant for RCCE during the COVID-19 pandemic. It also looks at good practice on timely, transparent risk communication by the Finnish Institute of Health and Welfare (THL).

Why it is important

Coordination of communication across government is identified by WHO as one of the core capacities needed for effective risk communication. Nonetheless, many countries find this coordination challenging. Finland offers an example of how it can be done successfully, and provides a model of good practice on timely and transparent communication.

Main RCCE core capacity* featured

2. Coordinating public communication

Other RCCE core capacities* and areas featured

1. Transparency and early announcement

3. Listening through two-way communication

4. Selecting effective channels and trusted key influencers

* See Box 1.

WHO policy context

In its *Emergency risk communication five-step capacity-building package* of 2018, the WHO Regional Office for Europe identified "transparent and early announcement" of health threats and "coordinating public communication" as two of the core capacities health authorities need for effective RCCE *(1)*. During the pandemic, WHO – both at regional and global level – has continued to stress the importance of health authorities communicating in a timely and transparent way with affected and at-risk communities, and the need to coordinate communication across government *(2)*. Both continue to be key principles of good practice for WHO and are stressed in the Regional Office's new RCCE capacity-building platform.

Context of Finland

Finland is a high-income country of just over 5.5 million people *(3)* located in northern Europe. In common with its Nordic neighbours (Denmark, Norway and Sweden) it has a strong tradition of open, transparent government and also investment in public health. In recent years, it has been a strong advocate for international preparedness against health emergencies. Most notably in 2014, Finland was one of the founding members of the Global Health Security Agenda, an alliance of countries committed to strengthening health emergency response capacities *(4)*.

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The THL is an expert technical institute that advises the Ministry of Social Affairs and Health. Its core tasks are health monitoring, disease surveillance and applied research and development to design interventions to promote well-being and health. Most of the time, THL mainly communicates to professional and expert audiences; however, during health emergencies THL has a legal duty to communicate to the public about its work.

Finland has a publicly funded health-care system. Local municipalities have the main responsibility for providing health care, though hospitals are run by regional authorities owned by municipal consortia. The THL provides information, advice and guidance to all the different organizations involved in providing social and health care.

Whole-of-government emergency coordination

Finland has a whole-of-government, whole-of-society approach to emergency response. The normal protocol is for the Ministry of Social Affairs and Health to lead the response to major health-related emergencies, including leading on risk communication. In the early weeks of 2020, as COVID-19 spread and WHO declared a "public health emergency of international concern", the Ministry of Social Affairs and Health convened meetings of the Government Coordination Group. This brought together the state secretaries (senior civil servants) from each ministry, plus the director of the THL as the new virus was a health-related emergency.

In March 2020, the Finnish government declared COVID-19 to be a national emergency. This gave the government, acting in agreement with the President, wide-ranging powers to issue emergency decrees. These powers were used to implement public health and social measures, such as closures of schools, non-essential businesses and borders. By then, COVID-19 had become such a critical issue that the Prime Minister and her staff assumed overall leadership of the response.

Throughout the early months of the pandemic, the THL had a legal duty to communicate its latest information and advice to the public. In the first weeks of the pandemic this meant that Professor Mika Salminen, Director for Health Security at the Finnish National Institute for Health and Welfare, and the ministers for social affairs and health, gave regular joint press briefings. From March onwards, the press conferences were often held with the Prime Minister and other cabinet members.

Collaboration between the THL and Prime Minister's Office

> The big national campaigns on good hygiene and distancing, wearing masks and later on COVID-19 vaccines were all done as collaborations between THL and the Prime Minister's Office as well as the Ministry of Health and Social Affairs. … THL's team produced all of the key public health messages for graphic materials and social media videos in multiple languages. But the communication team in the Prime Minister's Office had expertise, contracts and funding to get these campaign messages and materials to a wide audience. It was also very helpful, in terms of maximizing press coverage, to be able to plan press briefings jointly with the Prime Minister's media team.

Extract from an interview by the author with Professor Salminen.

At the beginning of the pandemic the THL already had two experts on behavioural and cultural insights, one of whom is a social anthropologist. They have played an important role in informing the THL's risk communication. However, at the beginning of the pandemic, most of the communication experts in the THL worked on health communication on chronic diseases. Most of these were not used to having to produce messages and materials rapidly, under pressure and working with limited scientific evidence. The THL therefore used emergency funds released for the COVID-19 response to hire additional staff with the skills needed to do risk communication.

"During the acute phases of the pandemic, I was spending a lot of my time being a spokesperson on COVID-19. Luckily, I was able to delegate a lot of the human resources and administrative work I usually have to do as Department Director," says Professor Salminen. "I could concentrate on the COVID-19 emergency work and my deputy did the administration."

In the years before the pandemic, Professor Salminen had completed a high-level course in outbreak management with ECDC, which included a media training module. He had also completed communication and media training courses with the THL.

Reaching all at-risk communities

Part of the THL's legal duty to communicate to the public during cross-border health emergencies is that it should give all groups essential information at the same time. In the country's two biggest cities, Helsinki and Turku, around 15% of the population were born outside of Finland. Thus, in the cities, and many other communities in the country, information about COVID-19 needed to be available in languages such as Arabic, Estonian, Farsi, Kurdish, Pashto, Russian and Somali to make them accessible to migrant communities. This was in addition to making information available in Finnish, Swedish and three dialects of the indigenous Sami language. The THL maintains a multilingual, multi-ethnic team that can make essential information rapidly available in 11 languages. This team works with health departments in the municipalities to engage with migrant communities on COVID-19 and how to prevent it.

Impact

"Even in the acute stage of the pandemic, we never had a full lock-down in Finland. We did not have curfews. And we did not have laws on how many people you could invite into your home," notes Professor Salminen.

Like the people of other Nordic countries, Finnish people tend to have a high level of trust in their government and in their health authorities. It is interesting to observe that their health authorities reciprocate by having a high level of trust in the Finnish people.

"Our analysis was that if the government issued rules prohibiting inviting people, friends or relatives into their homes, there would be complaints and some push-back," said Professor Salminen. "But if we just make a recommendation, most Finnish people will behave in a responsible way. We think that nudging people in the right direction by motivating them gives better results than trying to force them with mandates."

Open, transparent and well-coordinated government communication in Finland undoubtedly helped maintain this high level of trust between the authorities and the people.

Looking to the future

As the COVID-19 pandemic moved out of the acute phase, coordination of the Finnish government's response moved back to the Ministry of Social Affairs and Health. As this happened, the THL stopped working directly with the Prime Minister's Office.

Further information

Finnish government communication service:

https://valtioneuvosto.fi/en/frontpage

THL website:

https://thl.fi/en/web/thlfi-en

Ministry of Social Affairs and Health:

https://stm.fi/en/frontpage

References

1. Emergency risk communication five-step capacity-building package. Copenhagen: WHO Regional Office for Europe; 2017 (https://www.who.int/europe/publications/i/item/WHO-EURO-2018-2993-42751-59637, accessed 28 June 2022).

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3. Finland population. In: World Population Review [website] (https://worldpopulationreview.com/countries/finland-population, accessed 2 May 2022).

4. About the GHSA. In: Global Health Security Agenda [website] (https://ghsagenda.org/about-the-ghsa/, accessed 2 May 2022).

Lessons learned

- Having a whole-of-government system of emergency response with a high-level cross-government coordination group can facilitate coordination of public communication.

- As seen in many previous emergencies, timely and transparent risk communication helps build and maintain trust between health authorities and the public.

- Imposing a legal duty on a public health institute to communicate with the public during international emergencies, as has been done with the THL in Finland, appears to be effective in ensuring it communicates in a timely and transparent way.

- Even in a well-resourced public health system such as Finland, RCCE capacity needed to be reinforced during the pandemic.

- It is not always feasible to repurpose staff from related areas, such as communication on chronic diseases, into RCCE during an emergency. Health authorities need to ensure they have a sufficient number of RCCE specialists among their core staff.

Azerbaijan's 24/7 COVID-19 hotline helps identify and answer public concerns

At a glance

What the case study is about

This case study looks at the COVID-19 telephone hotline service operated by Azerbaijan's State Agency on Mandatory Health Insurance (SAMHI).

Why it is important

The ability to conduct two-way communication and listening is one of the essential RCCE capacities that the WHO Regional Office for Europe recommends all countries should have. Use of dedicated COVID-19 telephone hotline services, along with answering questions online and over social media channels, have been among the main means for conducting two-way communication in the WHO European Region.

Main RCCE core capacity* featured

3. Listening through two-way communication

Other RCCE core capacities* featured

4. Selecting effective channels

* See Box 1.

WHO policy context

The WHO Regional Office for Europe's advice to countries on RCCE capacity-building emphasizes the importance of listening through two-way communication. The Regional Office identifies this as one of the core RCCE capacities all countries must have in place to respond to pandemics and other health emergencies.

In the summer of 2020, the Regional Office published a guide for countries of the European Region on *Setup and management of COVID-19 telephone hotlines (1)*. It notes that hotlines are "among the most commonly used tools by health authorities… in the WHO European Region" for enabling two-way communication on COVID-19. It identifies three main functions of a hotline in an emergency: 1) listening to the questions callers

ask so as to better understand the public's interest and concerns; 2) providing callers with accurate information; and 3) showing that the health authority is open and approachable. All this builds trust. The guide also outlines a set of principles – such as service orientation, being community-led, using emotional intelligence and building trust – that should guide a hotline service on COVID-19. It gives practical advice on how to set up and manage a hotline, how to develop goals and strategies, and how to ensure the service is accessible to the most vulnerable communities. Finally, the guide details how to conduct data collection about the questions being asked to the hotline service in a practical and ethical manner, which enables systematic listening to target audiences.

Aida Farajova, Chief Specialist at SAMHI responsible for the COVID-19 hotline, talks to one of the operators. © SAMHI.

Context of Azerbaijan

Azerbaijan is an upper-middle-income country of around 10 million people located in the south Caucasus region. In recent years, the country has been pursuing a policy of achieving high-quality, sustainable universal health coverage through a government-backed system of social insurance. Since becoming operational in 2016, SAMHI has been a key player in achieving this vision. Its main role is to provide a package of health services to people in return for their mandatory insurance fees. SAMHI is the owner and sole shareholder of the Azerbaijani Management Union of Medical Territorial Units (TABIB), which has been operational since 2019. TABIB is responsible for the management and supervision of health-care facilities that provide care to the people insured by SAMHI. It also acts as Azerbaijan's national public health institute. These two agencies – SAMHI and TABIB – have had joint responsibility with the Ministry of Healthcare for delivering Azerbaijan's national-level response to the COVID-19 pandemic.

SAMHI and the COVID-19 hotline service

The 1542 COVID-19 hotline at SAMHI became operational in March 2020. Later, the incorporation of other services into the call centre (information on mandatory health insurance and other related issues, support lines for psychological and outpatient services etc.) meant it could receive more requests and provide an even better service.

"What we did early on was to create an FAQ document for SAMHI based on the recommendations of WHO and the decisions and resolutions of the Ministry of Healthcare and TABIB," says Aida Farajova, the Chief Specialist at SAMHI responsible for the COVID-19 hotline service. This document, which is frequently updated, was published on SAMHI's website. Call centre operators are doctors and receive training on how to use the FAQ document to provide consistent information to callers.

When the COVID-19 hotline started up in 2020, its staff, equipment and infrastructure came from a telephone-based information service SAMHI was already in the process of rolling out.

The call centre and its staff (currently 23 members) operate as a service within SAMHI. As the call-centre service expanded in 2020 and 2021, additional staff were recruited to supplement the core team, which was initially based on qualified doctors. Doctors sent from medical institutions, volunteer doctors (unemployed), students from Azerbaijan Medical University and psychologists were closely involved in the operation of the COVID-19 hotline.

Volunteers were involved on a rotating basis to keep the hotline running 24 hours a day. Since the new structure of the call centre service was approved, the number of volunteers has been reduced by hiring new staff. Currently just one student from the Medical University is working at the hotline.

Over the months following its launch, the hotline expanded to included various dedicated services, for example on getting COVID-19 test results. A specialist call centre linked to the hotline offers information on the mandatory health insurance scheme as well as COVID-19 related services such as setting up an appointment to get vaccinated. These specialized call centre services are available five days a week from 09:00 to 18:00, but operators at the 1542 number are available 24 hours a day, seven days a week and can answer questions about COVID-19.

The services operate in the Azerbaijani language but many of the operators also speak either Russian or English: some speak all three languages.

Data gathering and social listening

"As well as the operations group [staff who operate the call centre], we have a research group that evaluates the questions, the responses to them … and what people are concerned about," says Ms Farajova. The research group also collects questions the call centre has been unable to answer. It then works with experts in SAMHI and TABIB to develop answers. Sometimes, when a new answer is available, the operations group will ring back the caller whom they had previously been unable to help.

Asked about sharing of data and reports from the call centre with public health decision-makers, Ms Farajova reports that "All the information or statistics relating to a particular question or topic is regularly provided to everyone working in the call centre. Some of the statistical data is then made freely available by SAMHI's Marketing and Public Relations Department".

The top topics on which callers asked questions during 2021 included: access to treatment for people in need of hospitalization; how to place people exposed to COVID-19 in appropriate quarantine; inpatient medical services; medicines to treat COVID-19 and other illnesses; registering for COVID-19 vaccination; COVID-19 health status certificates; COVID-19 related international travel and re-entry into Azerbaijan (e.g. what type of test certificates are needs, what are the quarantine rules).

Azerbaijan makes use of WHO guide on COVID-19 hotlines

In summer 2020, the Regional Office's guide to the set-up and management of COVID-19 hotlines was published in English and Russian (1). The WHO Country Office in Azerbaijan shared this publication with the Ministry of Healthcare and SAMHI. Ms Farajova sees many similarities between the principles advocated in the guide and those adopted by the 1542 call centre. Key among these is the principle of building and maintaining public trust by being service oriented. "If you keep callers waiting for a long time their trust in the service decreases. This is why we have focused on efficiency, good time management and respect for our callers," explains Ms Farajova. This principle of being service oriented led SAHMI to hire extra call centre staff to cope with peaks of demand. Other principles from the Regional Office's guide that the 1542 call centre has been working to apply include: the importance of emotional intelligence; including the most vulnerable in the service; and safeguarding the privacy and confidentiality of callers.

Impact

Operators working at the call centre Monday–Friday typically receive about 80–130 calls per week. The weekend operators typically receive over 200 calls each. The operators promptly inform callers of the answers they receive from the relevant departments of SAHMI.

All calls are free regardless of whether they come from a fixed line or from a mobile telephone. During the interview, Ms Farajova emphasized that SAMHI has paid attention to increasing public satisfaction with the call centre service and the answers it provides to questions about COVID-19. This has included hiring additional operators so that calls are answered quickly. This enabled the service to rapidly refer people with suspected COVID-19 and other serious conditions to health facilities for treatment. The call centre has facilitated COVID-19 case finding and contact tracing, and has generated data on the information needs and concerns of the population.

Looking to the future

SAMHI expects the number of partners the call centre works with to continue to expand. The information the service gives will continue to be updated in line with the latest developments in the pandemic.

Further information

State Agency for Mandatory Health Insurance:

https://jis.az/en/clients/state-agency-for-mandatory-health-insurance/

Azerbaijani Management Union of Medical Territorial Units (TABIB):

https://azerbaijan.az/en/related-information/211

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Lessons learned

- Telephone hotlines such as SAMHI's 1542 COVID-19 hotline in Azerbaijan are an effective channel for two-way communication and listening during a pandemic.

- Repurposing an existing call centre service as a pandemic hotline can help put this service in place rapidly during the early stages of an emergency. In the case of Azerbaijan, SAMHI was able to have an initial COVID-19 hotline service up and running in a matter of weeks during February and March 2020.

- Engaging and training medical students, volunteers and retirees with shifts is an effective way to establish an expert workforce, meet the demand and keep costs down.

- The principles for successful management of a disease emergency hotline set out in the Regional Office's 2020 guide proved useful for SAHMI *(1)*.

How Ireland's Health Service Executive used social media for two-way communication and social listening

At a glance

What the case study is about

This case study looks at the use of corporate social media accounts by Ireland's Health Service Executive (HSE) as platforms for two-way communication with communities and individuals during the COVID-19 pandemic.

Why it is important

Two-way communication with at-risk or affected communities is one of the core RCCE capacities that countries need during a health emergency *(1)*. If the authorities are unable to answer people's questions or take into account their perspectives this erodes public trust and can foster rumours and misinformation. Listening through two-way communication enables health authorities to understand people's needs and concerns, as well as their perceptions and beliefs, and address them in relevant communication strategies and messages that cater to both the head and the heart.

Main RCCE core capacity* featured

3. Listening through two-way communication
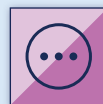
Other RCCE core capacities* and areas featured

2. Coordinating public communication

4. Selecting effective channels and trusted key influencers

C. Infodemic management/detection of rumours

* See Box 1.

Context of Ireland

Ireland is a high-income country in western Europe, with a population of just over 5 million people *(2)*. The HSE is the national agency that provides all of Ireland's public health services in hospitals and communities across the country *(3)*, and it has over 100 000 staff and contractors *(4)*. For many years HSE has been operating a national health telephone hotline called HSE Live. In 2009, during the H1N1 influenza pandemic, HSE Live opened a Twitter account (@HSELive) as an additional channel for communicating with the public, and in 2011 it created a corporate Facebook page. This case study looks at how HSE used these accounts, and particularly its Twitter account, for two-way communication during the COVID-19 pandemic.

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HSE's social media team focuses on two-way communication

In the years leading up to the COVID-19 pandemic, HSE mainly used its social media accounts for corporate communication and promoting its latest health campaigns. HSE did receive and respond to information requests via these accounts, but the service was intermittent over weekends. Requests came as direct messages as well as publicly visible postings. In 2019, the team received and responded to a total of around 2000 information requests over its social media accounts.

The HSE social media team's way of working was to change dramatically in March 2020. The first COVID-19 case was confirmed in Ireland on 29 February 2020. The situation escalated rapidly from there. By 8 March there were 19 confirmed cases and the government reported that community transmission was taking place in Ireland. On 11 March 2020, the day the Director-General of WHO declared COVID-19 to be a pandemic, Ireland recorded its first death from COVID-19 and had 43 confirmed cases *(5)*. On 12 March, Ireland's Taoiseach (Prime Minister) Leo Varadkar announced that schools, colleges and child-care facilities would be closed to stop the spread of COVID-19. He asked people to work from home if they could and signalled that the pandemic would mean "big changes in the way we live our lives" *(6)*.

Saturday 14 March 2020 was the day everything changed for us. I remember having a meeting with my boss, the Head of Digital at HSE. His remit covers the people working for HSE Live, Ireland's national health call centre, as well as the social media team. This was the busiest day either of the teams had ever experienced up until then. And it soon became clear that both services were receiving the same queries.

HSE Live had started to approach retired staff to help them with the huge volume of calls they were receiving about COVID-19. Their staff were mapping the information needs of the callers and using this to develop a script, which answered the most frequently asked questions about COVID-19. The social media team was already receiving a large number of information requests, most of them as direct messages via HSE's Twitter and Instagram accounts. It made sense for HSE Live and the social media team to coordinate and collaborate on answering these questions.

Extracts from an interview by the author with Muiriosa Ryan, Social Media Manager at HSE.

HSE's call centre, content and social media teams worked together with HSE's public health experts to keep the common talking points and FAQ document on COVID-19 and the information on HSE's website up to date and relevant. Answering questions on COVID-19 from 07:00 until 22:00, seven days a week, became a routine task for the social media team.

"I remember one day we received 1800 direct messages over HSE's Twitter account. We managed to respond to nearly all of them within 2 hours," says Ms Ryan. "This was nearly the same as the total amount of messages we received in the previous year."

The team began to anticipate developments which might cause a surge in questions. HSE put extra staff on shift for these.

"When the government was going to announce a new initiative on COVID-19 testing or a change in the travel rules, we knew the public were going to have a lot of questions," explains Ms Ryan. "We also knew that as soon as COVID-19 vaccines became available in Ireland people would want to know when and how to get vaccinated. What we didn't anticipate is getting a huge number of 'vaccine envy' calls. People calling to complain that their cousin or their friend had already been vaccinated but they had not even been offered a date yet."

HSE's social media team counters misinformation

"Vaccination rates in Ireland are very high. Most people are happy to be vaccinated. But we have a small number of very vocal anti-vaccination campaigners. What we have learned is that it is counterproductive trying to engage with them on social media," says Ms Ryan. Several years earlier HSE had tried running a social media based campaign to encourage teenage girls to get the HPV vaccine against cervical cancer. What happened according to Ms Ryan is: "The anti-vaxxers took over the campaign". What HSE focuses on now is getting misinformation from anti-vaccine campaigners and others deprioritized or removed from social media sites. When false information encourages dangerous behaviour or hampers people's decisions to protect their own health, countering it becomes a public health intervention.

In 2019, Ms Ryan and her manager met with counterparts at Twitter and Facebook to discuss how they could work together during a health emergency. This meant that HSE already knew who to contact in the big social media companies when issues arose during the pandemic.

In early 2021, HSE began the roll out of COVID-19 vaccines across Ireland. Countering online misinformation from anti-vaccine campaigners and their allies immediately became a high priority for the HSE social media team. "Twitter put a button on its site for all users in Ireland linking to HSE's vaccine website to make reliable information more accessible," says Ms Ryan. "They [the social media companies] have generally been pretty good at taking down misinformation when we report it. Content that HSE reports gets fast tracked for action seven days a week. Our biggest challenge is finding the time to keep up with all the misinformation being posted," concludes Ms Ryan.

Surge resources

In 2019, HSE's social media team consisted of 4 staff: 1 manager, 2 executives and an assistant. In 2020, the team was assigned 3 extra staff bringing the total to 7. The operational budget for social media also increased by around €100 000.

Impact

In total, HSE's social media team answered more than 50 000 questions from the public in 2020. As of October 2021, the team has answered more than 130 000 questions during extended hours (07:00–22:00), operating seven days a week.

Since February 2021, the HSE social media team has reported thousands of items of misinformation to social media companies. It typically reports 300–400 items each month. The overwhelming majority of items are misinformation about the COVID-19 vaccine, though some are misinformation about treatments or ways of preventing infection. Most items reported by the HSE are removed within 24 hours.

Looking to the future

"A few of us were here during the 2009–2010 pandemic, but most of my team only joined HSE in the last few years. It is good that a new generation of colleagues has learned how to work during an emergency," comments Ms Ryan. "The challenge now is retaining all that experience."

Further information

HSE Ireland's website and social media accounts:

https://www.hse.ie/eng/

https://twitter.com/HSELive

https://www.facebook.com/HSElive

https://www.instagram.com/irishhealthservice/?hl=en

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1. Emergency risk communication five-step capacity-building package. Copenhagen: WHO Regional Office for Europe; 2017 (https://www.who.int/europe/publications/i/item/WHO-EURO-2018-2993-42751-59637, accessed 28 June 2022).

2. Worldometer [website] (www.worldometers.info, accessed 2 May 2022).

3. Who we are, what we do. In: Health Service Executive [website] (https://www.hse.ie/eng/about/, accessed 2 May 2022).

4. HSE Organisational Structure. In: Health Service Executive [website] (https://www.hse.ie/eng/about/who/, accessed 2 May 2022).

5. Timeline: The key dates in Ireland's initial response to the global Covid-19 pandemic. The Journal. 13 June 2020 (https://www.thejournal.ie/timeline-ireland-coronavirus-5120358-Jun2020/, accessed 2 May 2022).

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Lessons learned

- The COVID-19 pandemic highlighted the unprecedented role of social media in disseminating both public health advice and false information.

- During an emergency, health authorities' corporate social media accounts are needed for two-way communication with affected and at-risk communities.

- Some groups and individuals may prefer to interact with health authorities via social media rather than via telephone hotlines.

- Engagement with social media users is optimized if their comments and questions are addressed in a regular and predictable way.

- There needs to be coordination and collaboration between the teams running two-way communication services on different platforms. This helps achieve consistent communication and efficient use of resources. Having a common script or FAQ document, as was the case in Ireland, is a good way to achieve this.

Working with religious leaders as internal mediators in Muslim, Christian and Ultra-Orthodox Jewish communities in Israel

At a glance

What the case study is about
This case study looks at the work done by Mosaica, a CSO based in Israel, to engage and mobilize Muslim, Jewish and Christian religious leaders to support the public health response to COVID-19.

Why it is important
The work of Mosaica provides a model for working with religious leaders as inside mediators to engage communities. WHO's guidance has for many years highlighted the key importance of trust in successful RCCE[1]. The COVID-19 pandemic in the WHO European Region seems to be providing further evidence for this. Countries where trust in government and public institutions is low appear to be experiencing the most challenges in persuading their populations to follow health advice. This is evidenced, for example, in lower uptake of COVID-19 related preventive measures including vaccination. Successful models of how to build trust with communities that are starting from a position of distrust are therefore highlight relevant.

Main RCCE core capacity* featured
4. Selecting effective channels and trusted key influencers
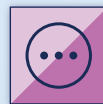
Other RCCE core capacities* and areas featured
3. Listening through two-way communication

F. Vulnerable groups

* See Box 1.

WHO policy context

Throughout the COVID-19 response WHO has emphasized the importance of community engagement to ensure all sections of society, and especially people in vulnerable communities, are reached. Religious leaders and faith-based organizations can play a crucial role in engaging and communicating with the communities they serve. Recognizing this, WHO has identified religious leaders as a priority target group to engage with *(1)*.

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1   Trust is the first priority for WHO in its very first piece of guidance on RCCE, which drew on lessons learned during the 2003 SARS outbreak – see WHO Outbreak Communication Guidelines. Geneva: World Health Organization; 2005 (https://www.who.int/publications/i/item/who-outbreak-communication-guidelines, accessed 2 May 2022). It is also a central concept in WHO's more recent guideline Communicating risk in public health emergencies. Geneva: World Health Organization; 2018 (https://www.who.int/publications/i/item/9789241550208, accessed 2 May 2022).

The WHO Regional Office for Europe participates in WHO's worldwide Community of Practice on Faith-based Organization and has contributed to the *World Health Organization Strategy for engaging religious leaders, faith-based organizations, and faith communities in health emergencies (2)*. That strategy aims to ensure more effective responses to health emergencies by strengthening collaboration between WHO, national governments and religious leaders. The intended result is that more people are better protected during health emergencies and enjoy better health and well-being along with improved trust and social cohesion. The Regional Office offered technical support and practical advice to country and area level partners on how health authorities, and indeed their local WHO offices, can engage with religious leaders and faith-based organizations *(1)*. During 2021, WHO also provided direct funding and technical support to selected CSOs, including Mosaica, which work with religious leaders.[2]

Context of Mosaica

"It is no secret we have a conflict in Israel," says Dr Daniel Roth, who is Director of Mosaica and also a lecturer on religion and conflict resolution at the Program for Conflict Resolution, Management and Negotiation at Bar-Ilan University. He is explaining the work of Mosaica – a CSO dedicated to conflict resolution, dialogue and consensus building – prior to the COVID-19 pandemic. Mosaica ha 25 staff in offices across Israel as well as operations in the West Bank and Gaza Strip. Since being founded some 20 years ago the CSO has been in crisis mode more or less non-stop. "We are constantly trying to negotiate cease-fires between Jewish and Arab communities. Our operations are a series of crises – though up until 2020 it was about ending or preventing armed conflict. In a way, COVID-19 has been just another crisis for us," explains Dr Roth.

It is the network of contacts and relationships of trust that Mosaica has built while working to end or prevent armed conflicts that laid the basis for its work during the pandemic. Dr Roth and his colleagues routinely engage local religious leaders to help mediate between communities in conflict, appealing to their common religious imperative to act to preserve human life. Mosaica has long trusted relationships with Muslim and Jewish religious leaders, as well as Christian religious leaders serving Arab communities in Israel. These leaders tend to be very influential on their religious communities, even though they could be perceived by some as hardliners.

Actions taken by Mosaica early in the COVID-19 response

Mosaica has been engaging with religious leaders on COVID-19 since the start of the pandemic. "Already as far back as February 2020 we were talking to senior Muslim and Jewish religious leaders about closing mosques and synagogues because of COVID-19," recalls Dr Roth. Then in September 2020 a dangerous and false conspiracy theory about COVID-19 and WHO began circulating among the Muslim-Arab community in Israel and the West Bank and Gaza Strip. Some religious leaders acted as multipliers for the misinformation by passing it on to their followers. "Within 24 hours we managed to gather the most influential Muslim religious leaders in a zoom meeting together with senior staff from the WHO Regional Office for Europe, and had them say to their followers COVID-19 is real," recalls Dr Roth. "Some also had to say the message they gave before [when they spread the misinformation] was wrong and that they had investigated properly with the top health professionals."

Partnership between Mosaica and WHO

In 2021, the Regional Office gave financial and technical support to Mosaica under its initiative on innovative cooperation with CSOs.5 "The difference our cooperation with WHO made is that it has enabled us to expand our capacity and be proactive on COVID-19 rather just reacting to crises," said Dr Roth. He went on to give the example of being able to dedicate time and resources in 2021 to developing proactive COVID-19 prevention campaigns with religious leaders ahead of the three biggest holy festivals of the year: Easter (with Christian leaders), Passover (with Jewish leaders) and Ramadan (with Muslim leaders). The financial support from WHO also helped Mosaica in its work with religious leaders to encourage vaccine uptake in their communities. As Dr Roth explains, this work was quite labour intensive:

> Every time the health authorities want to introduce a new policy we need to go to the religious leaders and negotiate their approval of it. If they issue a religious ruling supporting the policy then their followers will support it. So, when the government wanted to introduce vaccination for children, we needed to meet with the religious leaders. When the government wanted to introduce booster jabs, we needed to meet with them again.

2   For more about the Regional Office's activities with CSOs see Breakthrough WHO initiative launched in Europe to engage and empower civil society organizations in health emergency responses. In: News [website]. Copenhagen: WHO Regional Office for Europe; 2021 (https://www.who.int/europe/news/item/16-06-2021-breakthrough-who-initiative-launched-in-europe-to-engage-and-empower-civil-society-organizations-in-health-emergency-responses, accessed 28 June 2022).

Support from WHO has enabled Mosaica to raise awareness of the role that religious leaders have played in responding to the COVID-19 pandemic in Israel. Mosaica has produced a short film featuring three religious leaders – one Jewish, one Muslim and one Christian – who explain how they have engaged with their communities and with each other to protect lives during the pandemic.

Mosaica and the religious leaders it engages with drafted a *Declaration of religious leaders from the Holy Land in response to COVID-19*. This was endorsed at an inter-religious zoom meeting held together with representatives of the Regional Office.

Another aspect of the partnership with the Regional Office is that it enabled Mosaica to commission academic research looking at the impact that engagement with religious leaders has had in meeting public health goals. These include a study led by the University of Haifa's School of Public Health to examine the impact that religious leaders had during the response to COVID-19. As explained by one of the researchers, Dr Jumanah Essa-Hadad of Azrieli Faculty of Medicine, Bar-Ilan University, this study has three main tracks: "interviews with religious leaders, interviews with health professionals and focus group discussions with community members".

A further study being carried out by the Department of Middle Eastern Studies of Bar-Ilan University, examines how the imperatives of religion and science are reconciled in the religious rulings, known as *fatwa*, issued about COVID-19 by the Muslim religious leader Mosaica has been working with.

Work with the Israeli Ministry of Health and its EOC

The Ministry of Health's Emergency Operations Centre (EOC), which coordinates the national response to the pandemic, has a Community Desk function incorporated into it. This desk is staffed by two officials: one who coordinates with, and gives input from the perspective of the Israeli Arab communities; the other who coordinates with Israel's Ultra-Orthodox Jewish communities.

Throughout the pandemic Mosaica has had a lot of contact with the Community Desk officer who works with Israeli Arab communities. "At the start of the pandemic the officer was on the telephone to my colleague Sheik Ra'ed Badir about five times a day," says Dr Roth. Mosaica's network of contacts among the Muslim and Christian religious leaders who serve Israeli Arab communities is particularly strong. These leaders have been essential partners for Mosaica in negotiating numerous ceasefires over the years. However, they are also key interlocutors and representatives for the whole of the Arab Israeli community. It is also critical to note that the senior Islamic leaders have strong ties with and influence over the global Muslim community, and therefore the engagements were well beyond the scope of the Muslims inside Israel.

Mosaica's network of contacts also include the Jewish Ultra-Orthodox religious Zionist movement (known as the *Hardal* community).

Insights into building and maintaining trust

"It is important not to confuse having a grand title with having real influence," says Dr Roth. Mosaica regularly conducts mapping exercises to understand which religious leaders have influence in the different communities and regions where it works. A key lesson learned from this is that looking at the formal hierarchy within a particular religious group, and who is most senior within the hierarchy, does not always tell you which leaders have the most influence on the ground. This means, though, that you must be prepared to engage religious leaders who some may regard as extremists, if they are the ones with real influence in a community.

"When a crisis starts, work with the network of trusted contacts you already have. Don't try and set up new networks," Dr Roth states. Talking about the dilemma Mosaica faced at the start of the pandemic he says: "We decided if we tried to be everything to everyone we would fail". This is why Mosaica targeted just one of the religious Jewish groups, with which it was already working, and has a larger strategic interest in continuing to engage, during the pandemic.

"You build trust by doing something practical that benefits a religious leader's community, such as negotiating a cease-fire," concludes Dr Roth. He believes that doing this type of practical but difficult work with a community is a more effective way of building trust than holding facilitated dialogue meetings or public conferences. The success Mosaica is having in engaging Muslim, Christian and Jewish religious leaders on COVID-19 is built on years of successful engagement with these same leaders to manage or resolve armed conflicts.

Impact

Anecdotal evidence from the field is that individual religious leaders have influenced hundreds of their followers, who had previously been hesitant, to take the COVID-19 vaccine. It is hoped that studies being conducted by Mosaica's academic partners will produce a fuller quantification, and better understanding, of the impact that religious leaders have had in their communities during the pandemic. This evidence, once it becomes available, will support the design and roll-out of more and even better RCCE interventions involving religious leaders – both in Israel and other countries.

Finally, the cooperation with Mosaica enriched the contribution that the Regional Office was able to make to the *World Health Organization strategy for engaging religious leaders, faith-based organizations, and faith communities in health emergencies (3)*. The practical know-how generated by its work with Mosaica has also helped the Regional Office develop an implementation tool on how to engage with religious leaders and faith-based organizations *(1)*.

Looking to the future

Ongoing and future studies conducted by Mosaica's academic partners will help enhance understanding of the health impacts of working with religious leaders and identify lessons that can be applied in future emergencies. Mosaica will share the results from its studies with the Regional Office as some of the lessons identified will likely be of international relevance.

Further information

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2. World Health Organization strategy for engaging religious leaders, faith-based organizations, and faith communities in health emergencies. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/347871, accessed 2 May 2022).

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Lessons learned

- COVID-19 highlighted the role of religious leaders as key influencers in their communities.

- Religious leaders have the potential to be highly effective "inside mediators" who can reconcile science and society. They can dispel rumours with messages backed by science and religion, increase social cohesion, and facilitate engagement between health authorities and communities.

- Before deciding which religious leaders to target, health authorities should map which leaders have the biggest influence "on the ground" in the community. These may not be the leaders who nominally have the most authority within the hierarchy of their religion. These influential leaders may include some whose views may be perceived as outside the mainstream yet have significant influence.

- Developing relationships of trust with religious leaders can take a lot of time and effort. It is better to develop these relationships before an emergency, rather than trying to do it during one.

WHO engages with youth on COVID-19 in Kazakhstan and across the WHO European Region

At a glance

What the case study is about

This case study looks at work done in the WHO European Region to engage youth in the response to the pandemic, featuring both Region-wide initiatives and country-level work – particularly in Kazakhstan and also in Armenia.

Why it is important

Youth have been among the most affected by the pandemic's indirect impacts *(1)*. Factors such as disruption of education, loss of job prospects and loss of social interaction have caused widespread anxiety for many and more serious mental health issues for some.

Main RCCE core capacity* featured

4. Selecting effective channels and trusted key influencers

Other RCCE core capacities* and areas featured

3. Listening through two-way communication

F. Vulnerable groups

* See Box 1.

Context – the impact of the pandemic on youth

Young people have been among the most affected by the pandemic's indirect impacts *(2)*. School-age children and university students have had their education disrupted and been unable to see their friends; young people leaving education have struggled to find work because of the economic impact of the pandemic; and some young people have been exposed to domestic violence or sexual abuse during times when they could not leave home. Nearly all have experienced anxiety and loneliness.

WHO Regional Office for Europe starts early in engaging youth on the pandemic

In April 2020, the Regional Office directly engaged with young people in the Region through a series of interactive webinars to emphasize WHO's COVID-19 messaging and to understand younger people's perceptions of the pandemic. Through this interaction, WHO learned just how concerned young people were with the situation and how much they wanted to be part of the solution. In response to WHO's outreach, Global Shapers, the youth network of the World Economic Forum, created a Facebook group to share WHO information and messages through their networks, and to track rumours and misinformation.

Between September and December 2020, the Regional Office held a series of ad hoc consultations with representatives of the International Federation of Medical Students' Associations (IFMSA), the Youth Health Organization (YHO) and several Global Shapers hubs in the Region to understand more about how the pandemic had impacted them. Support for mental health, combatting loneliness and improving educational and employment opportunities were key areas of interest.

Yerkezhan Kadessova from Kazakhstan is an applied policy researcher with an interest in patient engagement. She has been a member of the Global Shapers hub in Kazakhstan for just over two years and participated in the discussions with the Regional Office on its approach to engaging with youth. "We helped by giving some youth insights on the [WHO team's ideas]. The document was then revised and spread to the WHO country offices, including the office in Kazakhstan. It was then up to the [country] offices to decide if they wanted to use it."

During this stage of the pandemic the Regional Office advocated for health authorities to:

- acknowledge the specific hardships young people have faced during the pandemic – for example, disruption of education, loss of employment opportunities and social isolation;

- avoid messages that stigmatize young people by blaming them for the spread of COVID-19;

- create targeted communication for young people (it is important to note that the first wave of health messaging about COVID-19 tended to emphasize the risk to older people, which may have contributed to low risk perception among youth);

- acknowledge that youth want to play a positive role in the response to COVID-19;

- engage with youth and their representatives as partners in the response to COVID-19;

- use positive messages that focus on what can be done while staying safe during the pandemic, rather than focusing on what cannot be done;

- use social media channels, storytelling and peer-to-peer communication to connect with youth.

WHO country offices support engagement with youth (2021–2022)

Following up on the work it did in 2020, the Regional Office and its network of country offices subsequently encouraged and facilitated engagement between national public health authorities and youth representatives. What follows is a case study from Kazakhstan on an initiative there and an update on youth engagement work in Armenia.

Case Study from Kazakhstan

Context – Kazakhstan more than a year into the pandemic

Situated between the Russian Federation to its north and China to its south-east, Kazakhstan is the largest of the five Central Asian Republics.[1] It has a population of just over 19 million people of whom around one third (6.3 million) are under 18. Schools in Kazakhstan were closed during the first case surge in the pandemic in 2020 and did not reopen until September 2021. With school online and most public facilities closed opportunities for young people to meet friends and socialize face to face were very limited. The long, cold Kazakh winter of 2020–2021 was therefore a difficult time for most young people.

Request for support from the Ministry of Healthcare

In early 2021, the Ministry of Healthcare asked the WHO Country Office in Kazakhstan to work with them to develop a video on the issues facing young Kazakhs during the pandemic. It would be a video by young people, for young people, and would enable them to share emotions, experiences and advice. The young people in the video would talk openly about what they found difficult during the pandemic, but then give advice to their peers on how to overcome these challenges.

Process of making the video

Zhanna Perzadayeva is a specialist communication consultant working for the WHO Country Office in Kazakhstan. In February 2021, with financial support from the Government of Germany and the EU, she hired a creative agency to help make the video. The agency, which is based in the capital Nur-Sultan set up the filming with a group of teenagers in Kazakhstan's biggest city Almaty. "They also conducted a survey [in Almaty] of about 15 teenagers asking them how they were feeling during this difficult period of COVID-19," said Zhanna. "They asked them: what did you do during lockdown?; what difficulties did you face?; why is it so difficult being alone?" The frustrations voiced in the survey – from unreliable wi-fi connections disrupting online learning to

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1   The other four Central Asian Republics are Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.

Youth in Almaty, Kazakhstan meet safely in a park: scene from the video on youth and COVID-19. © WHO Country Office in Kazakhstan.

feelings of boredom and isolation from spending all day at home in front of a screen – all fed into the script for the video.

In the video, nine teenagers (six female, three male) of differing ages and ethnicities tell the story of how the pandemic has affected their lives. They start by talking about all the negative impacts it has had, and about their anxieties and frustrations. But then they talk about what they have done to cope and make themselves feel happier: baking cookies, painting, taking the dog for a walk, talking to friends online, playing their guitar. The video ends with all of the young people meeting in a park in Almaty. They maintain a safe distance, but one has brought her dog and one has brought his guitar. They interact and have fun.

How the RCCE principles are reflected in the video

The teenagers featured in the video helped to design the script and were empowered to give voice to their experiences. Because of this, the video uses a storytelling approach to acknowledge the hardships that young people in Kazakhstan experienced during the pandemic. Mental health issues are addressed in an empathetic, non-stigmatizing way. The video showcases the positive

role that youth want to play in responding to the pandemic, and ends with the young people giving advice to their peers on maintaining their health and well-being.

Distribution and impact of video

The video was made in both Kazakh and Russian languages and has been shown on the national Kazakh and Russian-language television channels. It has been distributed via the social media pages of the WHO Country Office and the social media channels of partners such as the Ministry of Healthcare, the EU and Global Shapers.

"I helped as a member of the Kazakhstan hub to spread the video on our platforms [on Facebook and Instagram] and those of our partners," said Yerkezhan Kadessova, the youth from Global Shapers. "I gave the video to a public-relations guy in our hub and he did a lot to promote it."

The video gave its viewers practical advice on how to maintain health and well-being during the pandemic in a format and style recognized as good RCCE practice by the Regional Office. It is challenging to verify the real-world impact on people's behaviour of a single communication intervention; nonetheless, the video was well received by the Ministry of Healthcare's partners and stakeholders.

Update from Armenia: winter 2021–2022

During 2021 and early 2022, WHO staff in the Regional Office and its network of country offices continued engaging with youth representatives and facilitating contacts between health authorities and young people. This has involved WHO staff organizing briefings and engagement meetings both at regional and country level.

One such briefing and engagement meeting was organized as a virtual event by the WHO Country Office in Armenia in February 2022. Some 20 young people from two youth organizations – European Youth Parliament and Armenian Progressive Youth – joined a teleconference with representatives of WHO and the Armenian authorities.

The youth participants asked many questions, especially regarding the risks and benefits of the COVID-19 vaccine. The meeting ended with agreement to engage further on practical ways in which youth organizations can support the COVID-19 response.

Further information

Watch the video on the Facebook page of the WHO Country Office for Kazakhstan:

Russian language version

https://www.facebook.com/WHOKazakhstan/videos/483501316088548

Kazakh language version

https://www.facebook.com/WHOKazakhstan/videos/190652476281745

For more information on the challenges youth face during the pandemic and on promotion of COVID-19 safe behaviours follow the links below:

Behavioural and cultural insights shed light on how the pandemic has left youth behind

https://www.who.int/europe/news/item/11-07-2021-behavioural-and-cultural-insights-shed-light-on-how-the-pandemic-has-left-youth-behind

Young people and COVID-19: Behavioural considerations for promoting safe behaviours

https://www.who.int/publications/i/item/978-92-4-002831-9

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Lessons learned

- Active engagement with youth groups since the early weeks of the pandemic has helped keep its impact on young people high on the policy agenda in the Region.

- The experience at the regional level and from Kazakhstan shows the benefits of engaging youth in developing messages and materials aimed at them. This helps ensure that the material is relevant, credible and appealing to the target audience. Involving youth representatives in publicizing the materials helps target the most effective channels for reaching young people, which can ensure they are widely seen by them.

- Youth want to be partners in the response to health emergencies. As seen in Armenia, they appreciate the opportunity to talk directly to senior health officials and experts. They are also keen to play a positive role in responding to COVID-19 when empowered to do so.

Если Вы в течение последних 14 дней были в китайском городе Ухань, и у Вас есть какие-либо из нижеуказанных симптомов, обратитесь к врачу

ЖАР

КАШЕЛЬ

ЗАТРУДНЕННОЕ ДЫХАНИЕ

При появлении симптомов в течение 14 дней после отъезда из Китая, для бесплатной консультации и лечения, обратитесь к своему лечащему врачу,

А ЕСЛИ

заметили какие-либо симптомы в аэропорту, позвоните на горячую линию МЗ РА 8003

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新型冠状病毒感染 (2019-nCoV)

ZVARTNOTS

如果您在最后14天内去过中国武汉市和出现出现症状

应该联系医疗专业人员

出现发热   干咳

Pre-testing COVID-19 RCCE messages and materials in Armenia and the Russian Federation

At a glance

What the case studies are about

These two case studies look at how and why to pre-test messages before launching an RCCE campaign. The examples looked at are two campaigns encouraging COVID-19 prevention behaviours: Armenia's adaptation of the WHO Regional Office for Europe's #DoItAll campaign in 2021; and a campaign run in the Russian Federation in summer 2020.

Why they are important

Message pre-testing is best practice as recommended by WHO and other United Nations agencies. Nonetheless, during emergencies such as a pandemic, health authorities are sometimes tempted not to do it – especially where they are short of time and resources. These case studies illustrate why pre-testing is crucial, even during emergencies, to ensure message effectiveness and resource optimization, and how it can be done relatively quickly and cheaply.

Main area featured

B. RCCE in support of prevention measures

Other RCCE core capacities* and areas featured

3. Listening through two-way communication

4. Selecting effective channels and trusted key influencers

* See Box 1.

WHO policy context

WHO has long recognized pre-testing of messages and materials as good practice in RCCE *(1)*. This was emphasized by the Regional Office in its *Emergency risk communication five-step capacity-building package* of 2017, which devotes a chapter to this subject *(2)*. This will be an important recommended action to practitioners on WHO's new RCCE capacity-building platform.

The reason WHO recommends pre-testing is because sometimes audiences understand, or react to, a message in a way the message's authors had not anticipated. When this happens, the audience will probably not accept the guidance and in turn not adopt the behaviours the health authority wants them to. According to internal advice on pre-testing circulated by the RCCE team in the Regional Office,[1] its purpose is to investigate:

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1   Extract from WHO Regional Office for Europe guidance note to WHO country offices on message pre-testing (internal document, 2020).

- clarity – are the messages clear to the audience?

- behavioural intentions – do the messages have an impact on the audience's intention to initiate or maintain protective behaviours?

- emotional response – do the messages trigger negative emotions such as anxiety or anger?

When it runs RCCE campaigns aimed at populations across the European Region, the Regional Office asks its country offices to "localize" centrally developed messages and materials. "Localizing" means more than just translating messages and materials into the language(s) of the country; it also means adapting them to the unique social and cultural context. Given these adaptations of language and content, it makes sense to do pre-testing on a country-by-country basis. This is why, early in the pandemic, the Regional Office reminded country offices of the importance of pre-testing messages and materials. Its internal guidance suggested a number of methods for doing this:

- focus group discussions

- online surveys

- intercept interviews.[8]

Each of these techniques has its own inherent advantages and disadvantages, as outlined below.

The quantitative technique of an online survey can test messages and materials on a large sample of people from the target audience(s). These show the messages and materials to people on a computer or on their mobile device and asks them to fill in a questionnaire about them. The survey can be conducted on hundreds or even thousands of people, which generates statistics and makes the results likely to be representative. The disadvantage is that the questions have to be quite narrowly focused: there is not much scope for participants to raise issues or concerns that the researchers may not have thought of. The other disadvantages of surveys are that collecting the data can be slow, labour intensive and/ or expensive, especially if you aim for a large sample – and survey design and analysis require a high level of skill.

The two qualitative methods proposed are pre-testing using focus group discussions, which are approximately 1-hour moderated discussions with 6–10 people from the target audience(s); or intercept interviews (stopping people from the target audience at random on the street or some other public place and asking their views). The advantages of these techniques are: they provide more depth of discussion and insight, in that they allow input from members of the target audience in their own words; they enable participants to raise issues or concerns

that the RCCE team may not have thought of; and they can be conducted relatively quickly and cheaply. The biggest disadvantage of rapid qualitative studies is that the sample sizes tend to be small – maybe 20 or fewer. This means you cannot be sure how representative the feedback you get is of the wider audience.

The Regional Office gives suggestions on how to work with partners, such as other United Nations agencies, local universities, CSOs or communication research agencies who may have expertise in using these techniques. It also gives advice on how country office staff can do these studies in-house.[8]

This double case-study looks at two different approaches to pre-testing:

- The WHO Country Office in Armenia tested messages and materials using focus group discussions conducted by an external agency.

- The WHO Country Office in the Russian Federation conducted pre-testing using an online

- survey and in-house resources.

Region-wide risk communication campaigns

In the spring and early summer of 2020, when the first waves of COVID-19 were hitting countries in the European Region there was a huge demand for reliable, accurate information on how people could protect themselves and their families from COVID-19. The Regional Office, working closely with WHO headquarters, rapidly produced a range of risk communication materials giving science-based, easy to follow messages on COVID-19 and behaviours that can prevent it. Much of this output took the form of social media cards, short videos and posters in English.

At the beginning of 2021, most countries across the European Region began to roll-out COVID-19 mass vaccination campaigns. Many audiences, including many policy-makers, thought the arrival of vaccines meant other protective behaviours, such as physical distancing and mask wearing, could be abandoned. However, the emerging evidence on COVID-19 vaccines was that while they were highly effective in stopping people becoming seriously ill and dying, they did not stop transmission of the virus. The Regional Office therefore developed a Region-wide RCCE campaign called #DoItAll *(3)*, aimed at encouraging prevention behaviours. A set of key messages and campaign artwork was produced centrally by the RCCE team in the Regional Office. The frontline of the campaign, though, had to be in countries.

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Case study A: Armenia (focus group discussions)

This first case study looks at how the WHO Country Office in Armenia used focus group discussions to pre-test messages and materials for their audiences.

How the message pre-testing was conducted

The WHO Country Office and the Ministry of Health identified four priority groups for the #DoItAll campaign *(3)* in Armenia: health-care workers, teachers, young people and journalists. In mid-February a communication agency contracted by the Country Office conducted focus group discussions with people from these groups. These were held face to face in a hotel in Yerevan, the Armenian capital. The group moderators wore face masks and masks were available for participants. Whether they chose to wear masks during the discussion was one of the factors observed to assess their current level of compliance with COVID-19 protective behaviours. The consultancy managed to recruit 11 health-care workers (8 male and 3 female), 10 teachers (all female) and 9 young people (3 male and 6 female). The discussions lasted about 90 minutes for each group.

How the campaign was adapted

"The findings were very interesting. Not only because we found what messages may work, what messages might not work and what risks are associated with the messages that we developed; but we also identified the right channels and the right spokespeople to use [for the different groups]," says Anzhela Kzhdryan, who was the RCCE Officer at the WHO Country Office in Armenia at the time. "For instance, if we talk about teachers, we found that when [a COVID-19 prevention message] comes from the authorities or parents then teachers perceive it as criticism. But if it comes from a peer – another teacher – it is not perceived like that. That is why we started to work with different teachers that may be influencers."

Message pre-testing can identify barriers to behaviour change that the health authorities had not even thought of. For example, for the focus group discussion with teachers, Ms Kzhdryan found: "They want their students to wear masks, but the students' parents don't want this. So, we found another target audience to work with – the parents".

Another important result from the testing was that a message that had worked well in many other countries did not work in the context of Armenia. Some focus group participants found messaging about health workers being "heroes" to be embarrassing and inappropriate. In Armenia's historical, cultural and political context the term had strong military connotations.

The testing did, however, confirm that social media is a hugely important source of information and news in Armenia – especially, but not only, among young people. It confirmed that young people are the group most open to accepting WHO's messages on COVID-19 prevention behaviours, and most likely to advocate such behaviours to others in society. In response to this, the Country Office and its partners – the Ministry of Health and the EU – engaged social media influencers who could reach young people (see Table 3). In parallel, though, the campaign also used street advertising and stories in traditional mass media, such as television and newspapers, to make sure that Armenians not connected to social media were also reached.

Table 3. Armenian social media influencers engaged by the #DoItAll campaign

Name	Career	Instagram followers	Views achieved by post of campaign infographic
Satenik Hazaryan	Actress, television host/presenter at Panarmenian Media Group	32 600	4814
Artak Vardanyan	Television host/ presenter at Panarmenian Media Group	63 700	1000
Faina Harutyunyan	Fashion designer	54 000	1546
Hermine Stepanyan	Actress, television host/presenter at Panarmenian Media Group	12 500	435
Sona Sarkisyan	Musician	63 700	n/a
Diana Malenko	Actress, television host/presenter at Panarmenian Media Group	57 500	n/a

Resources and WHO support

The message testing and adaptation of #DoItAll campaign materials for the Armenian context was outsourced to a local communication agency. This was financed as part of a wider grant from the EU to Armenia to support its response to the COVID-19 pandemic.

Ms Kzhdryan, supervised the work of the agency. She also provided technical leadership for the implementation phase of the campaign. Other United Nations agencies and partners in Armenia, including the EU Delegation publicized campaign materials via their websites and social media channels.

Looking to the future

Experiences from the message testing in the #DoItAll campaign can serve as a knowledge base for future campaigns. Local communication agencies know how to recruit for, conduct and report on message testing in focus groups. Accessing their services, though, is dependent on continued funding being available for RCCE campaigns.

Case study B:
Russian Federation (online survey)

This second case study looks at how the WHO Country Office in the Russian Federation adapted messages and materials from the Regional Office in summer 2020. In particular, it looks at how online pre-testing was carried out in-house.

Demand for a WHO COVID-19 campaign

In spring and early summer of 2020, the first surge of COVID-19 was hitting the Russian Federation. The WHO Country Office was contacted by Vkontakte, the most widely used social media platform in the country, and asked to open an account to disseminate reliable, accurate information about COVID-19. The RCCE team in the Regional Office had, by then, produced a range of risk communication materials on the disease. The Country Office made translations of some of these materials, posted them on Vkontakte and monitored the audience reaction.

Rather than have localized materials live tested on a potentially very large audience, the Regional Office RCCE team suggested doing pre-testing to better tailor the materials for the Russian Federation context, and the Country Office supported this.

How the message pre-testing was done

The challenge the Country Office faced was that Moscow (where the Country Office is based) and other Russian Federation regions were then in lockdown. There was no way to organize face-to-face focus groups, and the Country Office did not have allocated funds to engage a market research company to do online testing. They therefore developed an online survey to test the messages and materials using free software (a Russian language version of Google documents), which they then promoted to their networks via email and messaging services (WhatsApp, Telegram).

A total of just under 100 people completed the survey. The respondents ranged in age from 8 to 51 and where more or less balanced 50:50 between male and female. Ola Manukhina, the communication focal point in the Country Office, and her colleagues then analysed the results.

According to Ms Manukhina, one of the challenges in analysing the online survey results was that for open questions some people gave very short answers; "for instance when asked how an image made them feel, some people just provided a one word answer and it was very difficult to understand. When they provided a full sentence it was much easier".

How the campaign was adapted

"One of the most vivid reactions we got was to the colour of the posters," says Ms Manukhina. "People didn't like the dark blue version of the poster. They said it was depressing. There was another poster in red and everyone said red is much better."

A graphic of a person covering their mouth and nose with their elbow to prevent the spread of droplets when they coughed or sneezed was not well understood and had to be redrawn. There were also many comments on the language used.

Fig. 3.

© WHO Country Office in the Russian Federation.

Test participants preferred the red version of the poster above but had difficulty understanding the graphic on covering your mouth and nose with your arm if you cough or sneeze. See Fig. 3.

When a text is translated from English into the Russian language it typically becomes 30% longer. The Country Office team had tried to keep close to the original when doing the translation so as to retain all the ideas and nuance it contained. However, the result was that test participants saw the posters as being too text heavy. Tone and expression that worked in English also did not always translate well for a Russian language audience. "The text sounded dry and formal to a Russian audience," says Ms Manukhina. "They said it's like something is being imposed from above." Even when the translation was adjusted a bit, the test audience still felt negative about messages that sounded like restrictions. When the messages were reoriented as an appeal to social solidarity, however, the audience were able to accept them.

I always keep alcohol handrub in my bag and clean my hands after touching surfaces in public places. **It's my lifelong habit.**

#MyHandsAreClean #DoItAll

SAVE LIVES
CLEAN YOUR HANDS

© WHO

Clean hands protect me from diseases. I wash them with water and soap at home and clean with alcohol handrub while out and about. **It's my lifelong habit.**

#MyHandsAreClean #DoItAll

SAVE LIVES
CLEAN YOUR HANDS

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Resources

The message pre-testing in the Russian Federation was all done using in-house capacity and free online resources for sharing the materials and gathering responses to the questionnaire. The "cost" was the time of WHO colleagues who designed the survey and sent it out to potential participants.

> "We invested time and effort in follow-up (after sending out the survey)," explains Ms Manukhina. "After a couple of weeks we got enough responses to have a decent sample."

The benefit of having done the pre-testing, was that the Country Office had more confidence that the materials worked with their target audience.

Looking to the future

Ms Manukhina believes the same technique for pre-testing of messages could be used again in future. However, she would want to ensure different people were approached. "If we approach the same people again then they know already what we are looking for. They are no longer such a representative sample," she says.

Further information

WHO Armenia website:
https://www.who.int/armenia

WHO Russian Federation website:
https://www.who.int/russian-federation

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Lessons learned

- Even when done with small-scale, rapid studies, pre-testing is critical to increase the likelihood that messages and materials achieve the outcome they were designed for and money is not wasted from having to redo the campaign after it is launched. Whatever technique is used, pre-testing is a vital quality check. Changing messages at a later stage will reduce the effectiveness of the campaign and affect the credibility of the source.

- Pre-testing always leads to new insights and improvements to draft messages and materials. This happened with the pre-testing in both Armenia and the Russian Federation, even though they used different techniques.

- The focus group discussions in Armenia highlighted issues that the RCCE team had not thought of when it launched the pre-testing. For example, they identified beliefs among parents that were a barrier to children wearing masks at school, which the team had not been aware of. They also identified that some Armenians might be offended by a set of messages that had worked well in other countries (one describing health-care workers as heroes – see case study). Participants in focus group discussions are able to say more, and so reveal more insights.

- The online survey conducted by staff from the WHO Country Office in the Russian Federation enabled the messages and materials to be tested on a sample of nearly 100 people, compared to a sample of 30 who participated in focus group discussions in Armenia. The results from the Russian Federation were likely to be more representative of the target audience. However, the range of insights generated were narrower and some of the responses were difficult to interpret.

- The key rule with pre-testing during an emergency is "do what is possible, but do it". During an emergency the RCCE team may have only a few days or weeks to pre-test a campaign. The team leader should look at the skills and resources available both in-house (e.g. do they have colleagues who know how to design and analyse surveys, or to facilitate and write up focus group discussions) and among partner organizations. They should then make a decision based on what is achievable with the resources they have access to, and in the timescale available.

How RCCE training helped contact tracers across the European Region: experience from the Western Balkans

At a glance

What the case studies are about

This case study looks at how RCCE supported COVID-19 contact tracing in the WHO European Region. It focuses in particular on experience from the area of Kosovo[1] in the Western Balkans.

Why it is important

At both global level and in the European Region WHO has promoted COVID-19 contact tracing, along with COVID-19 testing, as a key strategy to break chains of transmission, prevent people catching COVID-19 and, ultimately, save lives. However, to be successful, contact tracing programmes need engagement and support from the communities they are aimed at. This has been a clear lesson learned from the COVID-19 pandemic, and indeed previous health emergencies. This case study describes some practical steps supported by the WHO Regional Office for Europe to empower contact tracers with the skills and information they need to engage individuals and communities and enlist their support.

Main RCCE core capacity* and area featured

4. Selecting effective channels and trusted key influencers

B. RCCE in support of prevention measures
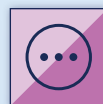
Other RCCE core capacity* featured

3. Listening through two-way communication

* See Box 1.

WHO policy context

Contact tracing is the process of identifying, assessing and managing people who have been exposed to a disease to prevent onward transmission. From early 2020 onwards, WHO advised its countries and partners to implement contact tracing programmes, including COVID-19 testing where possible, to break chains of

COVID-19 transmission *(1)*. Following this advice, many countries and areas used testing and contact tracing, combined with policies on quarantining of close contacts and isolation of confirmed cases, to supress or reduce the spread of COVID-19. WHO's global-level interim guidance on contact tracing in the context of COVID-19 identifies

1   All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

"community engagement and public support" as critical elements for successful contact tracing programmes *(1)*.

From the spring of 2020 onwards, the WHO Regional Office for Europe provided technical support to country and area level partners to help them ramp up their COVID-19 testing and contact tracing capacities. In the autumn of 2020, the Regional Office's COVID-19 Incident Management Support Team created a contact tracing working group. This was tasked with further scaling up WHO's technical support to country and area partners in the European Region.

Multi-country/area contact tracing training in autumn 2020

In autumn 2020, Michala Hegermann-Lindencrone became one of the technical leads on contact tracing in this working group on behalf of the Epidemiology Pillar of WHO's response to the pandemic in the European Region. She recalls: "The scale of contact tracing... [needed for COVID-19] was not something any health authorities or partners in the European Region had planned for. One of the first things we did was run multi-country/area workshops on how to set up a COVID-19 contract tracing system".

According to Kimberly Rambaud, a consultant working in the RCCE Pillar of WHO's pandemic response in the European Region since 2020: "Michala in the Epidemiology Pillar reached out to share that there was interest from country and area level partners to begin carrying out contact tracing trainings and that it would be good to include RCCE. We rapidly adapted our interim guidance on RCCE for contact tracing to a training format and quickly got on board".

WHO's RCCE experts such as Ms Rambaud, and later her colleague Dr Altug Akin (RCCE consultant with the Regional Office) conducted the RCCE part of the training alongside colleagues from the Epidemiology Pillar.

Five virtual trainings with participants from a total of 20 priority country and area level partners in the European Region were held in the autumn of 2020. Each workshop focused on the "what", "why" and "how" of establishing a COVID-19 contract tracing system. These online workshops lasted around 3 hours and focused in particular on:

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- how to plan the COVID-19 contact tracing system;

- training staff and volunteers to conduct contact tracing;

- the importance of incorporating RCCE techniques such as two-way communication and empathetic listening to effectively engage communities, build trust and earn support for contact tracing;

- use of digital tools for contact tracing;

- evaluating the performance of the contact tracing system.

Interim guidance on RCCE for contact tracing

In September 2020, behavioural insight surveys on COVID-19 were being carried out with WHO support in several countries in the Region. With the agreement of the public health partners involved, the WHO team added two questions on attitudes to contact tracing:

- If you had been in contact with someone who tested positive for COVID-19 and had no symptoms yourself, would you get tested if you had the opportunity?

- If you tested positive for COVID-19 and were asked to share with health authorities the names of people you had been in contact with, would you share all names?

The RCCE team at the Regional Office drew on the results from these surveys, and particularly the answers to these questions, to develop evidence-informed guidance on using RCCE to support contact tracing. Results for these questions were included in the interim guidance, and also used to develop the practical RCCE tools annexed to it *(2)*.

In September 2020 over 80% of people surveyed answered "yes" to being tested and over 90% answered "yes" to sharing all names. The most common reasons motivating people to do this included:

- I believe this helps stop the spread of COVID-19.

- This way I can protect other people.

- This is my responsibility as a citizen.

- I want to receive the appropriate care in case of a positive test.

The interim guidance advises health authorities and partners on how to use these insights to improve the success rate of contact tracing. It also provides ready to use tools such as message maps and a template leaflet for communities where COVID-19 contact tracing is taking place. While stressing the value of conducting further surveys and localizing messages, the interim guidance works through how insights from the September 2020 survey can be developed into messaging and other RCCE interventions. This is designed to resonate with, and reinforce, the insights on positive motivations to cooperate, leveraging on responsibility and solidarity, such as:

- Contact tracing can stop the spread of COVID-19.

- Contact tracing is among the key public health measures that can break the COVID-19 chain of transmission.

- To stop the spread, we must all help the contact tracers by getting tested, by sharing our contacts and by monitoring our symptoms.

- The September 2020 survey results also identified various common objections and barrier to action among people who did not want to cooperate with COVID-19 contact tracers. These included:

- I do not think the tests are reliable.

- I do not believe COVID-19 exists.

- I believe this could result in loss of income due to quarantine.

- I would cause inconvenience for the people whose names I shared.

The interim guidance proposes messaging and engagement strategies to address these and other objections. It advises on the importance of building and maintaining trust with the communities and individuals contact tracers work with. It gives guidance on what national health authorities leading contact tracing and individual contact tracers need to do to build and maintain trust, by putting an evidence-based theory on the factors driving trust into the practical context of contact tracing. This is illustrated in Table 4.

Table 4. How evidence-based model of factors supporting trust was applied to RCCE in support of contact tracing

Factors supporting trust (from evidence-based model (3))	Questions that help clarify how trustworthy contact tracers will be perceived by (possible) contacts (2)
Empathy and caring	Does the contact tracer understand me and my situation?
Honesty and openness	Is the contact tracer telling me the truth and not hiding information?
Dedication and commitment	Is the contact tracer acting primarily to safeguard my health?
Competence and expertise	Does the contact tracer have the required skills to complete the job?

RCCE as part of the second round of training

In the first half of 2021, the Regional Office's COVID-19 response team launched a second round of capacity-building to support contact tracing. Though still conducted as 2–3-hour online workshops, each was organised with an individual country or area level partner and their local WHO office. The aim of these workshops was to:

- tailor capacity-building to specific situations and contexts;

- further improve the skills of health workers and volunteers already involved in COVID-19 contact tracing efforts;

- increase the size of the workforce by supporting the training of more COVID-19 contact tracers.

Depending on the needs and preferences of the country/ area level partner, the workshops were conducted either as:

- training-of-trainers sessions – with intensive training for 6–18 senior epidemiologists from the partner organisation, who then adapted the training materials into their local language(s) and used them to run country/area level training sessions for their workforce of contact tracers; or

- direct training by the WHO team for the country/ area's workforce of contact tracers. These workshops typically had 100–370 participants.

RCCE training made up around 50% of both types of workshops. As well as looking at the interim guidance, proposed messaging and building trust, the RCCE training contained a practical exercise: a role play in which participants must try and persuade a reluctant citizen to name their contacts, or to agree to be tested against COVID-19.

Dr Akin recalls:

> "Role plays are great for engaging participants. You change from doing a lecture to a kind of performance. But doing the role play remotely is never easy. The scenario always had to be doing the contact tracing over the telephone. After each role play, other participants can comment on what their colleagues did well and what could be improved. Then we change around and the person role playing the reluctant citizen becomes the contact tracer."

During 2021, WHO organized a total of 12 of these COVID-19 contact tracing workshops with 10 countries/ area level partners in the European Region. These were held with partners in the Caucuses, central Asia, eastern Europe and the western Balkans. Two trainings were organized with WHO's office in Pristina and its public health partner in Kosovo.[1]

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1   All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

Context of Kosovo[1]

Kosovo[11] is an upper-middle-income area of the western Balkans subregion of Europe. It has a population of around 1.8 million, with just under 7% of the population aged over 65. Contact tracing there is performed by epidemiologists, public health specialists and family doctors, depending on the circumstance. WHO's public health partner there is responsible for the whole area and plays the lead role in organizing and conducting outbreak investigations and contact tracing. However, for major outbreaks this partner involves a network of six public health centres in the sub-areas of Peja, Prizren, Mitrovica, Gjilan, Gjakova and Ferizaj. Contact tracing is then organized on the basis of teams in each of these sub-areas.

At the start of the pandemic in 2020, WHO's area-wide partner had a central team of 20 staff attached to its Emergency Operations Centre as its contact tracing workforce. This team was rapidly doubled in size with internal surge staff redeployed within the organisation. This produced an area-wide team of 40 contact tracers. By the second half of 2020 it became clear that the COVID-19 contact tracing workforce needed to be expanded significantly. WHO's partner organisation started working with its six sub-area centres to achieve this. Additional staff, such as data clerks, technicians and family doctors were drafted in to help with the contact tracing effort, but some of them had little or no experience of doing contact tracing. This is why WHO's partner organisation was happy to have technical assistance from it in training its expanding contact tracing workforce.

WHO training-of-trainers workshops for Kosovo[1]

In May and June 2021, WHO organized two online training-of-trainers workshops with its public health partner in Kosovo[11], WHO's Western Balkans Sub-Region Hub and WHO's office in Pristina. Dr Pranvera Kaçaniku Gunga, an epidemiologist at the partner organisation, became part of its contact tracing team in early 2021. She recalls that the contact tracing training from WHO was timed rather well:

When I was appointed we already anticipated that COVID-19 cases were going to increase as we had seen our first case of the [highly transmissible] delta variant. We had an opportunity to increase our capacity, but it might not last long. We were lucky in May and June that the increase had not yet started and so the central team had time to go to each of the [sub-areas] and train teams there.

Dr Kaçaniku Gunga and five other experts from the area-wide contact tracing team attended the June 2021 workshop; a similar number attended the May workshop. The workshops presented contact tracing teaching materials developed by WHO; discussed how to localize these for the cultural, linguistic and operational context of the sub-area level contact tracing teams in Kosovo[1]; the courses also gave guidance on how to engage adult learners.

"We translated and adapted the WHO course to meet our needs and went to the [sub-areas]. We trained all the people put forward by the sub-areas and municipalities to be contact tracers. Pristina [the largest city in the area] has 6 or 7 municipalities, so we did two training courses there each with 20 or more participants," recalls Dr Kaçaniku Gunga.

The course materials developed by WHO covered: the basics of COVID-19 and how it spreads, why contact tracing is used to control and supress its spread, and good practice in contact tracing – especially use of RCCE to build trust with individuals and communities. They also contained some practical exercises to practice and embed the techniques recommended. Most notably, this included the exercise where a trainer or participant plays the role of a contact reluctant to cooperate with the authorities and another participant plays the role of a contact tracer trying to gain their trust and cooperation.

Dr Kaçaniku Gunga says the sub-area and municipal participants appreciated and enjoyed the RCCE component of the training. Asked whether the people she had trained had had the opportunity to use the interpersonal communication skills they practiced during the role play Dr Kaçaniku Gunga replied, "Of course. We had many, many occasions when people did not want to give their contacts or go into quarantine".
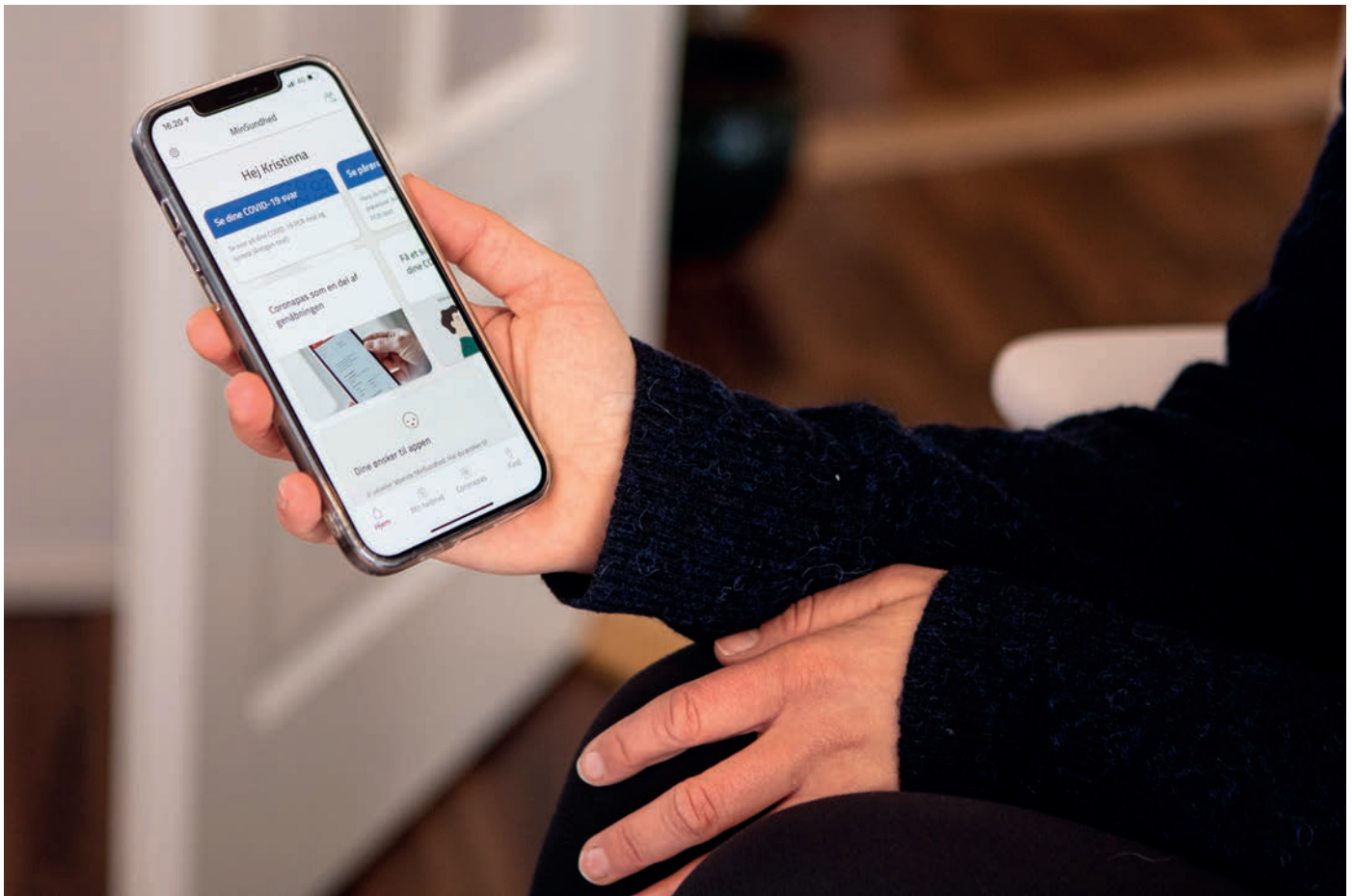
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She added that the central team in her organisation very much believed in the value of teaching contact tracers about RCCE. "From the beginning [of the pandemic] we saw that community engagement is a very crucial thing. For example, if you are trying to trace a cluster of cases in an educational setting you need to engage with the parents and the teachers or indeed the kindergarten staff."

Impact

The immediate impact of the WHO-led training-of-trainers workshops in Kosovo[1] in May and June 2021 was that it helped WHO's public health partner there to implement a three-fold expansion of their contact tracing workforce – from 40 to 120 contact tracers.

On 1 March 2022, the Regional Office and ECDC held a joint technical consultation meeting on COVID-19 contact tracing. This virtual meeting was attended by 120 participants from 39 country and area level partners from across Europe and central Asia, as well as experts from WHO and ECDC. Participants identified effective RCCE as one of the key drivers of success for pandemic response measures, including contact tracing (ECDC and WHO Regional Office for Europe, unpublished information from the First joint meeting on COVID-19 contact tracing, 2022).

Looking to the future

The joint technical consultation meeting on COVID-19 contact tracing held by the Regional Office and ECDC in March 2022 looked at the future of COVID-19 contact tracing. The participants broadly agreed that though most health authorities across the Region had scaled back COVID-19 contact tracing activities, the systems and competencies for this contact tracing – including how to use RCCE in support of it – should be maintained.

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1   All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

Country and area partners should be prepared to rapidly reactivate contact tracing should the epidemiological situation require it. In addition, participants anticipated that public health partners at country / area level will need to maintain a focus on COVID-19 contact tracing among vulnerable groups and in high-risk settings. The meeting also concluded that RCCE measures to inform and educate communities about the risk from COVID-19 will become even more important going forward as countries become more reluctant to impose restrictive measures *(7)*.

Further information

Website of WHO's public health partner organisation in Kosovo[1]:

http://niph-rks.org

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Lessons learned

- The COVID-19 pandemic showed very clearly that RCCE is a critical success factor for contact tracing.

- Contact tracing teams and their individual members should be trained on how to engage and build trust with the communities and individuals they work with. Establishing trust is key to gaining the cooperation of these communities and individuals.

- WHO showed that it was able to provide country and area level partners with valuable technical assistance on RCCE via virtual workshops.

CONTACT TRACING

Help stop the virus and keep your loved ones safe

What is contact tracing?
Contact tracing means finding all the people who have been exposed to a disease, like COVID-19, to prevent further transmission.

When a case of COVID-19 is confirmed, contact tracing means identifying anyone who may have been exposed, asking them to quarantine to stop any further spread of the disease, and following up with them for 14 days to monitor symptoms.

Why is contact tracing important?
When it is systematically applied and combined with quarantine and isolation, contact tracing breaks the chains of transmission of a disease and stops it from spreading. By participating in contact tracing, every person helps to stop COVID-19 transmission, protect vulnerable people, and avoid more restrictive measures.

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1   All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

Infodemic management in Bulgaria and Kyrgyzstan using HealthBuddy+

At a glance

What the case studies are about

These case studies describe the use of an innovative chatbot tool to facilitate two-way communication and listening about COVID-19, and to counter misinformation about the virus.

Why they are important

Two-way communication and listening to at-risk communities is an essential capacity for effective risk communication during health emergencies. New technologies such as chatbots offer the possibility for health authorities to implement two-way communication – and manage the "infodemic" of misinformation about COVID-19 – through new channels and at relatively low cost.

Main RCCE core capacity* and area featured

C. Infodemic management/detection of rumours

3. Listening through two-way communication

Other RCCE core capacity* featured

4. Selecting effective channels and trusted key influencers

* See Box 1.

WHO policy context

The WHO Regional Office for Europe's *Emergency risk communication five-step capacity-building package* identifies two-way communication and listening to communities at risk as an essential capacity that all health authorities should have in place *(1)*. Telephone hotlines continue to be among the most effective tools for conducting two-way communication. However, as more and more people in European Region countries have smartphones, text-based online question answering services are emerging as another very useful tool. These online services have the advantage that many aspects of the question answering, and data collection work, can be automated. This reduces the number of staff that health authorities need to deliver the service.

HealthBuddy+ was developed by WHO and UNICEF in the European Region as a service to provide automated two-way communication about the pandemic 24 hours a day, seven days a week. It provides instant, standard answers to the most frequently asked questions about COVID-19, an option to ask new questions and an option to report rumours.

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As well as being a tool for two-way communication, HealthBuddy+ also helps with infodemic management. WHO defines an infodemic as "excess information, including false or misleading information, in digital and physical environments during an acute public health event"*(2)*. This can damage trust in health authorities and science-based guidance, which in turn may lead to risk-taking and behaviours that harm health. WHO advocates strengthening systems for infodemic management within the RCCE response by, among other things:

• early identification and rapid rebuttal of rumours and misinformation

• promotion of trustworthy sources of evidence-based information on COVID-19.

HealthBuddy+ helps achieve both these aims.

HealthBuddy+ evolves from chatbot to app

In the early months of the pandemic in spring 2020 the Regional Office partnered with UNICEF's Europe and Central Asia Regional Office (UNICEF ECARO) to create a COVID-19 chatbot. A chatbot is a computer program that uses artificial intelligence to analyse questions asked by users, and then select an appropriate response to them from a database of answers to FAQs. UNICEF ECARO provided the technology for the chatbot while the WHO

Regional Office for Europe developed an extensive FAQ database with accurate answers, and facilitated its translation across 20 languages.

The national and international partners collaborating in the HealthBuddy+ project have access to an online dashboard where they can see instant visualizations of user data and apply interactive filters to it. With this tool they can see and analyse real-time data on public reaction to, and information needs regarding, the COVID-19 response.[1]

In May 2020, the chatbot service was launched as HealthBuddy on the websites of UNICEF ECARO and the WHO Regional Office for Europe *(3)*. At that time, the HealthBuddy service was available in seven languages: English, Greek, Italian, Kazakh, Portuguese, Russian and Spanish. In October 2020, the service was upgraded and rebranded as HealthBuddy+, including a mobile phone app (iOS and Android) *(4)*. The new functions on the app included the possibility to receive new information as alerts, share opinions and report rumours.

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1   The self-selecting sample of HealthBuddy+ users may or may not be representative of the wider population. However, at minimum it provides a starting point in social listening that can be triangulated with other sources of information.

Trusted international information on national platforms

A user survey carried out on HealthBuddy+ in early 2022 showed that national ministries of health were among the top channels used to find information about COVID-19 in countries of the European Region. However, WHO was a more trusted source of information than national authorities.[2]

The regional offices of WHO and UNICEF encouraged their country offices across Europe and central Asia to approach ministries of health about embedding the national language versions of HealthBuddy+ in key websites and promoting it to the general public and specific key target audiences as part of the COVID-19 response. This way, people could access the most trusted information on COVID-19 (from WHO) via one of the most widely used platforms in their country (the ministry of health website).

Case study A: Bulgaria

Context of Bulgaria

Bulgaria is a medium sized country in the Balkans region of Europe, with a population of just under 7 million people *(5)*. It transitioned to become a democracy in the 1990s, and in 2007 it became a member of the EU. However, the political situation in Bulgaria has been turbulent for many years and particularly unstable over the last two years. In 2021 alone, there were three national parliamentary elections *(6)*.

The political instability of recent years has eroded public trust in Bulgaria's government and institutions, including its health system. This is the type of environment in which misinformation can spread and be believed.

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Evidence-base for HealthBuddy+ initiative in Bulgaria

"I learned about the HealthBuddy+ tool in autumn 2020," says Dr Michail Okoliyski, expert on mental health and public health at the WHO Country Office in Bulgaria. "Bulgaria was having its first big surge of COVID-19, there was a lockdown and there was a lot of fake news and misinformation circulating. We had just received the results of a behavioural insights survey and this showed there was an unmet demand in Bulgaria for accurate and reliable information on COVID-19. Young people in particular felt they could not find this."

Another important finding in this survey – and indeed two previous ones run by WHO and the Bulgarian Ministry of Health – was that most Bulgarians did not trust their family doctor or primary care physician to give them good advice on how to protect themselves from COVID-19. In contrast to most other countries in the European Region, Bulgarians were more likely to trust the media (rather than their doctors) to provide accurate information on COVID-19 and its prevention. The most trusted institution of all was Bulgarian National Television (BNT).

Dr Okoliyski recalls: "We had meetings between UNICEF and WHO in Bulgaria on how to respond to the challenge of fake news and misinformation. We decided this tool [HealthBuddy+] was needed, but it needed to be adapted to the Bulgarian context". Based on the results of the behavioural surveys this meant finding a media partner to promote the service. "The partnership we developed with BNT has been our greatest success." Dr Okoliyski points out that this follows exactly the survey findings and makes the HealthBuddy+ chatbot available to Bulgarians via their most trusted channel of information.

Strong country-level partnership between WHO and UNICEF in Bulgaria

"The country offices here had a history of working together on issues like gender-based violence, digital solutions and advocacy. It was the most natural thing for us to mirror the regional-level collaboration [on HealthBuddy+] at country level," says Ivaylo Spasov, Communication for Social Change Officer at the UNICEF country office in Bulgaria. "I have very good and friendly relations with my WHO counterpart, Dr Michail Okoliyski. Both Michail and I are very positive and active. So it was just a matter of distributing the tasks."

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2   This data comes from a working document generated by the HealthBuddy+ team. The user survey received 476 responses from across European Region. Ministry of health websites were the second most widely consulted source of information – mentioned by 26% of respondents. The top source of information, mentioned by 27% of respondents, was social media. WHO was mentioned as the most trusted source of information about COVID-19 by 42% of respondents, compared to 15% for ministries of health.

WHO and UNICEF adapt HealthBuddy+ for Bulgaria

The initiative in Bulgaria started in autumn 2020. The UNICEF country office already had funds available and contracts in place to outsource the translation of the HealthBuddy+ database of FAQs. The FAQ materials for HealthBuddy+ are regularly being updated based on questions received from users, and advances in scientific knowledge about COVID-19 and its prevention. This meant that materials for translation arrived in several waves during the autumn of 2020. There was a substantial amount of new materials to be translated about COVID-19 vaccines, mental health and well-being.

WHO's role in the HealthBuddy+ project at the Region-level is to make sure the answers it gives about COVID-19 (and how to prevent it) are accurate and based on the most up-to-date scientific evidence. Keeping the information accurate and scientifically correct sometimes means using medical or public health terms in the answers. Once the FAQ materials had been translated into Bulgarian by contractors, they were proofread by UNICEF staff and then verified by the WHO Country Office. "They were reviewed by my colleague Lora Marinova and myself to make sure the health and medical terms in Bulgarian were accurate. This was a lot of work," says Dr Okoliyski.

Launch of HealthBuddy+ in Bulgaria

The Bulgarian version of HealthBuddy+ was embedded into the BNT website and "soft-launched" (i.e. made available without much publicity) towards the end of 2020. It was officially launched at an event with Bulgarian national media and key partners in February 2021.

Between the soft launch and the official launch in February 2021 the WHO and UNICEF country offices collected over 600 questions in Bulgarian that needed answers beyond what was available in the HealthBuddy+ FAQ database. "Some were jokes or silly questions, but most were really valid and important. We grouped them and consolidated them down. Then we translated the questions into English and sent them to the WHO and UNICEF regional offices for them to develop answers," recalls Dr Okoliyski. The regional offices of both organizations provide support by organizing the data for translation by the country offices, analysing the translated dataset, and using this dataset to develop new priority keywords for the chatbot. "Bulgaria made a positive contribution to HealthBuddy+ right from the start," says Dr Okoliyski.

"Dr Okoliyski and I gave many interviews to national media around the launch event for HealthBuddy+," recalls Mr Spasov. "But we also had a social media plan. This was key in helping users find the service. The support from the regional offices [of WHO and UNICEF] was crucial, especially in the first months. We adapted animations and social media cards from them to promote the service."

Partners were of key importance, both in promoting social media materials about HealthBuddy+ but also in embedding the chatbot element of the service into their websites. The Bulgarian National Centre for Infectious and Parasitic Diseases did this, as did BNT, Bulgarian National Radio and the Bulgarian Patients' Portal, a CSO website for patients *(7)*.

WHO and UNICEF continued support for Bulgarian HealthBuddy+

More than six months on from the official launch event, the WHO and UNICEF country offices have settled into a cycle of monthly review and regular updating of the Bulgarian version of HealthBuddy+ based on user questions, new scientific evidence, guidance from their regional offices, and the two organizations' key COVID-19 response priorities. Speaking in October 2021, Dr Okoliyski said, "Last month we got about 60 new questions. Some of the questions we could not answer because they were about national policies and so were outside WHO's remit". However, HealthBuddy+ provides links to national information when questions are specific to the context. As in other countries, Bulgaria has also developed a small but dedicated community of users who report misinformation and disinformation.

Asked about the amount of staff time needed to maintain the Bulgarian version of HealthBuddy+, the country offices estimate "a few days per month" for both of them. This is in addition to the time used by staff in the WHO and UNICEF regional offices, who conduct monthly user analytics, facilitate translation of 20 languages, develop new content and polls, maintain the central systems and analyse Region- and country-wide feedback.

Impact

"We have had excellent feedback about HealthBuddy+ from our partners and from end users," says Dr Okoliyski. The partnership developed with BNT is probably the project's greatest success. "It provided us with the basis for reaching millions of Bulgarians," he adds.

Mr Spasov agrees about the positive feedback from partners. He also points out that "Bulgarian television, radio and news websites have all been very interested in the innovation HealthBuddy+ represents. They see it as a new way of making scientific information accessible to the public".

Following a surge of questions when the service was launched, the number of questions answered by HealthBuddy+ in Bulgaria has remained fairly constant at between 1000–1500 user interactions per month.

Looking to the future

The WHO and UNICEF country offices in Bulgaria plan a publicity drive across social media and conventional media each time a new set of content for HealthBuddy+ becomes available in Bulgarian – with special focus on supporting positive mental health. "We already did some initial publicity for this new service around World Mental Health Day on 10 October," says Dr Okoliyski. "This focuses on helping people with anxiety, sadness and burnout."

Case study B: Kyrgyzstan

Context of Kyrgyzstan

Kyrgyzstan is one of the five Central Asian Republics and shares borders with Kazakhstan, Tajikistan and Uzbekistan. It is a lower middle-income country with a population of around 6.6 million. In recent years, Kyrgyzstan has undertaken wide-ranging reforms of its health sector.

Regional Office engagement with the Resource Centre for the Elderly

In June 2021, the Regional Office launched an initiative to invest in 11 CSOs in eight Member States. Its aim was to show how small investments in CSOs can have a meaningful impact on the response to COVID-19.

One of the CSOs the Regional Office invested in was the Resource Centre for the Elderly (RCE) in Kyrgyzstan. The RCE, which was already providing advice and support to older people in Kyrgyzstan, ran a project to promote COVID-19 prevention among this group. The project also addressed the impact of the pandemic on older people's well-being and aimed to strengthen their resilience against future emergencies. Key actions undertaken by the project included:

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- establishing a Council of Paramedics to coordinate access to prevention and treatment among the elderly;
- training community leaders and representatives of associations that work with the elderly on how to access public health services;
- setting up a website with the latest information on COVID-19 and how to access health services.

As well as providing financial support to the RCE project team, the Regional Office also gave them access to the latest WHO advice and tools on COVID-19. This included alerting the CSO to the development of the Kyrgyz language versions of the HealthBuddy chatbot and the HealthBuddy+ app. In November 2021, the Regional Office's Infodemic Management team organized an online workshop about these tools for Svetlana Bashtovenko, Director of the RCE, and two of her colleagues.

Promoting Health Buddy+ to civil society in Kyrgyzstan

"In November [2021], shortly after our workshop with the Regional Office, I shared information about HealthBuddy+ with 100 participants at a conference in Kyrgyzstan," says Ms Bashtovenko. "These included representatives from 35 health groups, including the Council of Paramedics and representatives from social services. We have also embedded the HealthBuddy chatbot in the COVID-19 pages of the RCE's website."

The RCE works with a network of 48 local CSOs across Kyrgyzstan. It has been promoting HealthBuddy+ to the health specialists in these organizations, training them in how to use it and making sure they have the internet connections and devices needed to access it. One of the challenges in communicating with the elderly in Kyrgyzstan is that many do not have internet access. However, a WHO-supported project in the country engaged health specialists to have regular contact with the elderly in their area and train them on using online platforms. In addition, they use HealthBuddy+ on their smartphones or tablets to give the elderly people they work with accurate answers to their questions on COVID-19.

Further improving local adaptation

The RCE is working with the Regional Office's Infodemic Management team to further improve the "localization" of HealthBuddy+. This involves the RCE identifying questions on COVID-19 that are of high importance in Kyrgyzstan, but are not currently answered by HealthBuddy+. It also involves advising on sources of local content from Kyrgyzstan. "For example, the Ministry of Health's COVID-19 Task Force has a Telegram group that sends out up-to-date information on the epidemic here. It would be useful for HealthBuddy+ to link with those updates," advises Ms Bashtovenko.

Impact

In January 2022, when this case study was written, the RCE had only been working with HealthBuddy+ for a few months. Nonetheless, the RCE website receives many visitors and the HealthBuddy chatbot feature on it is already proving popular.

Looking to the future

The RCE and its partners are enthusiastic about the potential for HealthBuddy+ to fight misinformation and promote prevention measures in Kyrgyzstan during 2022.

The RCE is interested in working with the Council of Paramedics to get their field workers to report rumours and misinformation via HealthBuddy+. The Council's members visit elderly people in their homes, which gives them a view of the misinformation circulating at community-level.

Another area in focus in 2022 is training elderly people to access the HealthBuddy+ app directly. "We live in a digital age and apps are the basis of our information," says Ms Bashtovenko. "Even the elderly need to know how to use them."

Further information

Official website of HealthBuddy+:
https://healthbuddy.plus/index

Bulgarian National Centre for Infectious and Parasitic Diseases:
https://www.ncipd.org/index.php?lang=en

Bulgarian Patients' Portal:
https://www.portalnapacienta.bg

Bulgarian National Television:
https://bntnews.bg/covid19.html

Resource Centre for Elderly – Kyrgyzstan:
https://rce.kg

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Lessons learned

- The results of a HealthBuddy+ user survey point at people having trust in WHO and using national health authorities' websites to access information. HealthBuddy+ bridges these two aspects, as it is embedded in national channels.

- When WHO and UNICEF join forces on a project, it becomes easier to persuade governments to support it too.

- HealthBuddy+ and its chatbot feature have proved to be a valuable tool for two-way communication and listening during the COVID-19 pandemic in Bulgaria and Kyrgyzstan.

- HealthBuddy+ has also made a significant contribution to infodemic management and managing misinformation on COVID-19 in the countries where it is used.

- The data dashboard linked to HealthBuddy+ enables partners to analyse real-time data on public reaction to, and information needs regarding, the COVID-19 response.

- Experiences from Bulgaria, Kyrgyzstan and other countries in the European Region, suggest that the use of automated online tools such as HealthBuddy+ should be planned for in future health emergencies.

- Concrete projects like HealthBuddy+ are a strong partner engagement and relationship building tool with United Nations partner agencies, as well as national stakeholders (e.g. BNT in Bulgaria).

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7. Bulgarian Parents' Portal [website] (in Bulgarian) (https://www.portalnapacienta.bg, accessed 9 June 2022).

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Use of behavioural insight surveys to guide RCCE strategies and actions in France, Sweden and Ukraine

At a glance

What the case studies are about

During the COVID-19 pandemic, the WHO European Region has seen unprecedented efforts to gather and analyse social science evidence and apply it to RCCE strategies and actions. Use of regular quantitative behavioural insight (BI) surveys in particular has been encouraged and supported by the WHO Regional Office for Europe. Here we look at three examples of how regular BI surveys were used in different countries:

- use of nationally developed BI surveys in France;

- use of adapted versions of a standard BI survey developed by the University of Erfurt for WHO in Sweden and Ukraine.

Why they are important

Empowering communities and individuals to practice preventive behaviours, including wearing face masks, distancing and practicing good hand hygiene, as well as getting vaccinated, is key to stopping the spread of COVID-19. It will continue to be key in future pandemics too. Social science evidence such as BI survey results, can help health authorities better understand these behaviours and their drivers.

This evidence and these insights can help ensure that population perspectives are considered in the overall pandemic response. An evidence-informed approach, including regular gathering and analysis of relevant data is essential for a nuanced and appropriate targeting of RCCE efforts, including communication and engagement interventions, and policy and programmatic planning.

Main area featured

+ D. Use of social science data to inform RCCE

Other RCCE core capacities* and areas featured

3. Listening through two-way communication

4. Selecting effective channels and trusted key influencers

+ B. RCCE in support of preventive measures

+ F. Vulnerable groups

* See Box 1.

WHO policy context

WHO has long advocated the basing of public health interventions on scientific evidence.[1] The definition of evidence used by the Regional Office is wide and can include methodically collected data and expert opinion, as well as results from peer-reviewed studies *(1)*. These case studies look at the use of social science data, collected through BI surveys, to inform RCCE strategies and actions. See Fig. 4 for how the framework is adapted for national studies.

Already in 2020, the Regional Office advised that comprehensive pandemic responses be informed by multiple sources of data, including BI surveys *(2,3)*. The Regional Office, supported by the University of Erfurt, Germany, launched a tool for collection of BI data in April 2020 including a protocol and questionnaire *(4)*. Since then, more than 30 countries and areas within the Region have made use of the tool either with direct support from the Regional Office or independently. Variables in these studies include COVID-19 risk perception, health literacy, intention to practice protective behaviours, well-being, trust and vaccination intentions.

Case study A: France

Context of France

France is member of the Group of Seven (G7) of advanced industrial nations and a permanent member of the United Nations Security Council. Its national public health agency, Santé publique France (SpF), was created in 2016 and has a mission to protect and improve public health. Within SpF, the Unit for Prevention of Infectious and Environmental Risks (UPRIE) uses RCCE to prevent COVID-19 and to promote the uptake of COVID-19 vaccines. Collecting and analysing health-related data is a core activity of SpF, encompassing a range of data – from traditional indicator-based disease surveillance and mortality statistics through to behavioural data, risk perception data and rapid alert systems linked to event-based surveillance. On 23 March 2020, SpF launched a cross-sectional survey of knowledge, risk perception and behaviours relating to COVID-19 called CoviPrev *(5)*. Data are collected using computer-assisted web interviews among a representative sample (for age, gender, socioeconomic group and geography) of 2000 respondents in each round. The sample is drawn from mainland France.

From March to June 2020 the survey was run on a weekly basis and now continues monthly. "As well as collecting extensive social-demographic data, CoviPrev has modules

on mental health, prevention behaviours such as wearing face masks, and also attitudes to vaccination," explain Ms Oriane Nassany and Dr Isabelle Bonmarin, of UPRIE. Their role is to translate the extensive raw data into clear messages for stakeholders and the media. The findings are also used to support policy-making and to inform the public.

Using data to understand vaccine demand and guide RCCE actions

In November 2020, CoviPrev results showed that 47% of respondents in France considered it certain or probable that they would not get vaccinated against COVID-19 when vaccines became available *(6)*; by December, that number had increased to 60%.[2] Dr Zoë Heritage, Project and Research Officer in UPRIE, recalls that at the time, when no vaccine was yet available but several were undergoing regulatory review, there was no question of communicating to specific populations: "All the channels you would expect in a mass communication campaign such as television, posters, print and social media were mobilized to explain why vaccination was important to reduce the impact of the pandemic".

Early in 2021, CoviPrev showed more positive intentions with respect to COVID-19 vaccination overall, but still high rates of reluctance to be vaccinated among specific groups. Among these groups, young people had concerns about vaccine safety and low perceived benefit to their own health. Media and social media monitoring picked up a lot of talk about the "undesirable effects" of vaccines. In early summer, one of the local health authorities promoted a campaign targeting students and other young adults that seemed to increase their uptake of the vaccine by highlighting the "desirable" effects of being vaccinated, such as being able to go on dates or go to parties again. The campaign was rolled out to other regions in France.

Vaccine hesitancy and low trust in government

By October 2021, with 85% of the eligible population vaccinated *(7)*, the picture revealed by the data had evolved yet again. "If we look at the monthly survey, we see vaccine hesitancy correlates closely with people who say they no longer have confidence in the government," adds Dr Heritage. Given this low trust among the remaining unvaccinated in messages coming from the government and other authorities, SpF has tailored an approach to better equip health professionals and social workers who have direct contact with people from groups with low vaccine uptake to respond to their concerns about vaccination. "For example, we have developed a newsletter in the form of FAQs. Each issue is co-written

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1   An example of this is the establishment by the WHO Regional Office for Europe of the Health Evidence Network in 2003 and the launch in 2012 of the Evidence Informed Policy Network (EVIPNet).

2   Vaccination against COVID-19 became available to the highest priority groups in France on 27 December 2020.

Table 5. Survey responses on COVID-19 showing top reasons reported for intention in relation to vaccination

I will definitely get vaccinated	I will probably get vaccinated	I will definitely not or probably not get vaccinated
Protect myself	Side effects	Side effects
Protect others	Vaccine effectiveness	Perceive Covid-19 as a mild disease
End the pandemic	Choose vaccine	Safety aspects
Solidarity and responsibility	Practical aspects	Underlying medical conditions or being pregnant
Return to "normal"	Protect myself	

Note: The responses above represent the most commonly reported factors regarding decision-making for vaccination against COVID-19. Answers are grouped according to intention to get vaccinated. *Source*: Public Health Agency of Sweden.

with social workers and other frontline staff who work with people living in poverty, such as recently arrived migrants or those who are staying in homeless shelters," says Dr Heritage.

Impact

France went from only 40% of respondents saying they intended to be vaccinated against COVID-19 in December 2020 to achieving 85% vaccine coverage among adults aged 18 years and older by October 2021. Many factors contributed to this success, including reliable vaccine supply in early 2021 and a well-resourced public health system capable of distributing and administering the vaccines country-wide. Effective RCCE based on timely, robust data likely played a significant role in this positive situation.

Looking to the future

As more people get vaccinated, those remaining unvaccinated tend to be strongly entrenched in the decision not to get vaccinated for whatever reason they may have. This requires an even more tailored approach based on an understanding of peoples' concerns, trusted sources of information and issues of access to vaccines. France encourages an interpersonal communication approach in which health and social care professionals discuss vaccination during routine or other clinic visits. The CoviPrev survey continues to collect information to help tailor this and other approaches to the COVID-19 pandemic.

Case study B: Sweden

Context of Sweden

Throughout the pandemic, the Public Health Agency of

Sweden (PHAS) has supported a small team of BI experts to collect and interpret data, in addition to experts working in some local health authorities. When planning for the introduction of the COVID-19 vaccine in late 2020, it was clear that these analyses would be essential for providing insights into reasons for accepting or delaying vaccination, as well as practical aspects and information needs. Sweden has a strong public health system that has traditionally achieved high levels of routine childhood vaccination. However, past experience has shown that pockets of lower vaccination coverage exist, which could have had an impact on COVID-19 vaccination as well.

Use of BI data at the national level

Using a questionnaire adapted from the Regional Office's BI survey tool, PHAS conducted regular population-based surveys on COVID-19 vaccine acceptance in March, April and June 2021, with approximately 5000 adult respondents. The June surveys also included 16- and 17-year-olds to better understand their perspectives on vaccine acceptance.

Survey results from March to June showed consistently high levels of vaccine acceptance, with over 90% of respondents reporting that they would definitely or probably get vaccinated. This high level of acceptance was seen among men and women, and across age groups. The June survey found that 16–19-year-olds had a similarly high level of acceptance to people aged 20 and over. Anders Tegnell, Chief Epidemiologist at PHAS points out that the June 2021 survey results "fed directly into the recommendation by the Agency for the COVID-19 vaccination programme to include 16- and 17-year-olds".

"Most people are positive towards vaccination, and we know that reasons for delaying or refusing vaccination can include questions or concerns about the vaccine, as well

A COVID-19 vaccine outreach team at work in Stockholm. Personae of vaccine hesitant people in Stockholm communities were developed using data from BI surveys. These helped vaccine outreach teams to tailor their communication and engagement. © Magnus Sandelin.

as practical aspects of vaccination," says Sarah Earnshaw-Blomquist, a PHAS analyst working with acceptance of vaccination against COVID-19.

The surveys included open questions to participants on their reasons for accepting, or not accepting, the vaccine; the responses are summarized in Table 5.

Regular reports of these BI survey results and analyses were shared by PHAS with the Ministry of Health and Social Affairs, the Medical Products Agency, and other national agencies and regional health authorities responsible for implementing the vaccination programme.

Use of BI data at local level in Stockholm County

In Stockholm County, a region with 2.4 million inhabitants, the regional health authority combined information gained from the national level BI surveys with the results of local studies. This showed that the reasons for lower intentions to vaccinate included worries about unknown side effects or fertility, as well as confusion over the need to vaccinate after suspected or confirmed infection with COVID-19.

Stockholm county's in-house BI expert then compiled all the data to develop a series of personae (fictional profiles that represent groups of similar people in a target audience) of Stockholm residents who are defined as "vaccine hesitant" based on their lower intentions to accept vaccination. These profiles improved understanding of these behaviours and contributed to overall vaccination strategy and planning. Frontline vaccination teams used the information to develop communication and engagement strategies tailored to addressing the concerns of the different personae and supporting them in making an informed decision in response to the invitation to vaccinate.

Anna Johansson, a communication expert working for Stockholm County says that in her experience being able to back up recommendations on communication and engagement with data makes them more credible: "Every time we do a study they [the response team leaders] want us to present the material to all the vaccination teams and all the managers as it is an important knowledge base upon which informed decisions can be made about the overall vaccination programme, including communication aspects."

Country resources and WHO support

The BI team in PHAS adapted the questionnaire developed by the Regional Office and the University of Erfurt to the Swedish context. Experts from Sweden have been active participants in a BI community of practice led by the Behavioural Insights team at the Regional Office.

Impact

Using BI data collected at the national and county levels in Sweden allowed for targeted interventions that directly addressed the priorities and concerns of the population in the country, including younger people and those less inclined to get vaccinated against COVID-19. Magnus Thyberg, the head of the vaccination programme in Stockholm County confirms this saying, "We have used insights from these studies as well as other sources to inform the vaccination programme with regard to the specific reasons why individuals may delay or refuse vaccination".

Looking to the future

BI is an established function in PHAS and some of Sweden's regional authorities such as Stockholm County. It has proved a core intervention so far in the COVID-19 response and is continuing to be used.

Case study C: Ukraine

In Ukraine, WHO took the lead on collecting BI data to directly contribute to an evidence-based pandemic response. Staff at the WHO Country Office in Ukraine work directly with national partners to adapt, collect and interpret BI data, with a particular view towards building trust for behavioural change.

Context of Ukraine

Ukraine began a process of health sector reform in 2016. Its health sector has also had to manage disruption and upheaval caused by the humanitarian crisis in eastern Ukraine in 2014. At the government level, surveys by think tanks and private polling companies in 2020 and previous years showed that trust in institutions is rather low.[3] Issues around public trust and upheaval mean that RCCE in Ukraine was always going to be challenging in the context of COVID-19. A "one size fits all" approach to RCCE was never likely to be successful. BI would be needed to design tailored engagement, communication and outreach.

"Ukraine has always been multi-layered and complex. The purpose at the beginning [of the pandemic] was to understand where to focus our interventions, particularly the communication aspect of the response," says Dr Aron Kassahun Aregay, Pillar Lead for Surveillance and Health Information in the Country Office's COVID-19 Incident Management Support Team (IMST).

Using BI surveys to guide RCCE and the wider response

The Country Office COVID-19 IMST localized the BI survey tool created by the Regional Office and has conducted regular BI surveys since May 2020, not long after the start of the pandemic. Shortly after this Dr Alona Mazhnaia, a social science and BI expert joined the Country Office. Dr Mazhnaia adapts questionnaires and analyses data, working with WHO colleagues, government authorities and United Nations agencies and other international partners.

In 2020, data from the BI surveys was used to define target groups, messages and tactics for RCCE by WHO, the Ukrainian Public Health Centre and the Ministry of Health. The surveys were used "like a snapshot to monitor people's perceptions of COVID-19," explains Dr Mazhnaia. The team were also able to monitor "what sources of information [people] trust and where they go for COVID-19 related information".

Results showed that vaccine acceptance was strongly correlated with the perceived attitude towards the vaccine of close friends and family. Dr Mazhnaia highlighted that "This contributed to developing a communication campaign that targeted the older population through their grandchildren".

As the pandemic evolves, the BI surveys continue to be important for informing Ukraine's RCCE, particularly in relation to the roll-out of COVID-19 vaccines. However, the response team and Ukrainian policy-makers have become increasingly interested in using these surveys to understand public attitudes to all preventive measures.

Sharing BI survey results and coordinating research across partners

WHO shares results from its regular surveys with a wide range of partners through focused topic discussions at coordination meetings and an online dashboard (8). These partners include the Office of the Prime Minister, the Office of the President, UNICEF and the United Nations Development Programme (UNDP).

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3   A survey by the Razumkov Centre in 2020 found that 78% of Ukrainians do not trust state agencies and officials. See: Public trust in government weakening – poll. In: UNIAN [website]. 2020 (https://www.unian.info/society/trust-in-government-poll-reveals-public-attitudes-in-ukraine-11135681.html, accessed 9 May 2022).

The focus on BI surveys by WHO and other partners led the Ukrainian government to establish a Behavioural Insights Technical Working Group (BI TWG). The BI TWG was established to facilitate harmonization between partner organizations conducting studies to gain BI related to COVID-19 and its prevention. The BI TWG has a mandate to provide evidence for effective and appropriate response interventions, and policies and mitigation strategies.

Not only is the BI TWG a platform to inform the COVID-19 response, it is also a forum to present and review findings from BI studies, identify data and information gaps, and share and receive feedback on research protocols for planned BI studies. These can help generate ideas for studies to address identified data gaps or raise professional standards for conducting BI studies. BI TWG also acts as a network to disseminate new BI literature and/or findings from WHO, the United States Centers for Disease Control and Prevention and other leading public health research institutions.

Country resources and WHO support

In Ukraine, WHO provides financial support for data collection and continues to engage Dr Mazhnaia to help design tailored surveys, conduct regular and deep-dive analyses on specific topics (e.g. vaccination, testing, contact tracing) and carry out statistical analyses. Ukraine's Public Health Centre has been involved in these activities and has invested in continuing to develop its BI capacity. The Centre currently chairs Ukraine's BI TWG.
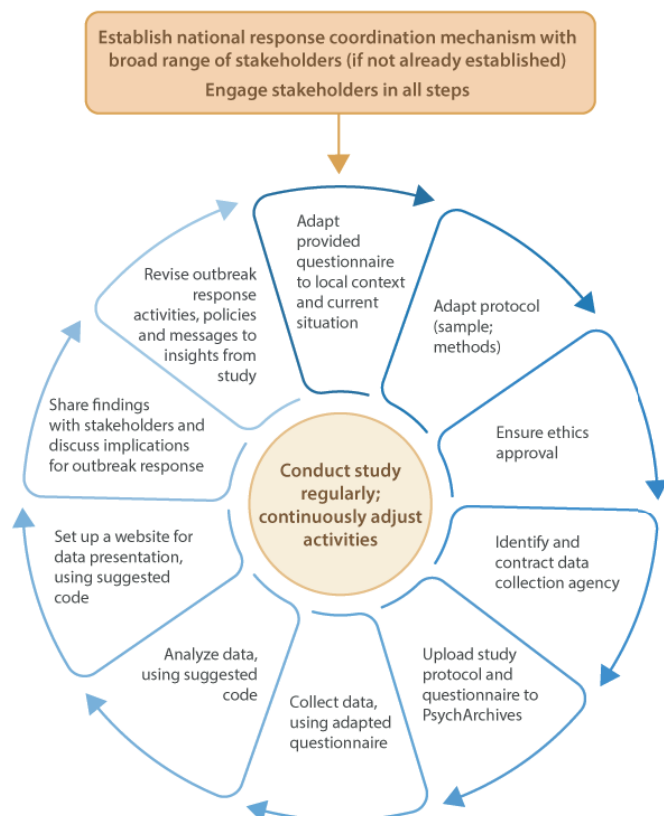
The WHO BI team in Ukraine have been active participants in a community of practice led by the Behavioural Insights team at the Regional Office.

Impact

BI survey results together with other research data helped the COVID-19 Vaccination Communication Center to define key priorities for communication campaigns, key messages, and day-to-day communication. They helped us to prioritize key audiences based on their vaccine acceptance rate, identify the main drivers for those who got vaccinated and to convince other people to get the shot. Also, we used data on key barriers to shape messages and content. For example, if we saw that people were not getting vaccinated because they didn't trust the vaccines, we would produce more content on vaccine effectiveness, how they work, and how they were produced and tested.

Svitlana Kisilova, Strategic Communication Consultant, COVID-19 Vaccination Communication Center (Ukraine).

Fig. 4.

Further information

Santé publique France:

https://www.santepubliquefrance.fr

Public Health Agency of Sweden:

https://www.folkhalsomyndigheten.se/the-public-health-agency-of-sweden/

Center for Public Health of the Ministry of Health, Ukraine:

https://phc.org.ua/en

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Lessons learned

- Designing effective RCCE interventions is a technical area of pandemic response that requires a methodical, evidence-led approach. Understanding people's risk perception, beliefs and attitudes, health literacy, protective behaviours, trust and other such factors is at the core of effective response interventions.

- Regular BI surveys add valuable perspective, depth and nuance to the overall response when taken together with epidemiological data, information on health systems and other concerns. These data can help inform policy decisions as well as RCCE interventions.

- Social science evidence such as BI survey results and expert opinion can help pandemic response teams identify specific groups that are vaccine hesitant and what is driving their hesitancy (see examples in case studies from France and Sweden). It can also identify barriers to uptake of other prevention measures. Once barriers have been identified, interventions can be tailored to address them.

- Pandemic response teams need to have access to skilled experts who can interpret BI survey results.

These experts need to have the knowledge and skills to turn data and other evidence into information for public health action. They then need to be able to work with technical and programmatic teams to help translate this into appropriate public health actions on the ground.

- Experience from France shows that BI survey and social listening data can contribute nuanced information to help guide pandemic response decisions – through the use of quantitative surveys, qualitative methods such as focus groups and interviews, traditional and social media monitoring, and other approaches.

- Experience from Sweden shows that creating personae based on BI data can be an effective way to identify the characteristics of audiences for effective targeting.

- Experience from Ukraine shows that if multiple partners in the RCCE response are conducting BI studies a technical working group can help maximize the value of the combined research effort and avoid unnecessary duplication by sharing results and coordinating research efforts.

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Use of expert opinion from social scientists to guide RCCE strategy and actions in the United Kingdom (Scotland)

At a glance

What the case study is about

During the COVID-19 pandemic, the WHO European Region has seen unprecedented efforts to gather and analyse social science evidence and apply it to RCCE strategies and actions. Some national and international health authorities have used expert opinion from social scientists to guide their decision-making. This case study looks at an example of this from the United Kingdom, where social scientists in the Scottish Government COVID-19 Advisory Group helped guide Scotland's RCCE strategy and actions.

Why it is important

Often during health emergencies, authorities need to make decisions rapidly. Data and peer-reviewed studies relevant to the specific threat they are facing may either be unavailable or limited – particularly in the early stages of an emergency. Using expert opinion therefore becomes a key input if a health authority wants to "follow the science" in its decision-making. During the COVID-19 pandemic WHO and some national health authorities sought expert advice from social scientists as well as biomedical experts as a basis for their emergency decision-making. An evidence-informed approach is essential for a nuanced and appropriate targeting of RCCE efforts, including communication and engagement interventions as well as policy and programmatic planning.

Main RCCE core capacity* and area featured

D. Use of social science data and expert opinion to inform RCCE
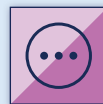
Other RCCE core capacities* and areas featured

3. Listening through two-way communication

4. Selecting effective channels and trusted key influencers

B. RCCE in support of preventive measures

F. Vulnerable groups

* See Box 1.

WHO policy context

WHO has long advocated using research results, as well as other relevant context, to inform public health decisions (1). Relevant context to inform decision making can include unpublished data, evaluation reports / After-Action Reviews and expert opinion. This case study looks at the use of expert opinion from social scientists via an expert advisory group to inform RCCE strategies and actions.

Taking advice from leading experts is seen by WHO and many national health authorities as a way to assure the quality and credibility of emergency decision-making. Two prominent expert groups that advise WHO on health emergencies are:

- the IHR Emergencies Committee, which advises the WHO Director-General on public health events of international concern and how to exercise his powers under the International Health Regulations (2);

- the Strategic and Technical Advisory Group on Infectious Hazards (STAG-IH), which advises the WHO Health Emergencies Programme (WHE) at global level. WHE consults it regularly about the various emergencies it manages as well as programmatic issues (3).

Similar expert groups exist to advise country and area level partners in several parts of the European Region. This case study looks at the contribution made to guiding RCCE strategy and actions by social scientists on one such expert advisory group: the Scottish Government COVID-19 Advisory Group.

Context of the Scottish Government COVID-19 Advisory Group

Scotland is one of four nations that make up the United Kingdom: the other three are England, Northern Ireland and Wales. Finance, border control and relations with WHO are managed at United Kingdom level. Most other aspects of health-care delivery and public health are managed by the nations.

In March 2020, the Scottish Government decided it needed additional scientific analysis and advice on the impact of COVID-19 in Scotland. It therefore created the Scottish Government COVID-19 Advisory Group (4) to supplement the work on epidemic modelling and advice already being done by the United Kingdom Government's Scientific Advisory Group on Emergencies (SAGE) (5). Though the majority of the Scottish Advisory Group members are from the fields of medicine, epidemiology and public health, it includes four social scientists:

- the Scottish Government's Chief Social Researcher, Dr Audrey MacDougall; and Chief Social Policy Adviser, Professor Linda Bauld;

- two professors of social psychology: Professor Nick Hopkins of the University of Dundee and Professor Stephen Reicher of the University of St Andrews.

The Advisory Group reviews both biomedical and social science data. Its members draw on this data and also their own expertise and knowledge to develop their advice.

In spring of 2020, the Advisory Group met several times each week. Meetings then became weekly in mid-2020, fortnightly towards the end of 2020, and less than once a month in much of 2021. The meetings then became weekly again towards the end of 2021 when the Omicron variant emerged (6).

What happens at meetings of the Advisory Group

The first item on the agenda of Advisory Group meetings is usually a review of the most recent epidemiological data from Scotland, the rest of the United Kingdom and around the world. The Advisory Group then reviews new opinions coming from official bodies such as SAGE or WHO, as well as new research findings. This part of the agenda includes a review of data from BI surveys produced by the United Kingdom Office of National Statistics. On a few occasions, results from social science studies commissioned by the Government of the United Kingdom or Scottish Government have been presented, such as a study on the re-opening of nightclubs and other large gatherings. However, the majority of data and research results presented tend to be from the biomedical sciences.

This is in line with other national and international multidisciplinary COVID-19 advisory groups. One reason for the dominance of biomedical research in their discussions is that there is more funding available for this than for applied social science studies. Figures compiled by Behavioural, Environmental, Social and Systems Interventions (BESSI), a consortium of social science and interdisciplinary researchers, show that by November 2021 a total of 2465 randomized control trials (RCTs) for medicines to prevent or treat COVID-19 had been registered, compared to just 16 RCTs to test behavioural and environmental change interventions (7).

Fig. 5. Survey results on whether COVID-19 public health advice is known, understood and actionable

—— I feel clear what is required of me under the current restrictions
---- I think the advice from the Scottish Government is clear and helpful

77%   80%   79%   77%

66%   65%   65%   62%
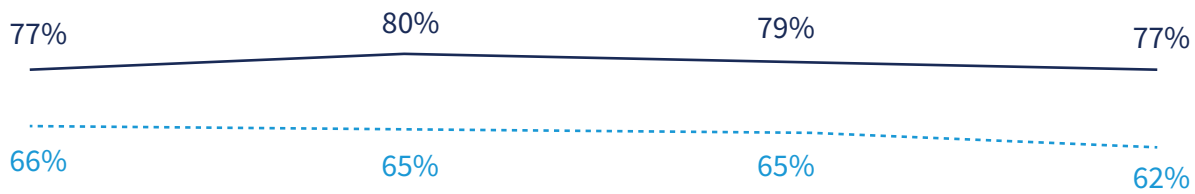
12–13 Jan   19–20 Jan   26–27 Jan   2–3 Feb   9–10 Feb   16–17 Feb   23–24 Feb

Source: Scottish Government *(12)*.

How the Advisory Group combines data and expert opinion to produce advice

The social scientists on the Advisory Group use their expertise to help analyse and interpret data from regular behaviour insight surveys in Scotland. They supplement insights from the survey results with insights coming from their broader experience. For example, the social psychologists could give insights into the importance of group dynamics and social norms in individual decision-making. In the context of the COVID-19 pandemic in Scotland, this led the Advisory Group to offer the following advice:

- To build and maintain trust with the public, government leaders need to be consistent in practicing the behaviours they advise citizens to follow. For example, if leaders asks citizens to wear face masks and observe safe distancing it is important they are seen to be consistently observing these behaviours too.

  - In early 2020, this advice had been based on research and theory about trust from long before the pandemic. Nonetheless, it was subsequently vindicated by events elsewhere in the United Kingdom later in 2020 when there was a significant drop in trust of government leaders responsible for the COVID-19 response in England as a senior official was revealed to be flouting the rules *(8)*.

- Messaging should stress the values of social solidarity and the need to protect the vulnerable. This is particularly important when communicating and engaging with youth and young adults.

  - BI survey data showed that most Scots in these younger age groups regarded the threat to their own health from COVID-19 to be low. However, the data showed they were concerned about the threat it posed to older and more vulnerable people in their community.

- In some instances, there are barriers to action that will stop people practicing prevention behaviours even where RCCE interventions have made them want to.

  - An example of this is people wanting to follow RCCE messages about increasing ventilation in indoor spaces as a way to decrease the risk of infection, but being frustrated by practical restraints. Improving ventilation in modern office buildings, shops or restaurants can be complex and costly and involve calling in a ventilation engineer.

Combining data with expertise produces better insights

"The data don't speak for themselves. They don't just have a singular message. It's the interpretation that's the really important thing," says Professor Hopkins reflecting on the BI studies conducted in Scotland and the United Kingdom during the pandemic. The social scientists on the Advisory Group added value by helping health officials interpret the data, and analyse their options for action in response to it.

Impact

The Scottish Government has largely followed the advice its COVID-19 Advisory Group. For example:

*   The First Minister of Scotland, Nicola Sturgeon, and her government have been scrupulous in following COVID-19 prevention measures. When a senior official was caught breaking the rules in April 2020, the official was immediately asked to resign *(9)*.

*   The Scottish Government's RCCE messages on COVID-19 emphasize staying safe and protecting others *(10)*.

*   The Scottish Government's RCCE messaging on the need to improve ventilation in offices and workplaces has been backed up by £25 million in financial support to help businesses make these changes *(11)*.

The impact of this appears to have been positive, in terms of maintaining a relatively high level of trust among Scots in their government. The most recent survey data published by the Scottish Government showed high levels of trust and approval being maintained by the government (approval 67–68%; trust 68–71%), and very high levels of approval being maintained by the Scottish National Health Service (84–88%). A strong majority of respondents characterized advice communicated by the Scottish Government as "clear and helpful" and an even larger majority felt clear about "what is required of me under current restrictions" (Fig. 5).

Further information

WHO Strategic and Technical Advisory Group on Infectious Hazards:

https://www.who.int/groups/strategic-and-technical-advisory-group-for-infectious-hazards/about-us

Scottish Government COVID-19 Advisory Group:

https://www.gov.scot/groups/scottish-government-covid-19-advisory-group/

United Kingdom Government Scientific Advisory Group on Emergencies:

https://www.gov.uk/government/organisations/scientific-advisory-group-for-emergencies

Lessons learned

*   Designing effective RCCE interventions is a technical area of pandemic response that requires a methodical, evidence-led approach. Expert opinion from social scientists can be an important source of evidence, particularly when decisions need to be taken quickly.

*   External social science experts may be able to identify barriers to uptake of prevention measures that the health authority has not thought of – as in the case of ventilation advice in Scotland. Once barriers have been identified, interventions can be tailored to address them.

*   Pandemic response teams need to have access to skilled experts who can interpret social science data – such as results from BI surveys – and translate them into information for public health action. Having social scientists on an expert advisory group review and debate the data can help achieve a rounded analysis that identifies options for action.

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10. Coronavirus (COVID-19): staying safe and protecting others. In: Scottish Government [website]. Edinburgh: Scottish Government; 2022 (https://www.gov.scot/publications/coronavirus-covid-19-staying-safe-and-protecting-others/, accessed 10 May 2022).

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Inclusive governance: a community-level model from North Macedonia and a national-level model from Romania

At a glance

What the case studies are about

These case studies look at two different models for inclusive governance involving the Roma community in the south-east of Europe during the COVID-19 response: one at the local level and one at national level. The local-level case study looks at a project to create Roma community boards in North Macedonia. The national-level case study looks at the role played by the National Agency for Roma (NAR) in Romania during the first year of the pandemic.

Why they are important

WHO and global health partners such as the IFRC have long argued that good governance must be inclusive governance *(1)*. This applies especially in the area of preparedness for and response to health emergencies. However, models of what inclusive governance means can vary according to the unique culture, history and socioeconomic context of different countries. The Roma are an ethnic community of around 10–12 million people, who live in several countries across the WHO European Region *(2)*. What is presented here are case studies on two different models of Roma inclusion in two countries of the Region.

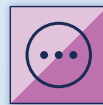### Main RCCE core capacity* and area featured

4. Selecting effective channels and trusted key influencers

E. Inclusive governance

F. Vulnerable groups

Other RCCE core capacities* and areas featured

3. Listening through two-way communication

* See Box 1.

Inaugural meeting of the community advisory board in in Shuto Orizari. © WHO

Context – the importance of inclusive governance

Concepts of good governance for health policies and programmes were developed by the WHO Regional Office for Europe's Governance for Health and Well-being Programme at a series of meetings in 2015 and 2016. Following these, the Regional Office developed a concept note and assessment tool on governance for health and well-being *(3)*. One of the key factors in this document's model of good governance is participation.

Throughout the COVID-19 pandemic WHO, both at international level and in the European Region, has stressed the importance of community engagement and empowerment as a driver of safe behaviours. In the context of the development of its *Global Action Plan for Healthy Lives and Well-being for All (4)*, WHO has put forward the following working definition of what engagement means:

Engagement is meaningful when the community manages to influence decisions on issues that affect their lives. When the community participates in decision-making to design, introduce, adjust and lift emergency interventions, full ownership of interventions is taken. Meaningful participation leads to community empowerment and behavioural change.

In both these case studies, the community does manage to influence decisions about the response to the pandemic – even if the processes involved are quite different.

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Case study A: North Macedonia

Context

Many tens of thousands of Roma people live in North Macedonia. Sensitivities around gathering data on ethnicity make it difficult to produce precise figures, but Roma are thought to account for 3–5% of the two million people who live in the country. They tend to live in distinct neighbourhoods or communities in the towns and cities, and many of these Roma communities have high levels of poverty and deprivation. Some lack amenities such as running water according to civil society reports.

Roma community boards project in North Macedonia

Local authorities and international partners in North Macedonia had been working with Roma-led CSOs since before the start of the pandemic. This case study focuses on a WHO project launched in 2021 to create community boards in four Roma communities. The aim of the project is to strengthen community resilience and response to future health emergencies. However, it has also facilitated Roma communities' engagement with health authorities around COVID-19.

The project should be seen in the wider context of successful engagement between the health sector and Roma communities in North Macedonia over a number of years. In particular, municipalities and international partners have worked with Roma CSOs in the country for a decade or more to promote acceptance of childhood vaccination by parents through a social accountability approach. This has been so successful that vaccine uptake in Roma communities is now thought to be higher than among other ethnic groups.[1] However, until recently, there had not been any projects to empower Roma communities to improve their resilience against emergencies.

Since May 2021, North Macedonian's Association for Emancipation, Solidarity and Equality of Women (ESE) has been working with Roma-led local CSOs in four municipalities to establish three community boards. Each board has 10–15 members and brings together informal leaders and influencers from the Roma neighbourhoods or settlements it covers, as well as representatives from the municipal authorities, and health, education, police and social protection services. Local businesses and any other relevant local stakeholders are also invited to participate.

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1   Unpublished estimate by UNICEF referred to by the North Macedonian CSO, Association for Emancipation, Solidarity and Equality of Women (ESE), during an interview and follow-up emails with the author.

"The intervention came at the right moment because the community has resources, especially human resources, but needed somebody to bring them together and guide them as to how they can help their own community," says Dzengis Berisha of the community-level Roma-led CSO STATION PET (focused on legal education and transparency). Mr Berisha works as a community-level coordinator for the project.

ESE, the project's lead CSO, organized training for community board members on emergency preparedness and response techniques, such as resource mapping and mobilization. This enabled the three boards to map all the assets available in their communities – for example, resources of the municipality, local ambulance and health services, schools, kindergartens, community groups and CSOs. The boards also mapped the most vulnerable groups and individuals in their community. They could then plan to make sure resources are used in an optimal way and the most vulnerable are taken care of during the COVID-19 pandemic and future emergencies.

The existence of the community boards has facilitated communication, dialogue and joint action in the response to COVID-19. Mr Berisha describes the boards' power to connect with the community as follows: "These are informal community leaders; people who are actively or passively contributing to community well-being". Community board members include "people who do not have a formal status in society, who are recognized as informal leaders by the community and young people, who are an active resource, especially at a time of crisis".

More than this, though, the boards can make sure the views and needs of the communities they serve are taken account of by the national health authorities in North Macedonia. Dr Ruzha Kostovska, an ambulance doctor and member of the Roma Community Board in Gjorche Petrov, says, "We engaged in strategic planning and integration of local priorities at the national level".

Impact

The community boards project in North Macedonia provides a trusted and credible channel of communication between Roma communities and the health sector and other key public bodies and stakeholders at the local level. Mr Berisha puts it this way: "The effect is completely different when somebody from the community is engaged in project activities, somebody who lives in the community, a neighbour or a friend. In my opinion, every piece of information coming from the community, and the access granted to particular settlements and neighbourhoods in the community, represent a positive outcome".

This view is echoed by Nezhlan Ismailovska, a 28-year-old member of the community board in the settlement of Trizla:

> At the onset of the crisis, the community did not believe in the coronavirus, thus the distribution of accurate information through capacity-building activities that took place within the project contributed to people's taking informed decisions and in turn to preventing further spread of the infection. The board's efforts have equipped the community with more knowledge and more capacity to respond to current and future emergencies.

Dr Kostovska points to the advantages for the health sector of having communities as full partners in the response: "Health workers cannot deal with the pandemic on their own. They need to cooperate with the communities and get support from resources available in the municipality".

Looking to future

The aim of the Roma community boards project in North Macedonia is to ensure communities continue in the long-term to partner with the health sector, municipalities and local stakeholders in emergency preparedness and response. Further trainings are envisaged to empower community members to support the health authorities in contact tracing when major outbreaks of COVID-19 or other diseases occur. The community boards have drafted community resilience plans that will benefit an estimated population of over 2500 Roma households. Community resilience plans have a dedicated community resilience team and form the basis for two years of collaboration.

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Case-study B: Romania

Context

Romania is a medium-sized country located in the eastern Balkans. It has a population of just over 19 million people *(5)* of whom many hundreds of thousands are Roma.[2] Many live in poor rural communities and speak their own language (Romani) rather than Romanian. Traditional Roma settlements or neighbourhoods in Romania are often crowded, with poor housing and lack basic amenities such as electricity or running water.

Engagement in pandemic response via Romania's National Agency for Roma

Improving the socioeconomic situation of the Roma community and promoting their inclusion have been government priorities since the 1990s. Programmes to support this priority have received significant financial and technical assistance from Romania's international partners, especially since its participation in the United Nation's Decade of Roma Inclusion 2005–2015 *(6)* and its accession to the EU in 2007 *(7)*.

The National Agency for Roma (NAR) is an independent government agency with a mandate to improve the economic and social position of the Roma minority in Romania. It does this by promoting Roma needs within government and providing expert advice to central and local government on Roma inclusion programmes. The NAR has around 23 staff of its own, but works with networks of Roma Health Mediators and Roma Education Mediators. These mediators are employed by the public authority (local council) responsible for the community they work in.

"No one in Romania was prepared for COVID-19," says Daniel Rădulescu, who was the President of the NAR until June 2020. "When the pandemic started it was a problem for the whole country, not just the Roma. All the government staff working in the Roma sector, particularly the Roma Health Mediators, had to be mobilized for the response."

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2   As in many European countries, there are sensitivities around gathering statistic on ethnicity in Romania.

The NAR and its county offices frequently work at local-level with Roma-led CSOs. There are about 70 of these across Romania. Mr Rădulescu was quick to realize the importance of CSOs in engaging with and empowering Roma communities. He had NAR establish a Consultative Committee bringing together this nationwide network of Roma CSOs. "The Roma CSOs in Romania are mostly focused on human rights. They did not have the capacity then to provide health advice or hygiene materials to communities. What they could do, though, was engage people at local level and document the challenges Roma communities face due to the pandemic."

The information gathered by the CSOs was compiled and analysed by SASTIPEN, the Roma Centre for Health Policies *(8)*. SASTIPEN presented its findings in June 2020 in a detailed report titled *Impact of COVID-19 on Roma Communities in Romania (9)*. This included data on people aged 65 and over and people with chronic conditions in nearly 700 Roma communities across the country. It also identified several major challenges for Roma communities during the COVID-19 pandemic. These included:

- Limited access to personal protective equipment such as face masks and disposable gloves for health workers serving Roma communities.

- Limited access to face masks or disinfectant solutions for community members.

- Limited access to running water in households in traditional Roma communities.

- Limited opportunities for Roma returning from abroad to properly self-isolate in their communities. Roma people often live in crowded, multi-generational households where it is impossible for a sick person to be isolated from others.

- Limited capacity for Roma people to make enough money to feed themselves and their families when the first lockdown happened. Many Roma people are subsistence farmers, day labourers or are working in the informal economy.

- Disproportionate impact on Roma children of school closures as most were unable to participate in distance learning. Many Roma households lack access to computers or the internet, and some lack access even to mains electricity.

- Upsurge of hate speech by people who want to portray the Roma as being responsible for spreading COVID-19. This was particularly visible on social media and various internet forums.

Between April and June 2020, the NAR collaborated very closely with staff and experts from Romania's network of county-level offices for Roma – to collect data on the situation of compact Roma communities that are vulnerable from a socioeconomic point of view. Based on these data and on the reports of the CSOs from the NAR Consultative Committee, in June 2020 Mr Rădulescu, as NAR President, sent a report on challenges facing the Roma to the Prime Minister of Romania. He accompanied this with a letter pressing for urgent action. He also shared the report with a Roma member of parliament and with representatives of the Department for Interethnic Relations within the Romanian Government to draw attention to the risks of speech inciting hatred and discrimination directed against Roma people.

Impact

"The letter to the Prime Minister put the Roma communities' real needs on the public agenda," says Mr Rădulescu. Romania's Parliament understood the urgent need to pass the law against Roma discrimination, and did so in September 2020 *(10)*.

The National Emergency Committee, which is chaired by the Prime Minister and has overall responsibility for the national pandemic response, now takes very seriously the regular information provided by the NAR regarding Roma communities and their needs in the context of COVID-19.

One very concrete action taken by the Romanian Government is that it started distributing emergency materials, including free food, to poor people – which includes many people in Roma communities. The supply of personal protective equipment in Romania also improved over time. The central government has committed to funding more posts for Roma Health Mediators, though local municipalities will need to bid for these posts.

Looking to the future

The NAR has asked that one of the priorities for the new National Strategy for the Roma 2022–2027 *(11)* should be extending the provision of clean water and modern sanitation in traditional Roma communities.

The NAR will continue to ensure that Roma communities are listened to and empowered, both at local and national level. The pandemic has led to a renewed focus on health emergency preparedness and response in countries across the world. The NAR is well positioned to ensure the Roma are partners in this process in Romania.

Mr Rădulescu would like to see more of the national and international funds for Roma inclusion going to projects led by Roma CSOs: "Local CSOs think about what their communities' real needs are. Because the needs can be very different in different Roma communities. We need more CSO-led projects and more flexibility from funders to accommodate the CSOs".

Further information

Association for Emancipation, Solidarity and Equality of Women (ESE), North Macedonia:

https://www.esem.org.mk/en/

National Agency for the Roma, Romania:

http://www.anr.gov.ro

WHO Regional Office for Europe cooperation with CSOs:

https://www.who.int/europe/news/item/16-06-2021-breakthrough-who-initiative-launched-in-europe-to-engage-and-empower-civil-society-organizations-in-health-emergency-responses

Lessons learned

- Countries in the European Region can have very different policies and structures in place for achieving inclusion and empowerment of minorities. There is not a "one size fits all" approach for inclusive governance work for every country. However, participation and the existence of a participatory structure can allow for community members to be part of and support emergency preparedness and response

- Local level models of empowerment such as the Roma community boards in North Macedonia can be highly effective. Nonetheless, engagement of civil society at the national level may also be very important. This is especially the case in countries where central government plays the lead role in emergency response. This may be achieved by expanding civil society involvement in coordination structures, such as Emergency Operations Centres, coordination headquarters or a relevant national emergency planning structure.

- The approach taken to inclusive governance needs to be tailored to the sociopolitical context and administrative realities of countries and their health emergency response systems or frameworks. Using a health-settings approach, emergency interventions can be tailored to take into account social determinants of health. Local CSOs and community leaders can advise on local resources available to support emergency preparedness and response.

- Civil society has previously been an untapped resource. COVID-19 has been a driver for the creation of new processes and structures in civil society. The pandemic has caused a shift in how many CSOs view their role, and how their role is viewed by authorities and other stakeholders, in health-care emergencies. From assisting with access to vaccines to spotlighting the impact of emergency measures on vulnerable groups, CSOs have played an essential role in highlighting communities' assets and needs.

- Civil society can act as a bridge between communities and health authorities. CSOs have deep links with the community, which have created trust with community members and allow for an understanding of community members' needs. There is a real value in working with civil society as a way to access hard-to-reach groups and build trust between communities and health authorities.

Nuri Dervishovski, a Roma community member walks with Dzengis Berisha, coordinator of the Roma civil society organization Stanica L.E.T. in Prilep, North Macedonia. © WHO

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3. Concept note. Assessment tool for governance for health and well-being. Copenhagen: WHO Regional Office for Europe; 2018 https://apps.who.int/iris/handle/10665/346163, accessed 28 June 2022)

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7. Roma equality, inclusion and participation in the EU. In: European Commission [website]. Brussels: European Commission; 2022 (https://ec.europa.eu/info/policies/justice-and-fundamental-rights/combatting-discrimination/roma-eu/roma-equality-inclusion-and-participation-eu_en, accessed 11 May 2022).

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9. Impact of COVID-19 on Roma communities in Romania. Bucharest: SASTIPEN; 2020.

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Annex: Discussion guide methodology

A. Staff/official of ministry of health or other organization that ran the intervention

Introduction

Hello, my name is ...[name].... I am working on a project for the World Health Organization (WHO) to document how communication and engagement have been used to help protect people from the COVID-19 pandemic.

WHO wants to write up a short case study about the intervention to … [describe in a few words] … which took place in [your country/region/community....in [date].

Do you remember this intervention?   Yes/No

Are you willing to talk to me about it?   Yes/No

[If the person you are talking to answers "no" to either of these questions then stop the discussion.]

Are you happy for me to record our discussion and use some of your words as quotes? I will send you the quotes for review before we use them.

                             Yes/No

[If answer is **Yes**]

Thank you. I will start recording. If at any point you wish to say something "off the record" please let me know and I will stop recording.

[If answer is **No**]

That is fine. I will not record our discussion and I will not attribute any quotes to you.

Theme & timing	Type of question	Question	Information sought
Background/context (approx. 2–6 minutes) Request for photos and data (approx. 1–6 minutes)	Narrow focus	*Please could you tell me your name and the name of the organization you work for?*	Name and organization
	Medium focus	*What was your role in the intervention?*	Details of role in intervention and scope of knowledge
	Medium focus	*Do you have any videos or photographs showing the intervention (or people/places involved with it)? Do you have any posters or artwork?* *Do you have reports, evaluations or data about the activity?* *If yes to any, seek permission to use it in the case study* *Can you tell me a bit about what was going on with COVID-19 in your [country/region/ community] when the intervention was launched? Why was this intervention needed?*	Access to photos or data and permission to use them What does photo/artwork/data show? Why is it important? Country/community context Deeper understanding of health issues/ challenges intervention was designed to address
Details of intervention (approx. 10–15 minutes)	Narrow focus	*When did the intervention start? Is it still going? If not, when did it stop?*	When did the intervention happen?
	Narrow focus	*Can you recall the overall objective of the intervention?*	Was there a clear objective or target set at the beginning of the intervention? If so, were staff aware of it?
	Narrow focus	*What groups or types of people was the intervention trying to reach?*	Was the target audience clearly defined? If so, were staff aware of it?
	Narrow focus	*Which organizations were involved in running the intervention? Who did what?*	Which organizations were involved and brief description of their roles
	Narrow focus	*Can you recall how many people in your organization (and its partners) worked on this intervention? What other resources were needed? (e.g. premises, equipment, supplies services)?*	Approximate overview of resources needed to run intervention
	Wide focus	*Tell me a bit about what the intervention did (or still does)?* *What would you do on a day-to-day basis when you were working on this intervention?*	Description of work done or service offered What were, or are, the key outputs/services delivered Number of people reached or served by intervention Individual perspective on how intervention worked (adds human interest to case study)
Impact (approx. 5–10 minutes)	Medium/wide focus	*What impact did the intervention have?* *Further prompts if needed: What achievement(s) are you most proud of? How did it help in the fight against COVID-19? Do you have some examples?*	How did the intervention make a positive difference? In general terms, what are the key successes/outputs? Are there specific examples or success stories that show the intervention's value?
Key factors for success/key limitations (approx. 5–10 minutes)	Medium focus	*What do you think were the factors that helped this intervention happen and be successful?* *Were there challenges or gaps that limited the success of the intervention?*	What were keys to success (e.g. availability of funding/expertise, cooperation with partner(s), leadership/political will, public trust)? For example, shortages of staff or funding, lack of cooperation, policy or legal barriers
Lessons learned (approx. 4–7 minutes)	Medium focus	*What do you think health officials in other countries can learn from this intervention?*	Probe for key "lessons learned" and most important things people trying to run this type of intervention need to know

B. Member of community or group that benefitted from the intervention

Introduction

Hello, my name is ...[name].... I am working on a project for the World Health Organization (WHO) to document how communication and engagement have been used to help protect people from the COVID-19 pandemic.

WHO wants to write up a short case study about the intervention to …[describe in a few words] … which took place in [your country/region/community]…. in … [date].

Do you remember this intervention?   Yes/No

Are you willing to talk to me about it?   Yes/No

[If the person you are talking to answers "no" to either of these questions then stop the discussion.]

Are you happy for me to record our discussion and use some of your words as quotes? I will send you the quotes for review before we use them.

Yes/No

[If answer is **Yes**]

Thank you. I will start recording. If at any point you wish to say something "off the record" please let me know and I will stop recording.

[If answer is **No**]

That is fine. I will not record our discussion and I will not attribute any quotes to you.

Theme & timing	Type of question	Question	Information sought
Background/ context (Approx. 10 minutes)	Narrow focus	*Please could you tell me a bit about yourself – like your name, where live and what you do.* Prompts: *Tell me a bit more about your community? Tell me about your family? Is it okay to ask how old you are?*	Name and context of person
	Medium	*Do you have any videos or photographs showing the intervention (or people/places involved with it)? Do you have any posters or artwork?* If yes, seek permission to use in the case study	Access to photos/videos and permission to use them What does photo/video show? Why is it important?
	Medium focus	*When and how did you first hear about or have contact with [name of project/intervention]?* *How often did you have contact with it after that?*	Details of time-frame and extent of contact with project/ intervention More context on their relationship to the project/ intervention
Details of the intervention	Medium focus	*What were your first impressions of [project/ intervention]?* Possible prompts: *Why was that? Tell me more about…?*	Personal perspectives and stories/anecdotes If possible, a good quote to use in case study
	Medium focus	*What were your experiences of the [project/ intervention] after that?* *Do you have any memories or stories about it you can share?* Possible prompt: *Do you have memories or stories about other people in your community interacting with [project/intervention]?*	
	Medium focus	*Do you think [project/intervention] was useful for your community? Why?* Prompt: *Can you give me an example of how [project/intervention] helped people in your community?*	Personal perspective on what worked (or did not work) Stories/anecdotes If possible, a good quote

World Health Organization

European Region

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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