



PREPSHIELD

Deliverable D3.1 – Engagement strategy

WP3 – T Pilot set-up / ST 3.1.1 Engagement strategy

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Task No.: 3.1

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Nature of the Deliverable		
R	Document, report (excluding the periodic and final reports)	x
DEM	Demonstrator, pilot, prototype, plan designs	
DEC	Websites, patents filing, press & media actions, videos, etc.	
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Dissemination Level		
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Project Summary

PREPSHIELD aims to foster a more holistic and citizen-centric approach to health crisis preparedness and management, by co-creating policy recommendations, methods and an AI-powered platform for crisis management to better prepare for and address health emergencies from a social and societal perspective. To reach this objective, PREPSHIELD will rely on the participation of public authorities, citizens (specifically from vulnerable and non-compliant groups), CSOs, DROs and healthcare institutions. Based on the needs of these groups, PREPSHIELD will develop recommendations for health crisis preparedness, management and communication as well as tools to simulate future crises through an iterative process, involving various pilots for their evaluation. These pilots will include a communication pilot, tabletop exercises and an online exercise, which will include all these stakeholders and take place at different scales in different countries: local (Hamburg, DE), regional (Piedmont, IT) and national (Romania). The online exercise will rely on a PREPSHIELD platform and app (built on the proven CRIMSON platform) to reproduce real-life crisis communication conditions and provide decision-makers with simulations and feedback on the behaviour, wellbeing, capacities, and resources of the other stakeholders. The project brings together a complementary consortium of five universities, two public authorities, one RTO, two non-profit organizations, one SME and two large enterprises from seven European Union countries (and Switzerland)

Document Objective and Executive Summary

This document outlines the recruitment and stakeholder engagement plan for the PREPSHIELD project, linked to Subtask 3.1.1, ‘Engagement Strategy’. The subtask’s goal is to gather and centralize information on effective engagement methods for stakeholders, with a focus on vulnerable and non-compliant groups. It also involves identifying key local multipliers, developing a tailored engagement process, and collaborating on targeted communication materials. This report primarily outlines planned or future activities, though it also includes some actions that have already been carried out.

The ultimate aim of the engagement strategy is to ensure meaningful participation of vulnerable and non-compliant groups in the PREPSHIELD pilot sites through local networks and focused communication.



The first section in this document presents the overall project structure along with the implementation timeline. Subsequently, it delves into the engagement strategy, covering the project's core objectives, recruitment and engagement activities, and a classification of stakeholder groups and their specific characteristics. This part also includes a stakeholder mapping conducted in the pilot sites, culminating in a comprehensive action plan for stakeholder involvement. Following this, the document describes the engagement methodology, highlighting the main components of the strategy and the iterative approach adopted to ensure continuous and adaptive stakeholder participation. Finally, it reflects on the lessons learned throughout the recruitment and engagement processes.

List Of Partners

N°	Participant organisation name	Acronym	Country
1	UNIVERSITA DEGLI STUDI DEL PIEMONTE ORIENTALE AMEDEO AVOGADRO	UPO	IT
2	RIJKSUNIVERSITEIT GRONINGEN	UG	NL
3	UNIVERSITETET I OSLO	UiO	NO
4	TECHNISCHE HOCHSCHULE KOELN	THK	DE
5	CS GROUP-FRANCE	CSG	FR
6	SOPRA STERIA GROUP	SSG	FR
7	EREVNITIKO PANEPISTIMIAKO INSTITOUTO SYSTIMATON EPIKOINONION KAI YPOLOGISTON	ICCS	EL
8	MINISTERUL AFACERILOR INTERNE	DSU	RO
9	SOCIETATEA NATIONALA DE CRUCE ROSIE DIN ROMANIA	RRC	RO
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Glossary

CSO	Civil Society Organisation
EC	European Commission
DRO	Disaster Response Organisation
NGO	Non-governmental organization
RTO	Research and Technology Organisation
TTE	Tabletop exercise
ST	Subtask
SME	Small and medium-sized enterprise
T	Task
TTE	Tabletop exercises
WP	Work package



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Introduction

The PREPSHIELD project comprises numerous interlinked tasks in the work packages 1 - 5, the combined effect of which is to ensure the systematic involvement of relevant target groups. An overarching engagement strategy is therefore central to the pilot sites, as success largely depends on the active participation of various stakeholders, particularly vulnerable and non-compliant groups.

The engagement strategy is based on the assumption that these stakeholders have different needs, barriers and motivations. Specific approaches are therefore necessary to address these and encourage their involvement. In collaboration with the pilot site leaders, strategies are being developed to recruit and engage target groups, particularly vulnerable or non-compliant ones. These strategies are incorporated into a tailor-made engagement strategy.

1. PREPSHIELD Project structure and phases

The following briefly outlines and graphically summarizes the **(1) work packages** in the context of **(2) project phases and activities** in the three-year project between September 2024 and August 2027. (see also fig. 1)

(1) The project is structured by the following work packages:

Work Package	Title	Main Objectives
WP1	Individual, Communal, Societal and Institutional Needs and Barriers for Health Crises	Develop a deeper understanding of the needs and perceptions of vulnerable and non-compliant groups, as well as institutional needs, to provide preliminary recommendations for improved crisis preparedness, management, and communication.
WP2	Tools for Crisis Preparedness and Management	Develop collaborative crisis management tools, including forward-looking scenarios and an AI-powered PREPSHIELD platform with a mobile app.





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WP3	Pilots and Iterative Evaluation	Recruit and train participants, conduct pandemic response pilots, simulate disease spread, evaluate communication strategies, and represent diverse societal responses, including those of vulnerable subgroups.
WP4	Recommendations and Tools for Inclusive Crisis Preparedness and Management	Translate project research into actionable recommendations and tools for policymakers, public authorities, disaster response organisations (DROs), healthcare institutions, civil society organisations (CSOs), and citizens.
WP5	Communication, Dissemination and Exploitation	Inform stakeholders about the project, raise awareness, and disseminate results to targeted audiences for practical use and impact.
WP6	Project Management, Data Management and Ethics	Ensure smooth project coordination, timely delivery of results, and compliance with ethical and data management standards.

(2) The work packages are embedded in the following project phases and activities:

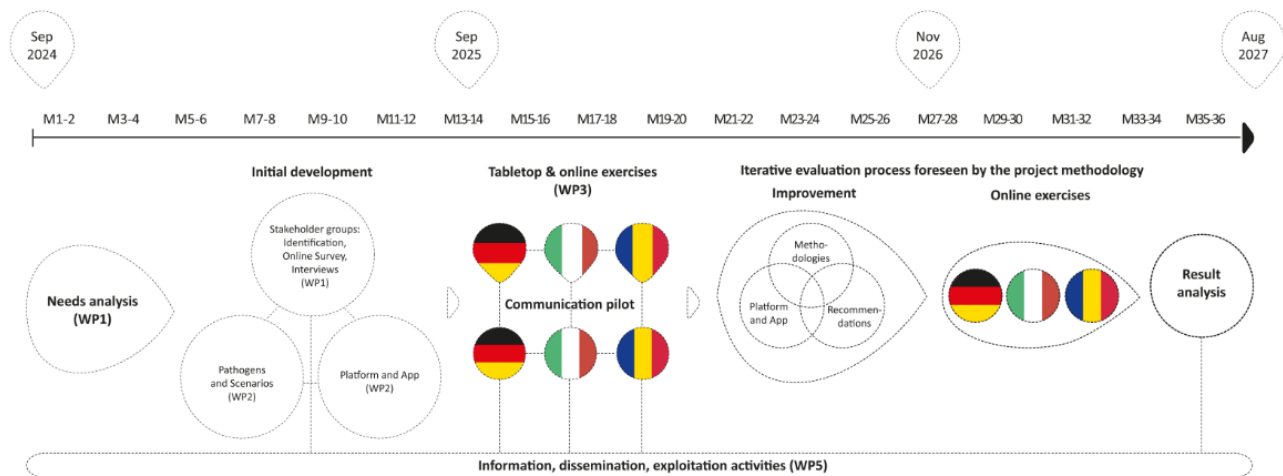



Figure 1: A simplified overview of the PREPSHIELD project with its work packages interlinked activities and phases within the overall process. It highlights the chronology and interdependencies between the work packages and activities.



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Information, dissemination, exploitation. WP5 activities are important at every project phase with their objectives to inform and raise awareness and to disseminate the project results to the target audiences for exploitation.


Needs analysis and initial development. After dedicating the initial project months to analysing the needs, experiences and perceptions of the general public (especially of vulnerable groups) and institutions during health crises (WP1), the development of pathogens and scenarios (WP2) and the platform and app (WP2) began, as did the identification and recruitment of potential stakeholders (WP1), which was particularly relevant for the engagement strategy. The online survey (WP1, ST1.1.2) and initial interviews (ST1.1.2, ST1.2.2 and ST1.3.2) were conducted in April and May 2025.

Tabletop & online exercises and communication pilot. Based on the literature review and expert interviews (in WP1), a communication pilot (WP3, T3.2) will be developed in the following months through online survey experiments for the three different pilots. During this period, the next major activity will be the Tabletop exercises (TTEs) outlined in WP3, Task 3.3. These exercises have been prepared over the past months using scenarios based on pathogens like H1N1 and Dengue, as detailed in the storybooks. The Tabletop exercises (TTEs) will be conducted on-site at the pilot sites as well as online (from autumn 2025 in project month 13 in Hamburg, in month 16 in Piedmont and online, in Romania in month 19 online).

Iterative evaluation process foreseen by the project methodology. All the acquired knowledge and preliminary results, such as the methodology, the app, the platform, and the preliminary recommendations, will be improved, reflected upon, and further developed in the next step of this iterative learning process. Subsequently, the improved communication pilot (WP3, T3.4) will be shared with the participants of the pilot sites in short training sessions in online exercises.


Result analysis. In the final months of the project, all interim findings will be evaluated in a result analysis. Together with recommendations for knowledge transfer to other disasters, guidelines for the digital transformation of health crisis preparedness and management will be developed. Other end products include an app and a platform: The PREPSHIELD mobile app and AI-powered backend platform is used to communicate, prepare for and respond to health crises. The app enables self-reporting, advanced surveys, targeted outreach, and the collection of demographic and well-being data. The platform identifies patterns in user data,



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supports authorities with tailored content and alerts, and helps detect misuse or misinformation.



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2. The PREPSHIELD engagement strategy

The inherent and basic aim of this multi-stakeholder engagement strategy is to recruit, engage and train participants. Engagement takes place at several levels. As well as pilot project-specific activities, it involves workshops on the app and the platform, and contributions from external experts who provide feedback.

In this project, engagement is understood as an iterative, relationship-oriented process that involves the active participation of stakeholders. This includes identifying and recruiting stakeholders, building trust with them and engaging in ongoing dialogue and mutual learning. The aim is to gain shared insights through transparent communication and collaboration, working together to achieve project goals. Motivation, trust, and sustainable relationships play a central role in this process.

In formulating the engagement strategy, this section sets out which engagement activities (in which WPs) are planned, and which have already taken place.

Work package 5, Task 5.2: Communication and dissemination material and activities

WP5 supports the engagement strategy by providing information in English, Italian, German, and Romanian through multiple channels. Targeted communication materials to raise awareness and build trust will be created, constituting a first step in recruiting stakeholders.

Work package 1, Tasks 1.1, 1.2 and 1.3: Needs, perceptions and best practices


The subtasks in work package 1 aim to develop a deeper understanding of both the needs and perceptions of vulnerable and non-compliant groups and institutional needs in health crises.

Work package 2, Tasks 2.2 and 2.4, tools for collaborative crisis management

Work package 2 focuses on developing tools for collaborative crisis management, including predictive scenarios and an AI-supported PREPSHIELD platform. In Task 2.2, joint design meetings will be organised for the PREPSHIELD platform with end users and developers. In Task 2.4.2, a toy model focusing on human behaviour in health crisis will be presented to stakeholders for evaluation.

Work package 3, Tasks 3.1, 3.2, 3.3 and 3.4: Recruiting, training and evaluating



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The engagement subtasks under Task 3.1 in WP3 focus on recruiting and training stakeholders for the tabletop exercises and online exercises. Following the communication pilot (Task 3.2) and the final TTE (3.3), updated best practices will be shared with participants through a short training session prior to the online simulation, with EC representatives invited to observe the final exercise (Task 3.4).

Work package 4, Task 4.2: Recommendations and tools

Task 4.2 finally concentrates on stakeholder group-discussions and valuations of the project results.

2.1. Project and engagement objectives


The projects' main objective is to foster a more holistic and citizen-centric approach to health crisis preparedness and management, by co-creating policy recommendations, methods and an AI-powered platform for crisis management to better prepare for and address health crises from a social and societal perspective. To reach this objective, PREPSHIELD will develop recommendations based on stakeholder needs.

The individual engagement activities in each WP are linked to the **four objectives — Information & dissemination, Needs identification & Crisis preparedness, Pandemic simulation & communication strategies, and Co-creation & policy improvement** — which, taken together, contribute to the overall project objective. **As engaging stakeholders is of central importance, the project objectives can therefore also be referred to as engagement objectives.** Engagement activities will take place in Work Packages 1, 2, 3, 4 and 5 and will be linked to their sub-goals, which will all build on each other and contribute to the overall objective. These sub-goals or **project objectives** are specified in the WPs in the corresponding tasks and subtasks and are detailed in the list of WPs in the grant agreement. With the participation of institutions and the civil population, the project has the following objectives, which are summarised below. (see fig. 2)

Information & dissemination (engagement activities in WP5)

Responsibilities include creating a project visual identity, website, social media accounts, newsletters and brochures, and ensuring the proper dissemination of project objectives to



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target groups through online channels, cooperation with relevant projects and event organisation.

Needs identification & crisis preparedness (engagement activities in WP1)

The aim is to develop a deeper understanding of the needs and perceptions of vulnerable and non-compliant groups, as well as the institutional needs in health crises. This will lead to the delivery of preliminary recommendations for better crisis preparedness, management and communication.

Pandemic simulation & communication strategies (engagement activities in WP2 and WP3)

This involves recruiting and training participants, conducting pilots to simulate pandemic containment and design meetings, evaluating communication strategies and representing the diverse responses of a heterogeneous society, including vulnerable groups.

Co-creation & policy improvement (engagement activities in WP4)

Based on these insights, policymakers, representatives of vulnerable groups and scientists will discuss the project results in co-creation workshops and suggest ways to improve health emergency preparedness and response.

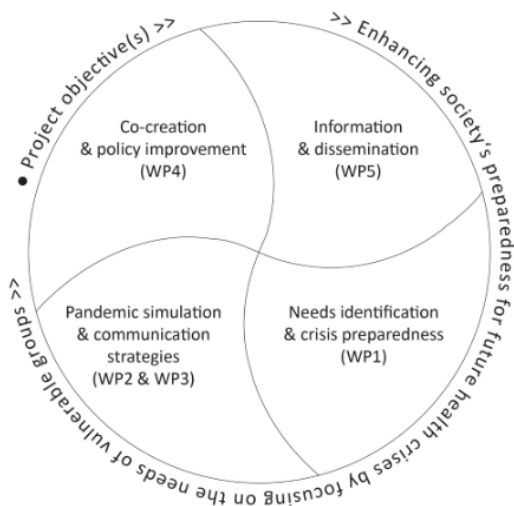



Figure 2: Project and engagement objectives.



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In section 2.1.1 *Expected Outcomes and Impacts* of the Grant Agreement, the following Key Performance Indicators (KPIs) were defined as expected outcomes. They are closely linked to the project and engagement objectives discussed in this section. As these outcomes are set for the end of the project, their full achievement cannot yet be assessed. Nevertheless, the following targets are particularly relevant in the context of engagement activities:


- **EO1:** Resilience pathways should be identified for at least five vulnerable subgroups, with participation of four new CSOs in crisis simulations.
- **EO2:** At least 50% of participants should show improved health literacy by project end.
- **EO3:** Inclusive communication recommendations should address at least 80% of the barriers identified in WP1.
- **EO4:** Over 50% of the identified barriers should be addressed in the training and pilot activities.
- **EO5:** At least three to four public authorities are expected to use agent-based modelling (ABM) in crisis preparedness.
- **EO6:** The PREPSHIELD platform should incorporate at least three AI simulation models, three forecast models, and two optimisation models, all based on interdisciplinary input.
- **EO7:** Over 50% of identified resilience factors should be addressed through training and pilot scenarios.
- **EO8:** Mental health monitoring should be included in 100% of pilot simulations; 50% of scenarios should include environmental or animal health dimensions.
- **EO9:** All data used must be anonymised and GDPR-compliant; at least four trustworthy AI models must be developed.

2.2. Stakeholder groups and their characteristics

The following sections focus on the stakeholders, or the people involved in the project who support it with their experience and knowledge. Understanding the characteristics of stakeholders is crucial for tailoring the engagement strategy and thus ensuring effective communication, prioritisation and engagement.

According to the literature, the classification and definition of stakeholders vary depending on the research context and specific questions addressed. Below is a classification of key stakeholder groups and their typical characteristics shown in a **detailed** and a **broad classification**. (see also figure 3) These classifications rely on the preliminary work from work package 1 (Task 1.1: Needs and perceptions of vulnerable and non-compliant groups



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with regard to health crises) and are supported by academic literature and institutional sources.

The classifications provide a preliminary guide to the stakeholder groups involved in the pilot projects (and beyond). Of course, the boundaries are not always so clear-cut.

Broad classification:

For research purposes, e.g., agent-based social simulation is used to analyze health crises. It is often necessary to adopt a simplified stakeholder structure. All stakeholders are broadly categorized into the general public and institutions, each playing distinct but interdependent roles.


General Public. The general public comprises individuals and communities who are both the recipients of health interventions and active participants in societal responses. Their behaviors, such as risk perception, compliance with health recommendations, and mutual support, are influenced by cultural norms, trust, and access to resources. Vulnerable populations within the public, including the elderly, migrants, and socioeconomically disadvantaged groups, require particular attention due to their increased exposure and limited adaptive capacity.

Institutions. Institutions encompass governmental agencies, healthcare providers, community organizations, private sector entities, and media platforms that design, implement, and communicate crisis management strategies. These actors are responsible for resource allocation, policy enforcement, health service delivery, and information dissemination.

Detailed classification:

Vulnerable Groups. Vulnerable groups are disproportionately affected by health crises due to socioeconomic, demographic, or health-related vulnerabilities. These groups include the elderly, low-income groups, migrants, and people with disabilities or chronic illnesses. They often face barriers to information, care, and compliance, like the digital divide and language issues. Non-compliant individuals are often found among vulnerable groups, rather than implying that all non-compliant groups are inherently vulnerable.



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Non-vulnerable groups. The general public or non-vulnerable groups are both recipients and actors in crisis response, with their behaviours determining the effectiveness of non-pharmaceutical interventions like social distancing and mask use. Individuals belonging to vulnerable groups also have different beliefs, levels of knowledge, trust and compliance.

The **characteristics of vulnerable groups were specified in WP1** in more detail to enable comparable recruitment in all pilot projects. Based on these criteria, the vulnerable stakeholders were and are being targeted in the pilot projects.

The key vulnerable groups include:


Older adults. Older adults, particularly those residing in economically deprived neighborhoods, are recognized as a vulnerable population (Hayden & Parkin, 2020; Pezzuti et al., 2021; Siller & Aydin, 2022; Tegeler et al., 2020).

Women. Women are disproportionately represented in healthcare and other frontline roles and often bear significant caregiving responsibilities, all of which contribute to their heightened vulnerability during crises. This vulnerability is particularly evident among subgroups such as pregnant women, mothers with children under five, and working women. Pregnant women may face increased health risks during pandemics, while mothers of young children are likely to experience elevated stress levels and reduced access to essential services. Working women, on the other hand, often encounter job insecurity and greater exposure to occupational hazards, further compounding their vulnerability. These gender-specific challenges have been documented in various studies and reports (Arzamani et al., 2022; Beckstein et al., 2022; Liu et al., 2023; Maestriperieri, 2021).

People living in poverty. Communities with low incomes—and individuals without stable housing—face considerable challenges in accessing essential resources during emergencies, a fact that has been starkly revealed during the COVID-19 pandemic (Beckstein et al., 2022; John et al., 2022; Maestriperieri, 2021).

People with chronic illnesses or underlying health conditions. Individuals living with chronic illnesses or underlying health conditions—such as diabetes, cardiovascular disease, chronic respiratory ailments, or immunocompromised disorders—are at a heightened risk during crises. These conditions can impair the immune response, thereby increasing the likelihood of severe complications. Epidemiological evidence from the COVID-19 pandemic consistently demonstrates that people with these health challenges face significantly higher



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rates of hospitalization, intensive care admission, and mortality. Furthermore, barriers to accessing regular healthcare and treatment during emergencies exacerbate their vulnerability, highlighting the need for targeted interventions and prioritized medical support for these populations (Garcia-Retamero & Cokely, 2017; Liu et al., 2023; Pera, 2020; Zalsman et al., 2020).

Minorities and marginalized groups. In Europe, minorities and marginalized groups face systematic disadvantages during crises (Beckstein et al., 2022; Liu et al., 2023; Siller & Aydin, 2022). Racial and ethnic minority communities often experience higher infection rates, limited access to quality healthcare, and discriminatory practices. Many individuals within these groups work in sectors that require frequent direct contact with the public, increasing their exposure to health risks. Similarly, Sexual and Gender Minorities (SGM) in Europe frequently encounter discrimination and have limited socioeconomic resources, contributing to poorer mental and physical health outcomes. Pandemic-related disruptions, such as delays in accessing medication and interruptions in educational services, have heightened risks for specific SGM subgroups, including transgender individuals and younger community members. Additionally, other marginalized populations—such as people with chronic or mental illnesses and sex workers—often face significant barriers in accessing essential services during emergencies, further exacerbating their vulnerability.

Migrants and refugees. Migrants and refugees often face vulnerabilities related to insecure immigration status and limited access to resources, and these challenges have been exacerbated during the COVID-19 pandemic in Europe (Liu et al., 2023; Maestriperi, 2021; Shannon et al., 2023; Siller & Aydin, 2022). For example, many migrants encountered significant barriers to accessing healthcare and COVID-19 testing due to language obstacles, fears of legal repercussions, and limited public health outreach. In overcrowded refugee camps and detention centers, such as those in parts of Greece and Italy, poor living conditions and inadequate sanitation facilities markedly increased the risk of virus transmission. Additionally, in some European countries, policy measures further marginalized undocumented migrants by restricting their access to financial and social support during the crisis.

Individuals with disabilities. Persons with disabilities—including those with intellectual, developmental, and physical impairments—are particularly vulnerable due to a complex interplay of biological, social, and economic factors (Macdonald & Morgan, 2021; Morgan et al., 2021; Shannon et al., 2023; Siller & Aydin, 2022). For example, individuals with



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intellectual disabilities often have underlying health conditions that predispose them to contracting infections at a younger age and to experiencing more severe symptoms. Studies in Europe have indicated that such individuals are more likely to require hospitalization for COVID-19 and suffer complications compared to the general population. Similarly, people with mobility impairments may face significant barriers in accessing timely medical care, resulting in delayed treatment and poorer health outcomes. In addition, social isolation and economic disadvantages exacerbated by disruptions in routine care and support services during the pandemic further compound these vulnerabilities, leading to an increased risk of mortality.


Intersectionality is both natural and expected as many of these characteristics often coexist within individuals – for instance, a woman living in poverty, or a man over the age of 65.

Non-compliant Individuals who do not comply with the relevant regulations are often found among vulnerable groups. Non-compliant Groups: Those with cognitive-behavioral disorders, pregnant women, panic-prone individuals, individuals with intellectual disabilities; with the following non-compliant features:

- Individual Health Conditions, including People living with dementia, People with bipolar disorder, People with Dark Triad traits, People with psychopathic traits
- Sociodemographic factors, including elderly unafraid of virus, lower education, migrants
- Social and Economic Context, including rural populations, people with low-income
- Little access to Information access, and low social trust

Government and Public Authorities. Government and public authorities are responsible for policymaking, funding, coordination, and enforcement of public health measures, operating at multiple levels including local, regional, national, and international. This group includes public health agencies like the Centers for Disease Control, European Centre for Disease Prevention and Control, World Health Organization, ministries of health, and emergency response units.



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Professionals in social or health care. Professionals in social or health care are frontline responders during crises. Such professionals include those working in hospitals, clinics, primary care, and emergency medical services. They often face resource limitations, burnout, and high exposure risk, playing a key role in detection, treatment, and communication. This category has four more specific subcategories:

- Physicians,
- Nursing Professionals,
- Allied health professionals
- Public health and administration professionals.

Communication Channel Stakeholders. One type of stakeholder is information intermediaries who utilize communication platforms (e.g., news media, digital alert systems, translation tools) to disseminate official guidance to the public. These stakeholders do not originate the messages but play a vital role in ensuring that the information reaches diverse audiences in a timely and accessible manner. By leveraging various communication tools, they help translate messages linguistically and culturally, which is particularly important for non-native speakers or marginalized populations. While their work significantly enhances the reach and clarity of public health messaging, they typically operate in a one-way communication mode and do not engage in building interpersonal trust or fostering direct dialogue with recipients.

Non-Governmental Organizations (NGOs). NGOs often work directly with vulnerable communities and play a more relational and interactive role. They engage in two-way communication, mediate between institutional actors and communities, and often have established trust networks. Their activities include tailoring messages, facilitating behavioural interventions, and providing feedback loops to authorities. Because they are embedded in the communities they serve, they are vital for promoting trust and ensuring compliance with public health recommendations.



Private Sector and Employers. The private sector and employers ensure supply chain resilience, infrastructure, medical supplies like PPE and vaccines, and innovation such as digital health tools. They are involved in business continuity planning and employee protection measures and can influence public behaviour through workplace policies.

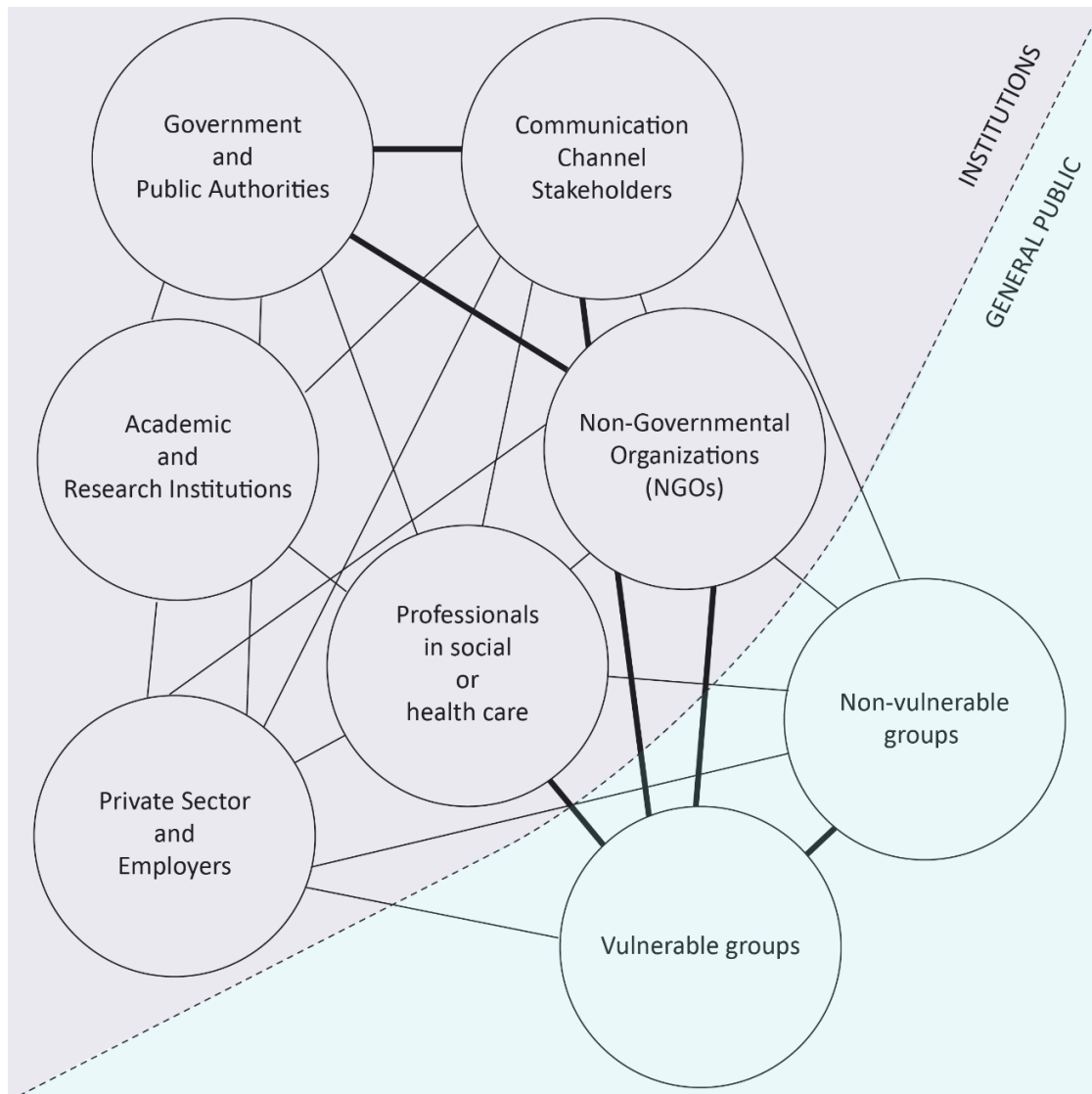


Figure 3: Stakeholder categories and their relational links across institutions and the general public in the context of health crisis preparedness.

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2.3. Stakeholder mapping in the pilot sites and other European countries

PREPSHIELD relies on the participation of institutions and the general public (specifically from vulnerable and non-compliant groups), mainly those from the pilot sites in Hamburg, Piedmont, and Romania, and additionally experts from Grenoble (France) and Maribor (Slovenia).

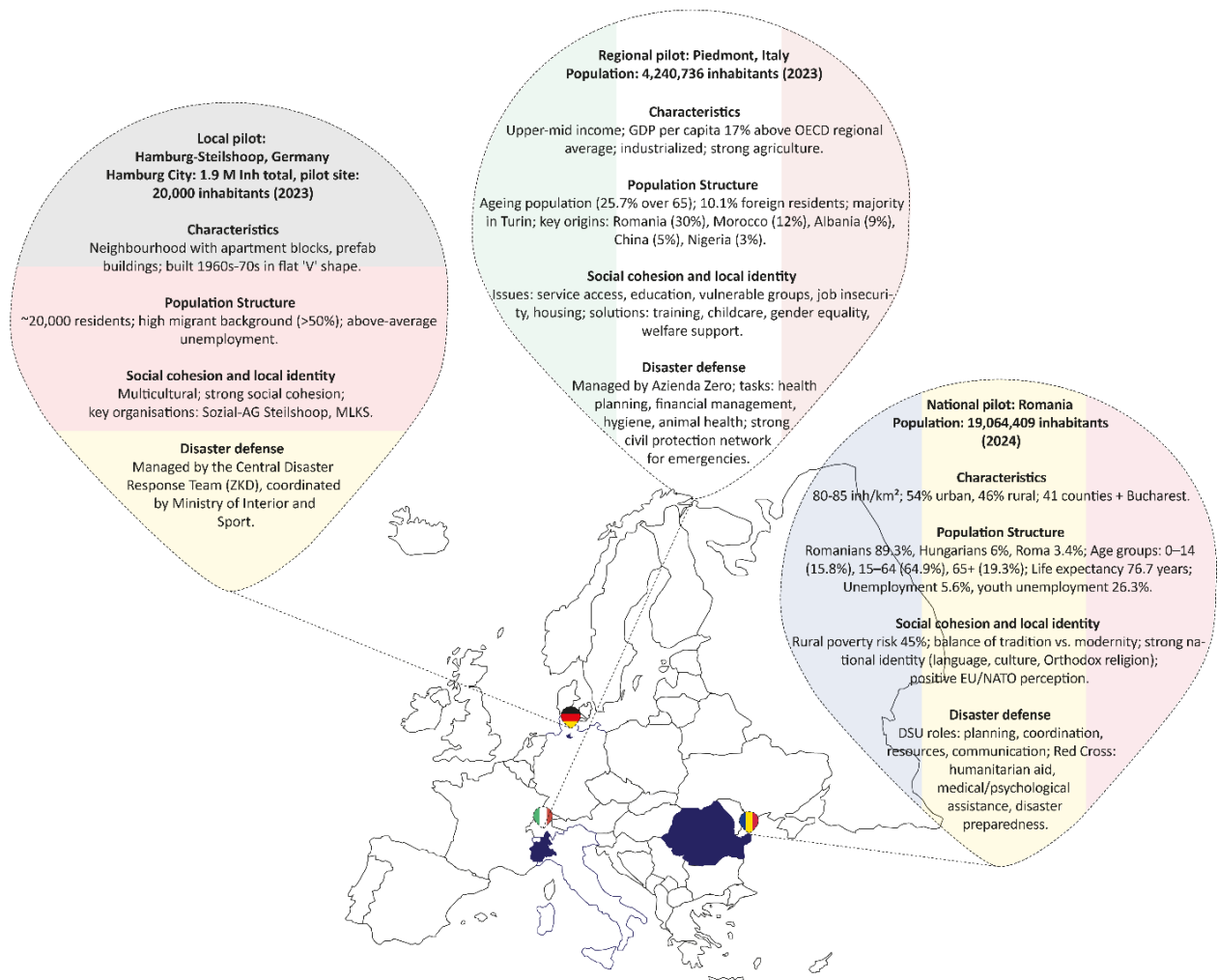



Figure 4: Pilot site profiles: Hamburg-Steilshoop, Piedmont, Romania. The illustration summarises the profiles of the pilots: their characteristics, population structure, social cohesion and local identity, and the disaster prevention strategy.

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Participation is planned in various formats that pursue interrelated research interests. Depending on the knowledge objective and the methods of the format, potential participants are identified and invited to attend. The recruited participants are assigned to predefined stakeholder groups: Vulnerable Groups, Non-vulnerable groups, Government and Public Authorities, Professionals in social or health care, Communication Channel Stakeholders, NGOs, Academic and Research Institutions and Private Sector and Employers. (see detailed definition under 2.2. Stakeholder groups and their characteristics).

Based on the needs of these groups, PREPSHIELD will develop recommendations for health crisis preparedness, management and communication as well as tools to simulate future crises through an iterative process.

2.3.1. Hamburg and the stakeholders involved

(1) Profile of the pilot site

Local pilot: Hamburg-Steilshoop, Germany


Hamburg City: 1.9 M Inh total, pilot site: approx. 20,000 inhabitants (2023)

Characteristics. The Steilshoop district is located in Hamburg's Wandsbek district. The neighbourhood is characterised by apartment blocks and prefabricated buildings, particularly in the northern area. This area was constructed in the 1960s and 1970s in the shape of a flat 'V', measuring approximately 1.5 km in width and 500 m in length. The large housing estate was once one of the best-known examples of a new era in post-war housing construction in Germany, with exemplary infrastructural facilities. Today, Steilshoop is a multicultural neighbourhood with a high population density.

Population Structure. Steilshoop is one of Hamburg's less affluent districts. The unemployment rate is significantly higher than the Hamburg average. More than 50% of the residents have a migrant background.

Social cohesion and local identity. The neighbourhood is characterised by a strong sense of community and multiculturalism, with families, clubs and religious communities playing



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a key role. Key organisations include the Sozial-AG Steilshoop and the Martin-Luther-King-Gemeinde (MLKS).

Disaster defense. Responsibility for disaster defence in Hamburg lies with all authorities, with central coordination provided by the Ministry of the Interior and Sport. The State Council directs disaster defence and sets tactical, political and administrative goals. In the event of an emergency, it can issue instructions and Senate resolutions. The Central Disaster Response Team (ZKD) assists and advises the State Council in this regard.

(2) Stakeholders in Hamburg

The list of the (planned) stakeholders in Hamburg, Germany, is shown below: The stakeholder list includes those recruited for the interviews, as well as those planned for the TTE and online exercises. They are listed according to their classification.

Vulnerable Groups. Participants classified by vulnerable groups were contacted via institutions and are represented / supported by them.


- 1 woman with disability (Interview/TTE)
- 1 man with a migrant background (Interview)
- 1 woman in poverty (Interview)
- 1 woman older than 70 years (Interview/TTE)
- 1 woman with chronic illness (Interview)

Non-Governmental Organizations. As ‘bridge builders’ between authorities and residents, these local institutions have enabled the recruitment of the following persons from vulnerable groups and partly support them during the interviews and exercises.

- Food distribution centre for people in poverty , 1 woman/leader of the team (Interview/TTE)
- Meeting place for elder people, Martin Luther King Church Community Steilshoop, 1 woman from the team (TTE)
- Religious leader of the MLKS- Steilshoop (Interview)

Professionals in social or health care. The Red Cross uses information received from the government and other organizations and uses the same communication strategies in all places in Germany, following their movement's fundamental principles (including



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impartiality, neutrality, independence, etc.). Therefore, the communication strategies of the Bavarian and Hamburg Red Cross do not differ significantly.

Interviews:

- Bavarian Red Cross, Project manager
- Daycare centre for little children, 1 man from the team

TTE's – (planned) recruitment:

- Housing and support concept for people living with disabilities and assistance, 1 woman assisting (team)
- Daycare centre for little children, 1 man from the team
- Technical Relief Service Hamburg, (requested for TTE-participation)
- German Red Cross Hamburg, (requested for TTE-participation)

Government and Public Authorities.

Interviews:

- Hamburg Fire Brigade (Ministry of the Interior and Sports), Rescue service, Medical director
- Wandsbek District, Health Department , 2 Doctors
- Wandsbek District Health Department , Division for Infection Control, Municipal Hygiene and Medical Services, 1 Doctor

TTE's – (planned) recruitment:

- Hamburg Fire Brigade (Ministry of the Interior and Sports), Press office, Head of Operational Communications
- Ministry of the Interior and Sports, (requested for TTE-participation)


2.3.2. Piedmont and the stakeholders involved

(1) Profile of the pilot site

Regional pilot: Piedmont, Italy

Population: 4,240,736 inhabitants (2023)



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Characteristics. Upper-mid income region with 2018 GDP per capita 17% above OECD regional average and 2% above overall OECD average; highly industrialized; significant agricultural sector.

Population Structure. Significantly ageing population, with approx. 25.7% over the age of 65 (as of 2023); one of the highest shares in Italy. In addition, foreign residents make up approximately 10,1% of the total population (2024). More than 51% of people with migrant backgrounds in Piedmont reside in the Metropolitan City of Turin. However, their presence has a greater impact on four other provinces, where it is higher than the regional average (10.1%): Alessandria (11.9%), Asti (11.1%), Cuneo and Novara (10.7%). Most of the foreign citizens residing in Piedmont come from European countries, of these 35% are from EU countries. Romania is the country from which 30% of foreigners in Piedmont come, followed by Morocco (12%), Albania (9%), China (5%) and Nigeria (3%).


Social cohesion and local identity. Challenges are unequal access to services, educational poverty, exclusion of vulnerable groups, job insecurity, and housing shortages. In response, the region under the Regional Operational Programme implements broad social inclusion measures: training, early childhood services, gender equality initiatives, and support for local welfare and the third sector—to promote social cohesion, innovation, and labor market integration.

Disaster defense. The management of health emergencies for the Piedmont region is managed by Azienda Zero. The following tasks are assigned to the Regional Departments of Health: health planning, financial management of the health fund, health assets and buildings, health and hospital assistance, public and food hygiene, animal health, supervision of health establishments, supervision of sector bodies. In parallel, Region Piemonte’s Civil Protection System plays a vital role in the broader coordination of emergency response, including health-related disasters such as pandemics. Piedmont has a well-developed and structured civil protection network that operates in close collaboration with municipalities, healthcare bodies, and national agencies.

(2) Stakeholders in Piedmont

The list of all (planned) stakeholders in the Piedmont region, Italy, is shown below: The stakeholder list includes those recruited for the interviews, as well as those planned for the TTE and online exercises. They are listed according to their classification.



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Vulnerable groups and Professionals in social or health care

Interviews:

- 3 migrants from a CSO identified
- 2 elderly from an elderly care facility
- 3 caregivers (2 working in the elderly care facility and 1 from the CSO)
- Professional in social or health care (7 in total)
- Allied health professionals (2)

TTE's – (planned) recruitment:

- CSO already active in Piedmont (5 people from vulnerable groups + 1/2 representative of the CSO as community leader)

Government and Public Authorities

Interviews:

- 1 Interview with Government and Public Authorities

TTE's – (planned) recruitment:

- Representatives of policy makers at the regional level of piedmont (public health officer, logistics officer, communication officer)
- 1 Representative of hospital direction team
- 1 Representative of primary care services (coordination of family doctors/nurses)
- 1 Representative of regional/municipal health authority


2.3.3. Romania and the stakeholders involved

(1) Profile of the pilot site

National pilot: Romania

Population: 19,064,409 inhabitants (2024)



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Characteristics. Romania has an average density of around 80-85 inhabitants/km², below the European average. About 54% of the population live in urban areas and about 46% in rural areas. The country is divided into 41 counties and Bucharest Municipality, each county having an administrative centre.

Population Structure. Romanians: 89.3%, Hungarians: 6%, Roma: 3.4%, Other ethnicities: 1.3%. The proportion of 0–14-year-olds is 15.8%, the proportion of 15–64-year-olds is 64.9% and the proportion of over 65-year-olds is 19.3%. Life expectancy in Romania is 76.7 years.

The average annual unemployment rate is 5.6%. Unemployment among young people under 25 is 26.3%, the highest rate in the European Union.

Social cohesion and local identity. Romania faces significant challenges in terms of social cohesion, particularly in rural areas. According to Eurostat data, the risk of poverty or social exclusion in rural areas is around 45%, 26 percentage points higher than in urban areas.

The country is at the crossroads between tradition and modernity, between strong local identities and European aspirations. Romania is characterized by a strong national identity based on the Romanian language, cultural traditions, and the Orthodox religion. At the same time, membership of the European Union and NATO is perceived positively by most citizens.

Disaster defense. The Department for Emergency Situations (DSU) is the main national coordinator for emergency management. DSU has the following key roles: planning and prevention, operational coordination, resource management, communication, and information. The Romanian Red Cross is a humanitarian organization auxiliary to public authorities, with the following responsibilities in disaster response: humanitarian aid, medical assistance, psychological first aid, disaster preparedness courses and first aid courses

(2) Stakeholders in Romania


The list of the (planned) stakeholders in Romania is shown below: The stakeholder list includes those recruited for the interviews, as well as those planned for the TTE and online exercises. They are listed according to their classification.

Vulnerable Groups and Representatives

Interviews:



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- 1 elderly person
- 1 of Roma ethnicity, uneducated
- 1 caregiver (during the pandemic) for his disabled father (since deceased).
- 1 chronically ill and 2 grandchildren
- 1 of Roma ethnicity, single mother, no income
- 1 mother retired on sickness, epileptic, precarious situation

TTE's – (planned) recruitment:

- Representatives of people with disabilities

Professionals in social or health care

Interviews:

- Health professionals from Clinical Emergency Hospitals – ED (2)

Government and Public Authorities


- Ministry of National Defense, Public relations officer (interview)
- Department for Emergency Situations, Secretary of State, Head of the Department (interview):
- Representatives of Department for Emergency Situations (planned TTE – Stakeholders);
- Representatives of General Inspectorate for Emergency Situations (planned TTE-Stakeholders)
- Representatives of national public health sector (planned TTE-Stakeholders)

2.3.4. Stakeholders in other European countries

From a methodological standpoint, the best practices are not intended for exclusive application to the pilot sites. Rather, they are meant to be relevant across the broader European context. Including the perspectives of other countries, such as France and Slovenia, is important to ensure that the recommendations can be applied more widely and are inclusive of a range of different health and social care systems and policy frameworks. This broader input helps to better understand commonalities and variations, ultimately strengthening the relevance and applicability of the best practices at the European level.

Interviews were conducted with professionals from the social and health care sectors: two from Slovenia and one from France.



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2.4. Action plan and engagement activities

This action plan roughly outlines a structured and phased approach for stakeholder engagement and participation throughout the duration of the PREPSHIELD project (M1–M36). It describes an iterative planning process with objectives to achieve. While the goals are clear, the process can be revised and adapted as necessary. This means that the engagement activities are continuously adapted, if necessary, based on the findings from previous activities, thus optimising them. Chapter 4 ('Lessons learned') contains a detailed presentation of the initial results and findings obtained from the cooperation with the individual stakeholders from the respective pilot sites. The final chapter, 'Reflections on the engagement measures', considers whether the theoretical requirements for successful participation set out in Chapter 3 ('Engagement methodology') were applied in the recruitment and engagement process.

The action plan aims to achieve the following objectives:

- raise awareness of the project,
- ensure inclusive participation,
- co-design tools and simulate real-time crisis response,
- derive best practices and policy recommendations for health crisis communication.

Targeted types of engagement through participation tools & techniques are:

- **Information** through digital Platforms: Website, social media (LinkedIn, Twitter), newsletters, online surveys; through printed materials: Flyers, posters, brochures in easy-to-read formats.
- **Communication** through interviews.
- **Communication & Co-creation** through in-person events like focus group discussions, workshops, tabletop exercises.
- **Co-Designing** through paper prototyping, wireframes, interactive UX testing.

The following overview of actions describes the phases and their objectives, as well as the participation instruments and techniques used in the planned project months.






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Project month	Phases & objectives	Participation tools & techniques
M1–M8	Awareness & Recruitment	<p>Creating communication material in English, Italian, German, Romanian: Visual identity, flyers, website, survey prep, local partner briefings</p> <p>Disseminating materials to vulnerable groups, NGOs, healthcare professionals, and public authorities</p> <p>Using accessible language for materials targeting vulnerable groups</p> <p>Organizing local project presentations to stakeholders in Hamburg, Piedmont, and Romania</p>
M4–M12	Data Collection & Interviews	<p>Conducting an online survey in all pilot sites targeting vulnerable groups and their representatives.</p> <p>Semi-structured interviews with stakeholders (vulnerable groups, healthcare professionals, NGOs, and authorities) from the pilot sites</p>
M4–M26	Co-Design & Testing	<p>PREPSHIELD platform co-design workshops: UX design sessions; design methodologies (e.g., wireframing, paper prototyping) with end-users and developers</p> <p>Model refinement in co-creation with experts (stakeholders)</p>
M12–M30	Simulation Exercises & Evaluation	<p>Tabletop exercises in Hamburg, Piedmont, and Romania with authorities, NGO's, professionals in social or health care, and representatives of vulnerable groups: Simulate pandemic scenarios and evaluate decision-making processes</p> <p>Training participants on updated best practices</p> <p>Conducting online simulations using the PREPSHIELD platform</p>
M28–M36	Co-creation & Policy Recommendations	<p>Workshops with policymakers, scientists, and representatives of vulnerable groups: Discussing project results and suggest improvements</p>

Engagement activities take place at several levels. As well as pilot project-specific activities, engagement involves workshops on the app and the PREPSHIELD platform, and contributions from external experts who provide feedback. The engagement activities—participation techniques and the associated recruitment and dissemination actions—are highly context-sensitive and tailored to the specific structures and networks in each pilot site.



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Engagement depends on various local conditions—such as the degree of centralisation in crisis management, the accessibility of stakeholders, and the availability of trusted networks.

The project is currently in the midst of the recruitment process. The activities listed below are therefore examples—either already implemented or concretely planned—that illustrate how each engagement activity is adapted to local realities. They show how recruitment and participation are designed to reach different stakeholder groups effectively in Hamburg, Piedmont and Romania, with a particular focus on vulnerable and non-compliant groups, public authorities, and healthcare professionals.

The differences in engagement activities for each stakeholder group are described in the following sections, divided up according to each pilot site. (A detailed table ‘Participation techniques, communication and dissemination activities’ in Annex 1 summarizes the engagement activities that have been conducted or are planned in all work packages.)

Online Survey as part of the Data Collection & Interviews Phase (M4–M12): Conducted in April & May 2025 across pilot sites.

Pilot Site	Participation Techniques	Recruitment & Dissemination Actions
Hamburg	Representatives of vulnerable groups in the Steilshoop district provided feedback on the survey questionnaire and dissemination materials (flyers, brochures, posters).	Recruitment through local networks (MLKS), newspaper announcements, institutional visits, accessible flyers, community notice boards, and direct outreach in social institutions, supermarkets, and pharmacies.
Piedmont	Online survey participation via QR codes and flyers targeting the general and vulnerable population.	Dissemination via CRIMEDIM’s network by email and in-person distribution of flyers in high-traffic locations such as train stations, religious buildings, libraries, and pharmacies.
Romania	Online survey aimed at the general population, including vulnerable groups, accessed via QR codes.	Distribution through Romanian Red Cross branches, E.G.A.L. centres, community-based dissemination, and partnerships with charitable associations under DSU protocols.



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Survey study (Interview-part) on the needs and barriers of vulnerable and non-compliant groups as part of the Data Collection & Interviews Phase (M4–M12): Conducted in May & June 2025 across pilot sites.

Pilot Site	Participation Techniques	Recruitment & Dissemination Actions
Hamburg	Semi-structured interviews (approx. 1 hour) with vulnerable groups and social institutions in German, using an interview guide based on WP1 literature findings.	Recruitment through local social institutions in the MLKS network, with personal visits, brochures in easy-to-read language, and follow-up via phone calls, visits, or email.
Piedmont	Semi-structured interviews (approx. 1 hour) with vulnerable individuals and their caregivers in Italian, guided by insights from WP1.	Participants recruited via CRIMEDIM’s established network, including community-based organizations and civil society organizations (CSOs).
Romania	Semi-structured interviews (approx. 1 hour) with vulnerable groups (e.g., migrants, elderly) in Romanian, using a guide developed from WP1’s literature review.	Recruitment conducted through Romanian Red Cross branches and the Department for Emergency Situations (DSU) network.

Interviews: Challenges to overcome for healthcare institutions and policymakers as part of the Data Collection & Interviews Phase (M4–M12): Conducted in April & May 2025 across pilot sites.

Pilot Site	Participation Techniques	Recruitment & Dissemination Actions
Hamburg	Semi-structured expert interviews (approx. 1 hour) in English with two doctors from the Wandsbek district health department, focusing on data collection and health literacy.	Stakeholders from authorities were recruited through direct requests, meetings, and project presentations at the Senate Chancellery.
Piedmont	Semi-structured interviews (approx. 1 hour) in Italian/English with social and healthcare professionals from Piedmont, France, and Slovenia, including one public authority representative from Slovenia.	Participants were recruited via CRIMEDIM’s network and additional project partner networks.
Romania	Semi-structured interviews (approx. 1 hour) in English with health professionals involved in the Covid-19 response, focusing on institutional data practices and health literacy.	Recruitment carried out through institutional networks, including the Romanian Red Cross and centralized coordination under the Department for Emergency Situations (DSU).




Expert interviews for communication in health crises as part of the Data Collection & Interviews Phase (M4–M12): Conducted in April & May 2025 across pilot sites.

Pilot Site	Participation Techniques	Recruitment & Dissemination Actions
Hamburg	Semi-structured expert interviews (45–60 minutes) conducted in English via Zoom with NGOs and healthcare/authority professionals, focusing on communication strategies during past health emergencies.	Stakeholders from authorities were recruited through direct requests, meetings, and project presentations at the Senate Chancellery.
Piedmont	Semi-structured expert interviews (45–60 minutes) in English via Zoom with communication leaders (e.g., university, hospital, Red Cross) about their roles in crisis communication.	Participants were contacted via project partners, who facilitated introductions and initial outreach.
Romania	Semi-structured expert interviews (45–60 minutes) in English via Zoom with healthcare professionals, public authorities, and communication platform representatives, focusing on risk and crisis communication.	Recruitment took place through project partners and local contacts from previous collaborations.

Tabletop exercises for multirisk health crisis preparedness and comparative evaluation of the platform as part of the Simulation Exercises & Evaluation (M12-M30):

Pilot Site	Participation Objectives and Techniques	Recruitment & Dissemination Actions
Hamburg (TTE on 16/09/2025 in Steilshoop)	Full-day, in-person tabletop exercise using a round-based scenario to simulate pandemic crisis management. Included feedback loops from experts and vulnerable group representatives; methodologically based on business wargaming and causal loop diagrams.	Approx. 15 participants including vulnerable group members, healthcare professionals, and public authorities. Recruitment was conducted partly via WP1 interviews and directly through institutions and networks in the Steilshoop district.
Piedmont (TTE in M16, hybrid format)	Hybrid tabletop exercise (partly in-person, partly online), simulating crisis scenarios with real-time decisions and AI-based feedback loops.	Participants from vulnerable groups, professionals, and public authorities were recruited via CRIMEDIM's network and collaborating NGOs and institutions.
Romania (TTE in M19, fully online)	Online tabletop exercise using agent-based simulation to explore crisis response strategies and stakeholder interaction in a virtual environment.	Recruitment included vulnerable group representatives, NGOs, social/health professionals, and public authorities through institutional networks and protocols between DSU and charitable associations.

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3. Engagement methodology

While the engagement strategy defines the overarching goals, stakeholders and basic actions of stakeholder engagement – the 'what' and 'why' – the engagement methodology outlines the specific methods, tools and processes for implementing the strategy – the 'how'. In short, the strategy provides the framework and the methodology implements it.


The PREPSHIELD engagement methodology is based on a triad. The **Project objectives** (chapter 2.1.) form the foundation and are considered the hard factors, which are embedded in the **Engagement components** (chapter 3.1.). As these engagement components are based on exchange processes and thus on the relationships between project team members and stakeholders, they also describe so-called soft facts such as intrinsic motivation or trust. Finally, project goals and engagement components are considered over time: This **Iterative engagement approach** (chapter 3.2.) further explains how tailored engagement activities evolve in cyclical phases, leading to increasingly dense insights.

3.1. Engagement components

These project and engagement objectives (see chapter 2.1.) are connected to **three engagement components: Identification of stakeholder groups and key local multipliers, Recruiting and building trust, Maintaining trust and learning.** (see fig. 5) They describe the relationships between project partners and stakeholders. These components are based on motivation, transparency, mutual trust and shared, iterative learning processes. The implementation concerning these components include communication strategies, interactive features, feedback mechanisms, participation incentives, collaboration tools or training programs. Being aware of these elements helps to ensure that the target groups become interested in the project and motivated and feel actively involved in the project activities.

The first engagement component and initial step is the **Identification of stakeholder groups** and key local multipliers, which includes recognizing the representatives of vulnerable groups. This is crucial as it helps in understanding the various interests and needs of different stakeholders. This component therefore aligns with the project objectives from WP5 (Visual identity & dissemination) and WP1 (Needs identification & crisis preparedness), which



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includes disseminating project information as well as gaining insights in the needs and perceptions in health crises.

Following this, the process involves **recruiting** of stakeholders **and building trust** with them, which is essential for fostering a collaborative and supportive environment. Not all, but particularly vulnerable groups share their experiences and needs in multiple formats and thus over a longer period of time. Therefore, the project objectives of WP1 and WP3 are aligned with this engagement component.

Once **trust** is established, it is important to **maintain** it during the whole process, where both researchers and participants **learn** from each other: in this reciprocal learning process researchers gain insights from the experiences and knowledge of the stakeholders, while stakeholders benefit from the discussions, exercises, and findings of the project. This engagement component aligns with the objectives of WP2, WP3 and WP4 (Co-creation & policy improvement). (see also fig. 5)

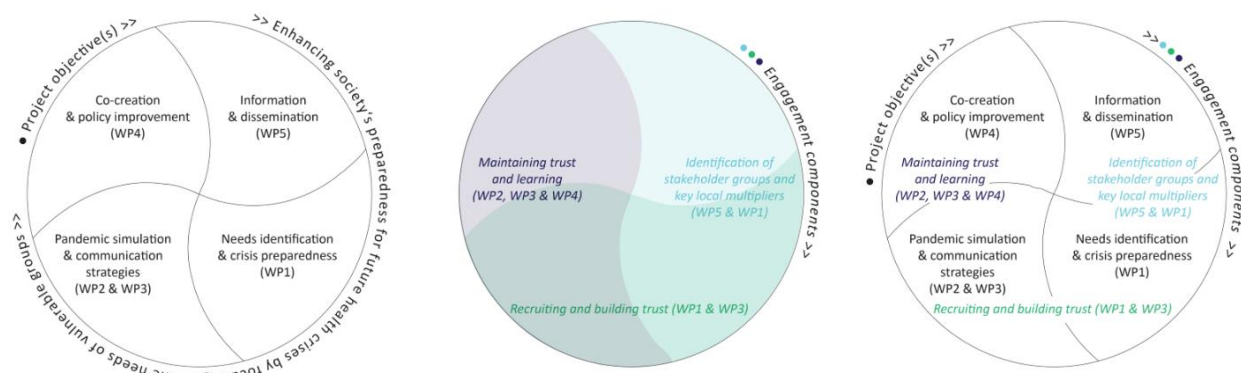


Figure 5: Project and engagement objectives > engagement components > overlays of both.

3.2. Iterative engagement approach

The term **iterative engagement approach** captures the idea of repeated, customized participation over different phases. Following, the engagement methodology is described from a temporal and perspective, consisting of cyclical, iterative loops or phases or an understanding of what aspects these phases should include. The engagement approach is also made up of a number of individual strategies based on the needs of each stakeholder in



order to reach and give access to a variety of people. This approach is also known as ‘tailoring’, where formats and activities are adapted to the specificities and needs of target groups or individuals. Each phase may include seven potential actions: (1) Identifying stakeholders, (2) Identifying key local multipliers & representatives, (3) Sensitive & clear communication, (4) Preparation & setting, (5) Binding & appreciation, (6) Letting go and (7) Evaluation. It’s important to note that not every aspect listed is relevant to every method. In addition, the seven actions are seen as complementary characteristics (and not necessarily sequential). Actions can be addressed simultaneously or be relevant several times in the phases, e.g. (3) Sensitive & clear communication. The following actions or recommendations are focusing mainly on the engagement of vulnerable and non-compliant groups and on the implementation of interviews or exercises. The actions mentioned are intended as guidance only. (see also fig. 6)

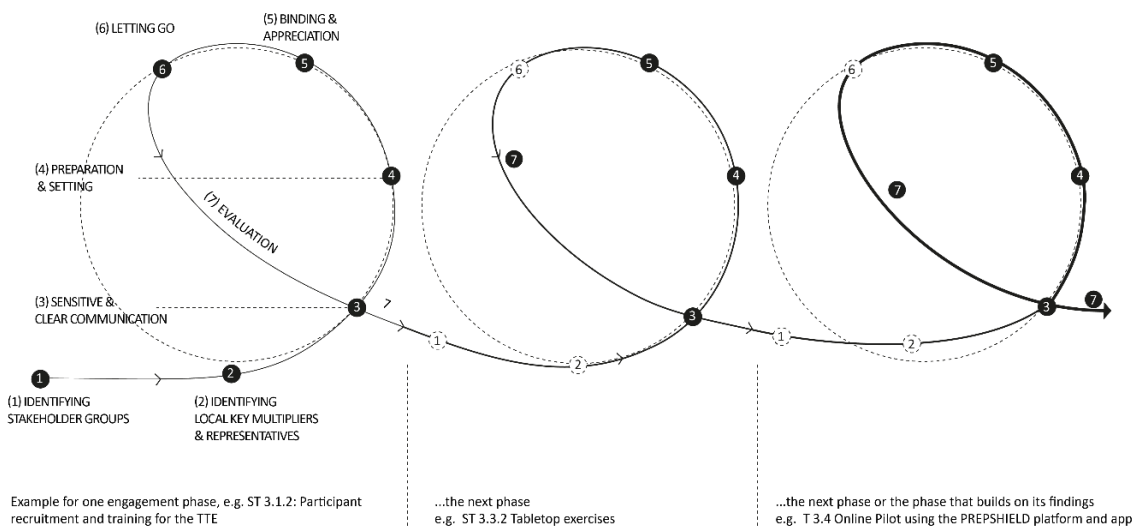



Figure 6: Illustration of the iterative engagement approach developed for the PREPSHIELD project.

(1) Identifying stakeholder groups and (2) Identifying key multipliers & representatives

With a focus on communication strategies during health crises or pandemics, the appropriate stakeholders are defined and delimited. This includes the identification of relevant networks, key local multipliers and representatives such as translators, grassroots initiatives, faith communities, health professionals – people of trust or people who already work with vulnerable groups. The recruitment of participants strives for gender equality. The

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results of the broad and detailed classification of stakeholder groups are based on the work of WP1 and can be found in the document under ‘2.2.1 Stakeholder groups and their characteristics’.

(3) Sensitive & clear communication

In the project, the core principle is that communication should be both sensitive and easy to understand. This is especially important when engaging with external stakeholders, such as vulnerable groups. The approach emphasizes low-threshold, respectful, and transparent communication to ensure accessibility for all participants.

To achieve this, communication strategies are tailored to specific groups or individuals. This includes providing information in multiple languages, including those from other countries, and utilizing accessible formats such as visual aids, sign language, or braille. Communication materials are simplified through the use of clear graphics, colours, and images to facilitate understanding.

It is also essential to assess the potential for different interpretations or misunderstandings of terms and visuals, ensuring that messages are conveyed accurately. Appropriate channels and formats are selected, such as direct phone calls, emails, flyers, social media, or community-based approaches, to distribute information effectively.


Presence and approachability are considered key elements in fostering trust and openness within the project. Additionally, the need for support from translators, facilitators, or community multipliers is evaluated—particularly during interviews or sensitive interactions—to ensure that all voices are heard and understood clearly.

(4) Preparation & setting

The project aims to ensure a successful engagement process by thoroughly preparing participants in advance of their appointments, such as interviews or simulations. Where appropriate, joint appointments with representatives may be arranged to offer additional support. The inclusion of psychological training for interviewers and psychological support for participants is also considered essential to foster a safe and supportive environment.

Building an atmosphere of trust and appreciation for participation is a central objective. To support this, the project seeks to create familiar and comfortable settings for participants. When beneficial, the involvement of trusted confidants or representatives is encouraged to



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help participants feel at ease. Providing adequate time for preparation is also a key priority to ensure that everyone involved feels confident and well-prepared.

The project emphasizes flexibility and accessibility in its formats to meet the diverse needs of participants. This includes ensuring that venues are accessible, offering transportation options, and providing all necessary technical equipment in full working order.

For the successful implementation of TTEs, the project envisions distinct spaces tailored to different activities—such as exercises, presentations, informal gatherings, and group discussions. Furthermore, the provision of quiet zones and safe retreat spaces is seen as essential to support participants’ well-being and provide opportunities for rest and recovery.

(5) **Binding & appreciation**

The project seeks to provide participants with a clear overview of the process, outlining the scope of their involvement, including what will be done, when, why, and with whom. Clear communication of the added value of participation and the benefits for each expert involved is considered essential. Time will be allocated for contact, if needed, through intermediaries or key local multipliers to facilitate engagement.


The project also aims to create opportunities for participants to ask questions, request changes, and engage in meaningful discussions. To demonstrate appreciation for their involvement, various incentives will be offered, tailored to the specific stakeholders, rather than relying solely on a letter of intent. Follow-up discussions will be planned to ensure ongoing engagement, address any further questions, and maintain open lines of communication.

(6) **Letting go**

The project prioritizes flexibility at every stage, adopting a strategy that allows for stepping back, maintaining distance, and ensuring ample space for interviewees. This approach will be consistently applied, from the planning phase and initial contact with interviewees to the selection of the appropriate survey form, organization of the interview setting, and conducting interviews in a particularly sensitive manner.

Flexibility in timing and location is a key priority. Interviewees will be free to choose when and how they participate, including the option for remote interviews (via video call or phone) or in-person meetings, with or without someone accompanying them. The project recognises



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that accommodating these preferences requires time, sensitivity, and the availability of safe, familiar, and comfortable settings.

(7) Evaluation

The project emphasizes the importance of interim evaluations, recognizing that questions may arise from both sides following data collection, such as after interviews. Adequate time will be planned for follow-up questions to ensure clarity and address any concerns. This process will prioritise clear and sensitive communication to facilitate mutual understanding and provide support where needed.

4. Lessons learned from recruitment and engagement


The following section addresses the challenges of recruiting and engaging stakeholders in the pilot sites in Hamburg / Steilshoop, Piedmont, and Romania. It also discusses strategies for overcoming these challenges.

The differences in scale between the three pilots are reflected in their networks, and consequently in their recruitment and engagement. While the local pilot in Steilshoop/Hamburg, benefits from direct contact with local institutions, the regional network is a key for the Italian pilot. In Romania, the existing network of a national organisation facilitates recruitment actions.

However, there are also similarities between the pilots. To achieve stakeholder participation, **trust-building, integrity, a sense of community** and **transparency** have been shown to be **essential strategies** in recruitment and engagement.

The most important lessons learned in recruitment and engagement relate to the participation of vulnerable groups, authorities and professionals in healthcare. The Hamburg pilot demonstrated that a successful approach to reaching vulnerable groups was via institutional representatives. These representatives act as gatekeepers, facilitating personal encounters. This was the only way to reach potential participants. Communication material was merely a means of providing more detailed information. Based on prior experience and informal feedback from authorities, early involvement—ideally from the proposal stage—can be beneficial in securing their cooperation.



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4.1. Lessons learned from recruitment in Hamburg

The following challenges became apparent during initial contact with the stakeholders **vulnerable groups and their representatives, higher authorities**:

- Lack of understanding and feeling unaddressed (communication material)
- Missing interest and motivation
- Critical attitude (distrust).

Proven measures for coping with these challenges:


1. Communication tools are developed with an emphasis on inclusivity, incorporating accessible text and image design to ensure comprehensibility across diverse target groups.
2. Engagement with relevant networks and institutions involves targeted outreach, including the dissemination of information, presentation of project aims, and facilitation of mutual exchange.
3. The recruitment of participants is guided by a jointly defined participant profile, followed by the identification of suitable individuals and the initiation of contact.
4. Initial interactions with potential participants involve a reflective discussion of previous experiences with health crises, accompanied by a personalized invitation and exploration of individual motivations for participation.

4.2. Lessons learned from recruitment in Piedmont

Health professionals and authorities

- Health professionals and policy makers showed **genuine interest** in participating and **sharing their experiences**, especially in relation to past health crises.
- Their **motivation** to participate **was high**, driven by a sense of **professional responsibility** and a desire to improve future emergency preparedness.



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- **Time availability** was a significant limiting factor due to ongoing professional duties and responsibilities.

Proven measures for coping with these challenges:

- **Leveraging existing trusted relationships:** Recruitment was more successful when we were introduced by individuals who had **already worked closely with them** during the pandemic. This helped build **trust, credibility, and accountability**.
- **Flexible scheduling:** Allowing participants to **reschedule interviews** and adapting to their **limited availability** enabled greater participation.
- Framing the project as **relevant and practice-oriented** encouraged their engagement despite time constraints.

Vulnerable groups

Limited availability of time was a key barrier, as many participants had other pressing priorities or irregular schedules.

Proven measures for coping with these challenges:

In-person recruitment during routine or planned activities within civil society organizations (CSOs) helped reduce the burden on participants, as it did not require extra time or effort on their part.

4.3. Lessons learned from recruitment in Romania


Health Professionals

The healthcare stakeholders contacted were either internal members of the Romanian Red Cross (RRC) or individuals from the organization's partner network. These stakeholders expressed their interest in participating in the interviews.

The main challenges encountered during this recruitment phase included:

- Ensuring a clear understanding of the project's purpose;
- Identifying qualified healthcare professionals outside the RoRC;



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- Coordinating and agreeing on suitable time slots for conducting the interviews.

Proven measures for coping with these challenges:

- Creating a clear and focused communication tool to effectively convey the project’s purpose and importance;
- Working directly with stakeholders who have previously participated in similar initiatives, especially those recognized for their active involvement in the community;
- Reaching out to key individuals, including those with hands-on experience in managing public health crises, as well as communication experts in the healthcare field.

Vulnerable Groups

To identify individuals from vulnerable groups, support was requested from local branches of the Romanian Red Cross. Once potential participants expressed willingness to take part, they were contacted directly by the person conducting the interview. It is important to note that these individuals were already beneficiaries of RRC’s social programs (e.g., the E.G.A.L. Centres).

The main challenges encountered included: the need to reach vulnerable individuals exclusively through intermediaries (such as local branch coordinators or trusted staff from the E.G.A.L. Centres), limited understanding of the project’s purpose, and reluctance to participate in online interviews.


Proven measures for coping with these challenges:

- **Involving program coordinators from RoRC branches** in the recruitment process of vulnerable groups and maintaining ongoing communication with them;
- **Providing relevant materials and clear information** to help explain the project’s purpose and spark participants’ interest in taking part in the interviews.

Health professionals and authorities

The health professionals from Clinical Emergency Hospitals – ED and policy maker, Secretary of State, Head of the Department for Emergency Situations, involved in the



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interviews, expressed their interest in participating and sharing their knowledge and experience regarding the previous health crises.

The invitation to participate in the interview was accepted with the intention to contribute to the improvement of the preparedness of an adequate response in health crises.

A significant challenge for setting up these interviews was in identifying a time availability considering their professionals responsibilities.

Proven measure for coping with these challenges:

- Enabling participant to reschedule the interview in accordance with the planned professionals activities;
- The main purpose and the activities carried out in the project for enhancing societal preparedness for future health crises encourage their involvement in participating in the interview.

4.4. Lessons learned from engagement in Hamburg

Vulnerable groups


The following challenges became apparent in the participation of vulnerable groups. These have already been set out in the Grant Agreement as ‘Critical risks & risk management strategy’:

- Dwindling engagement or drop-outs from participants
- Weak stakeholder outreach and weak impact

Proven measures for coping with the challenges of including vulnerable groups:

- A trusting relationship is fostered and sustained through structured, ongoing communication processes, including the regular dissemination of information regarding the project's progression. Such continuity of contact contributes to relational stability and transparency within the collaborative framework.
- The development of a productive working environment is achieved through joint negotiation of key parameters such as scheduling, choice of location—with particular



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consideration for safety and participant preferences—as well as the provision of adequate support structures. Attention is also given to creating an atmosphere conducive to motivation and constructive engagement

4.5. Lessons learned from engagement in Piedmont

Health professionals and authorities

- They appreciated opportunities to **contribute to improving future preparedness strategies**.
- Some participants preferred concrete, outcome-oriented discussions over general or theoretical reflections.

Proven measures for coping with the challenges:

- **Frame discussions around real-life cases or scenarios** by using examples from past crises (e.g. COVID-19 response) to ground conversations.

Vulnerable groups

There was **difficulty in understanding the purpose and usefulness** of the data they were asked to provide, which led to hesitancy. **Proven measures** for coping with the challenges:


- **Involving trusted community leaders** who had already built strong relationships within the group was essential to facilitate trust and explain the relevance of participation. Explaining the **value and potential impact of their contributions** in clear and accessible language helped increase understanding and engagement.
- Using a **familiar, informal setting** for initial contact allowed participants to feel more at ease and open to contributing.

4.6. Lessons learned from engagement in Romania

Health Professionals



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- The Health Professionals that we found showed their interest in helping with their knowledge and expertise in the project.
- Proven measure for coping with these challenge:
- To keep their attention to the project a couple of discussions have been held delivering information and answering their questions.
- Vulnerable group:
- The vulnerable group identified was not that easy to approach, because we can not reach them directly, but only contact person that they trust.
- Proven measure for coping with these challenge:
- To keep their interest in the project we had to use familiar words, give inside intel and show them, the importance of their interview/information provided.

5. Reflections on engagement activities


This chapter reflects on the practical application of the engagement methodology described in Chapter 3, including its components (3.1) and iterative approach (3.2), in light of the concrete experiences and challenges described in Chapter 4 ('Lessons learned from recruitment and engagement') across the three pilot sites: Hamburg/Steilshoop (Germany), Piedmont (Italy), and Romania.

It is important to emphasise at this point that only a few engagement activities have taken place so far. These experiences will inform the optimisation of the further engagement process.

The engagement methodology outlined in Chapter 3 served as a guiding framework for stakeholder interaction across all pilot sites. Its three components—identification, trust-building, and mutual learning—were implemented to varying degrees and tailored to local contexts. Likewise, the seven iterative actions (e.g., sensitive communication, preparation, appreciation, letting go) were flexibly applied depending on the stakeholder groups and engagement phase.

Hamburg offered a particularly illustrative example of the methodology in practice, especially in terms of stakeholder identification, trust-building through intermediaries, and fostering a reciprocal learning environment. Sensitive communication and preparation



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measures were directly informed by the engagement methodology, including tailored materials and safe settings. The iterative approach was visible through recurring engagement steps and regular contact with participants.

In Piedmont, the recruitment and engagement of healthcare professionals and authorities reflected the importance of trust and relevance, in line with the engagement components. Tailoring activities (e.g. flexible scheduling, use of real-life examples) echoed the iterative engagement approach. However, limited access to vulnerable groups required adaptations and a stronger reliance on trusted mediators.

In Romania, the methodology was selectively implemented, with strong emphasis on intermediaries for reaching vulnerable groups and clear communication to support understanding. While the iterative structure was less formalised, several key actions—such as flexible timing, support via familiar contact persons, and clarification of the project’s added value—were successfully applied.

With regard to 'Binding and Appreciation', it should be noted that incentives are being considered for all pilot projects.


Overall, the engagement methodology provided a coherent conceptual structure that was pragmatically adjusted in each pilot. Its principles—particularly those related to trust, tailoring, and sensitivity—proved critical for engaging vulnerable groups and institutional stakeholders alike.

Conclusion

With a focus on vulnerable groups the Engagement Strategy (D3.1) sets out a plan for engaging with and recruiting stakeholders for the pilots. It also draws on the initial lessons learned from the recruitment and engagement processes in each pilot to optimise future engagement.

This document is to be regarded as a reference for the overall engagement strategy of the PREPSHIELD project.



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Illustrations and tables

All illustrations were developed as part of the PREPSHIELD project.

Page 8, Figure 1: A simplified overview of the PREPSHIELD project with its work packages interlinked activities and phases within the overall process. It highlights the chronology and interdependencies between the work packages and activities.

Page 12, Figure 3: Project and engagement objectives.

Page 19, Figure 4: Stakeholder categories and their relational links across institutions and the general public in the context of health crisis preparedness.


Page 20, Figure 4: Pilot site profiles: Hamburg-Steilshoop, Piedmont, Romania. The illustration summarises the profiles of the pilots: their characteristics, population structure, social cohesion and local identity, and the disaster prevention strategy.

Page 34, Figure 5: Project and engagement objectives > engagement components > overlays of both.

Page 35, Figure 6: Illustration of the iterative engagement approach developed for the PREPSHIELD project.

Page 49—56, Annex 1, Table 1: Summarising all engagement activities that have taken place and are planned: participation techniques as well as recruiting and dissemination activities in WP5, WP1, WP2, WP3, WP4.




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Annex 1 Engagement activities : Participation techniques, communication and dissemination activities

This detailed table on the following pages summarizes the engagement activities that have been conducted or are planned in every work package. Many engagement activities and networks are still in their early stages of development. Activities that have already taken place or will take place soon are described in more detail. The table is structured as follows: As many of the activities in work package 5 lay the groundwork for the following work packages 1, 2, 3 and 4, the table begins with the communication and dissemination activities in WP5.

PARTICIPATION OBJECTIVES AND TECHNIQUES	RECRUITING AND DISSEMINATION-ACTIONS
WP5 Communication, Dissemination and Exploitation Engagement-objectives are to inform and raise awareness on the project.	
T5.2 Communication and dissemination material and activities	
ST 5.2.1 Communication and dissemination material and activities (M1-M36)	
Raising awareness among general public and institutions; informing potential Stakeholder groups: Vulnerable Groups, Non-vulnerable groups, Government and Public Authorities, Professionals in social or health care, Communication Channel Stakeholders, Non-Governmental Organizations (NGOs), Private Sector and Employers	Communication material, includes: - Visual identity (logo, graphic charter and project presentation templates) - Roll-Up and Poster, - PREPSHIELD Flyer and Case studies-Flyer Project website (including general information about the project, main research results, recommendations of best practices and dissemination material), Social media accounts (LinkedIn, Twitter), Newsletters (published every 6 months) and brochures summarizing the main takeaways



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PARTICIPATION OBJECTIVES AND TECHNIQUES

RECRUITING AND DISSEMINATION-ACTIONS

WP1 Individual, communal, societal and institutional needs and barriers for health crises
WP1 aims to develop a deeper understanding of both the needs and perceptions of vulnerable and non-compliant groups and institutional needs in health crises to deliver preliminary recommendations for better crisis preparedness, management and communication.

T1.1 Needs and perceptions of vulnerable and non-compliant groups with regard to health crises

ST 1.1.2 Survey study on the needs and barriers of vulnerable and non-compliant groups, Online Survey (April & May 2025)

Online Survey with vulnerable group (and their representatives)

HAMBURG

Participation of representatives of vulnerable groups in the Steilshoop district:
 - feedback on the questionnaire (WP1-survey and interview)
 - feedback on the dissemination material (flyer, brochure, poster)

Presentation, first contact and communication material:
 1. Newspaper article with announcement of the project.
 2. Creation of an info flyer – target group: multipliers, directors of social institutions. Obtaining feedback of people working and living in the district before distribution.
 3. Presentation of the project at a local working group with approx. 30 social institutions in the MLKS network.
 4. Visits of institutions with a high level of intersections of vulnerability. Presentation of the project for each team. First feedback and exchange with a first collection of ideas, conditions and options.
 5. Creation of an info flyer for the first survey – target group: inhabitants of the district. Form: in accessible language. Obtaining feedback of people working and living in the district before distribution.
 6. Creating an information board in the community center.
 7. Maintaining contacts with multipliers and management.
 8. Invitation of the local networks of MLKS by e-mail with the survey flyer (QR-Code).
 9. Advertisement by newsletter, poster and flyer in the social institutions of the district, in the pharmacy, doctor's office and in the supermarkets.
 10. Visits to institutions and individual interviews through direct acquisition.

PIEDMONT

Online survey disseminated through a QR code as well as physically through flyers. QR codes will be disseminated via email to CRIMEDIM's network, and printed flyers will be distributed in strategic locations (e.g., bus stops, train stations, shops, money transfers, religious buildings, libraries, pharmacies, hospitals, GP offices, retirement homes).

Participants were reached and recruited via CRIMEDIM's network and through physical dissemination of the flyer.





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ROMANIA

Online survey disseminated through a QR code: participants in the broad classification of general population	Participants were reached and recruited through: <ul style="list-style-type: none"> - Romanian Red Cross Branches - RRC E.G.A.L. centres - Community-based distribution - protocols between DSU and charitable associations
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ST 1.1.2 Survey study on the needs and barriers of vulnerable and non-compliant groups: Interview-part (May & June 2025)

In-depth interviews with vulnerable groups, professionals in social or health care and NGO's.

HAMBURG

Semi structured interviews with vulnerable groups (and social institutions): are being held in German lasting approx. 1h. The interviewed guide was shared by Rijks Universiteit Groningen and it was based on the findings of the literature review in WP1	<ol style="list-style-type: none"> 1. representations at social institutions in the MLKS network 2. visits and personal contact 3. brochure with information in easy language 4. maintaining in contact by a visit, a call or e-mail
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PIEDMONT

Semi structured interviews with vulnerable groups (and their caregivers): are being held in Italian lasting approx. 1h. The interviewed guide was shared by Rijks Universiteit Groningen and it was based on the findings of the literature review in WP1	Participants were recruited thanks to the CRIMEDIM's network with CSO and community based organizations
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ROMANIA

Semi structured interviews with vulnerable groups (migrants and elderly): are being held in Romanian lasting approx. 1h. The interviewed guide was shared by Rijks Universiteit Groningen and it was based on the findings of the literature review in WP1	Participants were recruited through RRC branches and DSU network.
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Task 1.2 Institutional needs with regards to health crises

ST 1.2.2 Challenges to overcome for healthcare institutions and policymakers (April & May 2025)


In-depth interviews and expert interviews with stakeholders from pilot sites (and other European countries) regarding the management of past health emergencies: policymakers, healthcare professionals, and health authorities.

HAMBURG

Semi structured interviews with 2 doctors from the Health Department, from Wandsbek district; in English, lasting approx. 1h. The interviewed guide was based on the findings of the literature review and the specific objective of the task (data collection and health literacy). Interviews were conducted by UPO	<ul style="list-style-type: none"> - Project info in January - first meeting, project presentation and recruiting at the Senate Chancellery in HH
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PIEDMONT



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Semi structured interviews with

- Professional in social or health care from Piedmont, France and Slovenia
- Government and public authorities (1 from Slovenia); in Italian/English, lasting approx. 1h. The interviewed guide was based on the findings of the literature review and the specific objective of the task (data collection and health literacy).
- Interviews were conducted by UPO

Participants were recruited thanks to the CRIMEDIM's network and other partners' network

ROMANIA

Semi structured interviews with:
Health professionals in charge of covid-19 health response; in English, lasting approx. 1h. The interviewed guide was based on the findings of the literature review and the specific objective of the task (data collection and health literacy).
Interviews were conducted by UPO

Institutional network
Collaboration under a central command.
Romanian Red Cross Network

ST 1.2.3 Improving governance of healthcare institutions and policymaking in the future (M6-M12)

Focus group discussions with relevant stakeholders from the pilot sites and other European countries

T1.3 Best practices for communication in health crises

ST 1.3.2 Expert interviews (April - May 2025)

In-depth interviews / Expert interviews with individuals responsible for risk and crisis management during past health emergencies in the pilot sites (at local, regional, and national levels) and in other European countries (if applicable), with a specific focus on communication strategies. These may include policymakers, healthcare professionals, and health authorities, but also (social) media or news professionals and religious or community leaders

HAMBURG

Semi-structured expert interviews with NGO's and Professionals in health care / authorities on Zoom conducted in English. The interviews last between 45 minutes and 1 hour.

Stakeholder-recruitment through direct requests, meetings, presentations.

PIEDMONT

Semi-structured expert interviews with Head of Communication at university; Director of External Relations at the hospital; Delegate of Communications at the red cross on Zoom conducted in English. The interviews last between 45 minutes and 1 hour.

Participants were recruited through project partners, who made the first contact and put us in contact with them.

ROMANIA





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Semi-structured expert interviews with professionals in health care, government and public authorities, representatives from communication platforms on Zoom conducted in English. The interviews last between 45 minutes and 1 hour.

Participants were recruited through project partners and local contacts from previous projects, who made the first contact and put us in contact with them.

PARTICIPATION OBJECTIVES AND TECHNIQUES

RECRUITING AND DISSEMINATION-ACTIONS

WP2 Tools for crisis preparedness and management

WP2 will develop the tools for collaborative crisis management, including forward-looking scenarios and an AI-powered PREPSHIELD platform and mobile app.

T 2.2: Functional specifications and UX co-design (M4-M26)

T2.2 will define the functional specifications and system architecture of the PREPSHIELD platform, focusing on its modeling, simulation, and decision support capabilities based on T1.1 outcomes. Functional specifications will translate user requirements into clear functionalities for software engineers, including a compliance matrix and platform architecture derived from these specifications. The architecture will leverage the scalable, modular, and secure Crimson crisis management solution. CS will organize co-design sessions with end-users and developers to prototype User Interfaces and establish the platform's modus operandi, using UX design methodologies such as paper prototyping and wireframing. These efforts will ensure practitioner engagement and high-quality collaboration, feeding into deliverables D2.2 and D2.3.

T 2.4: PREPSHIELD AI-powered multi-agent simulation models (M1-M26)

ST 2.4.2: Model refinement in co-creation with experts (M10-M26)

The toy model (developed in ST 2.4.1) will be presented to stakeholders during workshops to gather feedback based on their expertise. It serves as a training tool to illustrate reactions to health emergencies and raise awareness of unintended consequences. An initial agent-based model will be integrated into the platform's AI by SSG for M16 (TTE2) and continuously improved.



**PARTICIPATION OBJECTIVES AND TECHNIQUES****RECRUITING AND DISSEMINATION-ACTIONS****WP3 Pilots and iterative evaluation**

The goal of this WP is to recruit and train participants and conduct pilots in which decisions are made to contain a pandemic event. The aim is not only to simulate the spread, but also to evaluate communication strategies and represent the diverse response of a heterogeneous society with vulnerable subgroups.

T 3.1 Pilot set-up: participant engagement, recruitment and training**ST 3.1.1 Engagement strategy (M4-M8 DDL: June 2025)**

Overall strategy: partly a documentation, partly still in process of the engagement of stakeholder groups identified in WP1

ST 3.1.2 Participant recruitment and training for the TTE (M4–M18)

Planning of the On-Site Exercises (TTE's): The TTE and online simulation will include all stakeholder groups, approx. 15 persons per pilot site (they can, but may not have experiences in managing previous health crises)

To ensure active engagement and thorough preparation of all participants, a structured online training session with a duration of 90 minutes is conducted. This training aims to familiarize participants with the objectives and structure of the exercise and to provide a clear understanding of their specific role within the scenario. Participants are introduced to the general concept and flow of tabletop exercises, including common procedures and participation formats. Additionally, the setting of the exercise is explained in detail, covering aspects such as room layout and the simulated scenario. The goal of this preparatory session is to build confidence, clarify expectations, and enable meaningful and effective participation in the upcoming exercise.


ST 3.1.3 Participant recruitment and training for the online exercise (M18-M26)

FHH will make sure that each pilot study leader stays in touch with participants and recruits more from the target groups. They will improve the training program based on lessons from TTE and online exercise instructions from CSG and ICCS. FHH will also coordinate the training sessions to ensure they happen before the online exercises at each location.

T 3.2 Communication pilot for the improvement of health crisis communication strategies (M12–M22)

The literature review and expert interviews in T1.3 will identify key communication principles for disaster response and health emergencies, as well as points of contention (e.g., how to communicate uncertainty). Different strategies will be tested in online survey experiments (with general public) across various regions (considering variables like trust levels and population groups). The experiment results will also be discussed alongside qualitative analyses of tabletop exercises and online discussions. Recruitment is carried out by a survey company.

T 3.3 Tabletop exercises for multirisk health crisis preparedness and comparative evaluation of the platform**ST 3.3.2 Tabletop exercises (M12–M22)**

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The goal is to create a realistic environment for decision-making and communication to contain a pandemic, incorporating vulnerable groups. Participants (citizens, CSOs, DROs, healthcare organisations, public authorities) will manage a crisis based on a storybook. The tabletop exercise includes rounds for action and feedback from experts or PEREPSHIELD software. The first TTE (Hamburg) involves consortium participants and experts. The second TTE (Piedmont) uses a hybrid approach with AI and expert checks. The third TTE (Romania) relies on agent-based simulation. Iterative improvements will be made between TTEs. Targeted communication material will be created.

HAMBURG (16/09/2025, in Steilshoop)

The exercise itself is designed as a full-day, in-person event. It begins with a scenario briefing, introducing participants to the outbreak of a pathogen. Participants are then divided into teams and assigned to dedicated rooms to simulate realistic working conditions. The exercise follows a round-based structure with a strategic focus: a crisis management team makes decisions while an expert team and representatives of the affected population evaluate the proposed measures. The scenario develops over 3 to 5 rounds, incorporating simulated time jumps to reflect evolving crisis dynamics. The outcomes are discussed in a joint debriefing session. The exercise engages approximately 15 participants per pilot site, representing all key stakeholder groups as defined in the Grant Agreement—participants may or may not have prior experience in managing health crises.

The methodology combines business wargaming techniques with tabletop exercise practices commonly used in civil protection. The scenario is built on realistic dynamics using Causal Loop Diagrams derived from lessons learned during the Covid-19 pandemic. The scenario evolves dynamically based on the feedback provided by experts and representatives of vulnerable groups. This feedback is systematically analyzed using Fuzzy Logic to reflect complex decision-making processes and assess the impact of proposed measures.

Stakeholder from vulnerable groups, already recruited for interviews in WP1. Stakeholders from authorities and health professionals, partly recruited for interviews in WP1, partly ongoing recruiting process. People from vulnerable groups of relevant institutions were directly contacted. Also representatives of these institutions to accompany them.

PIEDMONT M16, hybrid in Piedmont

in the planning phase

Participants (vulnerable groups and their representatives from NGO's, Social and health professionals, government and public authorities) will be recruited thanks to the CRIMEDIM's network


ROMANIA (M19, online)

in the planning phase

Recruitment (of (vulnerable groups and their representatives from NGO's, Social and health professionals, government and public authorities) through Institutional networks. The existence of protocols between DSU and charitable associations

T3.4 Online pilot using the PREPSHIELD platform and app (M21-M30: M26 in Hamburg, in M27, in Piedmont, M28 in Romania)



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Following the communication pilot and final TTE, updated best practices (for preparedness, response and communication) will be shared with the participants in the different pilot sites through a short training. This training will be provided before the online simulation takes place in each pilot site: EC representatives will be invited to watch the final online exercise.

PARTICIPATION OBJECTIVES AND TECHNIQUES	RECRUITING AND DISSEMINATION-ACTIONS
WP4 Recommendations and tools for inclusive crisis preparedness and management	
Draws lessons from the research conducted in the project on crisis preparedness, management and communication for policymakers, public authorities, DROs, healthcare institutions, CSOs, citizens.	
T4.2 Policy recommendations for health crisis preparedness and response (M28-M36)	
Co-creation workshops - online and onsite in combination with consortium meetings and TTE together with policy decision makers, representative of vulnerable groups and scientists: Building upon the results of the comparative case studies, UG will develop a theory-driven policy analysis to identify a set of context-mechanisms-outcomes (realist evaluation approach) that can be helpful for policy makers. In co-creation workshops, policy decision makers, representative of vulnerable groups and scientists will discuss the project results and suggest ways to improve health emergency preparedness and response.	

Table 1: Summarising all engagement activities that have taken place and are planned: participation techniques as well as recruiting and dissemination activities in WP5, WP1, WP2, WP3, WP4.

