COVINFORM

CORONAVIRUS VULNERABILITIES AND INFORMATION DYNAMICS RESEARCH AND MODELLING

D4.4 Synthesis and lessons learnt on governmental responses and impacts

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Executive Summary

The research conducted in COVINFORM has provided in-depth analysis on the multi-dimensional socio-economic and behavioural impact that relate to the COVID-19 pandemic and the relevant multi-layered responses from national, regional and local governmental entities, international organizations, non-governmental organizations and relevant stakeholders. In particular, Work Package 4 (WP4: Government responses and impact assessment) emphasizes on analysing governmental responses to combat the COVID-19 pandemic. The COVINFORM consortium partners have conducted desktop research in the respective target countries as well as empirical research that involve expert interviews, demonstrating that the main outcomes that are produced by this deliverable stem from a comparative analysis on data drawn from the aforementioned research activities. The current deliverable, D4.4 Synthesis and lessons learnt on governmental responses and impacts, aimed to synthesize the data drawn from the empirical and desktop research, by conducting an interpretation of the analysis between the governmental structure per country and adaptations for COVID-19: As of *January 2020 until March 2021* and as of *March 2021 until April 2022*. As it has been observed in the desktop and empirical research, with the subsequent production of deliverables D4.1 and D4.3, governmental responses are tailored and encompass social, economic, legal and cultural factors that influence governmental measures against COVID-19, including adaptations to accommodate the needs of vulnerable groups and official public stakeholder representation. The governmental structure in most of the projects target countries, can be characterised as national-decision making structure with the provision of administrative powers to main governmental entities such as Ministries rather than regional points of governmental authorities, while governments that emphasized on a fragmented, semi-independent structure encountered challenges and friction between regional, local and national points of authority in matters such as adequate communication and funding. In addition, regarding cultural, legal, social and economic factors, social interaction rate and family ties, measure implementation and legality as well as emphasis on economic support in hard-stricken businesses are common phenomena. Moreover, the majority of COVINFORM target countries have addressed vulnerability with encompassing interpretations whereas in several cases a looser terminology, that of “groups at risk” was preferred, nevertheless, most COVINFORM target countries identified elderly citizens, particularly with chronic illnesses and children as the most vulnerable populations, whilst single-parent citizens, minorities, businesses and employees faced with abrupt stoppage of their activities closely followed. Concluding, in regard to official communication efforts, most COVINFORM target countries preferred centralized communication strategies with the utilization of live press briefings lead under the guidance of state officials and renown epidemiologists as well as traditional and contemporary means. Most experts are observed to concur that the public is more inclined to comply if a healthcare expert in an information dissemination-related leadership role or a well-respected official. However, experts suggest that successful pandemic management depends on the publics compliance with public health measures and highlight that certain measures induce fatigue (e.g., restriction of movement) have a set period of effect and may result in opposing results such as social unrest. Deliverable 4.4 concludes with several recommendations based on the analysis of the available data.

Contents

Acronyms & Abbreviations

Term	Description
COVID-19	Coronavirus Disease
D	Deliverable
EMA	European Medicines Association
EU	European Union
EUDCC	European Union Digital Covid Certificate
ICU	Intensive Care Unit
NPIs	Non-pharmaceutical interventions
UK	United Kingdom
WHO	World Health Organization
WP	Work Package

1 Introduction

The COVID-19 pandemic has evolved as a global health crisis since the beginning of 2020, thus, severely impacting the wellbeing of the global society by introducing multilayered and multidimensional negative influence to the living conditions of citizens across the globe. Similarly, COVID-19 has significantly challenged governmental structures, societies, and citizens. The impact of COVID-19 has placed additional weight on societal inequality, socio-economic vulnerabilities, and division within marginalized communities, thus, greatly enhanced pre-existent issues. As it has been aforementioned in previous deliverables such as D4.3, the main objective of the COVINFORM project is to capitalize on the sixteen consortium partner's multidisciplinary expertise, conduct analysis and critique responses on COVID-19 at a governmental, regional and local level, emphasizing on public health, socio-economic, legal and cultural factors that influence community and decision making, official communication strategies that have been adopted by developing risk assessment models which are based on qualitative data on a European level and are aimed at the eventual creation of an online digital portal and a visual toolkit with members of the government, healthcare professionals and citizens as end-users. D4.4 aims to synthesize and interpret the findings of D4.1 – D4.3 from an interdisciplinary and intersectional perspective, within the theoretical framework established in WP2 and WP3 respectively. Moreover, T4.4 will aims to develop policy and practice recommendations in order to be delivered to policymakers in WP8.

The main objective of work package four (WP4: Government responses and impact assessment), as discussed on D4.1 is to emphasize on governmental responses and structures, by reviewing them at a national, regional and local level in order to perform an in-depth analysis on the key governmental responses and their impact in the target countries[1]. More in particular, this deliverable aims to draw data from the main outcomes of D4.1, a concrete baseline report with chapter that relate to each country partners have conducted their research, specifically data which relate to governmental structures and responses, vulnerability and communication, that stem from primary sources such as governmental policies and guidelines, official assessments and reports, as well as secondary sources discussing governmental responses such as scholarly studies and grey literature among others.

Moreover, D4.4 draws data and the main outcomes from D4.3, a concrete report that stem from a high level of empirical research conducted by each consortium partner in the COVINFORM research project, exploring the three following dimensions as descripted in D4.3: "Pandemic planning and preparedness, Governmental approaches to defining and addressing vulnerability, COVID-19 responses on multiple levels of governance, Economic and social welfare responses to COVID-19 Socio-political, legal, and ethical factors influencing government preparedness and response" (D4.3 Analysis: Government responses to COVID-19 and impact assessment, p.9).

This report has identified the imperative need to include and draw data from both baseline report "D4.1: Baseline report: Governmental responses", D4.2 "Primary empirical research on governmental responses" and D4.3 "Analysis: Government responses to COVID-19 and impact assessment". This was required in order to synthesize, interpret findings on governmental responses and impacts from an interdisciplinary and intersectional perspective. This modus operandi provided valuable input through in-depth analysis, assist with the identification of key issues, have supplemented and contributed to

[1] Austria, Belgium, Cyprus, Germany, Greece, Israel, Italy, Portugal, Romania, Spain, Sweden, Switzerland, United Kingdom, Ireland.

the work of WP5 and WP6, which respectively emphasize on examining the responses of healthcare workers and community responses, resident interviews towards COVID-19. Concluding, the scope of this report deems as necessary the inclusion of the aforementioned sources which are required for the interpretation and synthesis of the findings on governmental responses and relevant multi-layered impact, aimed at developing policy and practice recommendations that will delivered to policymakers in WP8.

Section 2 introduces readers to the governmental structure in each target country and adaptations made to combat COVID-19: as of January 2020 until March 2021, which include the relevance and importance of national and non-nationalized structures, as well as initial governmental responses during the COVID-19 pandemic. This section draws data on the findings and main outcomes mainly from "D4.1: Baseline report: Governmental responses". Section 3 elaborates on governmental responses and impact assessment specifically for towards vulnerable groups, the response measures implemented and how socio-economic, legal and cultural factors influence decision making and official communication strategies. This section mainly draws data from D4.3, the "D4.3 Analysis: Government responses to COVID-19 and impact assessment", focusing on March 2021 until April 2022. Section 4 proceeds to a concise comparative analysis by interpreting the main outcomes collected by the COVINFORM project, to date, and highlights differences and similarities on the responses in the ever-evolving pandemic, lessons learned and good practices, as well as identifying research and policy gaps that could be improved with the implementation of tailored measures and adjustments. Section 5 concludes with the development of policy and practice recommendations intended to be delivered to policymakers, with Section 6 to conclude the report.

2 An introduction to the methodology of the COVINFORM research project

The main institutions that form the national, regional, and local responses to the COVID-19 pandemic are governments and governmental organisations. Their management of particular problems, priorities, and vulnerabilities have shaped the development of the pandemic and the associated societal willingness to comply with the temporary regulations. This section elaborates on how government officials who have been involved in the development of the policies have experienced the pandemic and their role in it. It builds on the complex system approach of Work Packages 3 that sets up a framework that considers institutions, communities, and various contexts as systems that coincide and 'form' and reconstitute each other. Contributing insights into how governmental institutions formulate and adapt their pandemic measures through the usage of qualitative interview data with the officials and representatives of these institutions.

It describes the analytical methodology used to explore governmental responses to the COVID-19 pandemic in the COVINFORM partner countries. In particular, this section discusses sources utilized and research methods applied, as well as the limitations. What follows is first the methodological framework (subsection 2.1), methods and participant selections (subsection 2.2), Data collection: interviews (subsection 2.3), Privacy and confidentiality (subsection 2.4), Analysis method (subsection 2.5) and finally the limitations (subsection 2.6).

2.1 Methodological framework

The methodological framework underpinning the analysis of the governmental officials' pandemic experiences in the COVINFORM countries extends the methodology used in T4.1, T4.2 and T4.3. These methodologies include desktop research to assess the governmental structures, main actors in decision-making roles, the main social, economic, cultural, and legal, as well as adaptations of the governmental responses towards vulnerable groups, and the main means of communication.

The policy documents that have formed the backbone and provided structure to the pandemic responses. Nonetheless, without understanding the social processes behind the development of these policies, it is difficult to understand to what problems or anticipated problems they were a reaction, what goals were deemed to be most important, and what values underpinned the measures. The main qualitative methods that were used in the empirical research of WP4 were expert interviews. Indeed, the personal accounts of the people who developed these pandemic policies helps to understand the ways in which these documents were used on a day-to-day basis as guidance to specific contexts of the living and working conditions of societal groups in different countries. This chapter thus employs an interpretivist analytical framework to offer a rich description and historization of the knowledge formation processes that have led to certain events and outcomes. Such a style of analysis allows for theory building rather than testing, as it brings to the fore the circumstances, feelings, emotions, and various pressures that the interviewee identifies as constructive of their pandemic realities.

2.2 Methods and participant selection

The empirical research employed semi-structured Interviews with a range of governmental actors. Here we describe the approaches taken and the practice of conducting interviews during a pandemic (& translation, topic guide design, online and in-person practice, audio-recording, consent, confidentiality and use of pseudonyms). More details can be found in D4.2.

The analysis of this chapter is mostly based on interviews with the people in charge of developing, implementing, and operationalizing the public health policies. Important interview themes include the procedures in which pandemic policy has been implemented, the experience of cross-institutional collaborations, and the consideration of vulnerable people in operationalization of the measures. The officials engaged with in this analysis includes governmental actors, public authorities, and policy makers. For instance, representatives from ministries of health, regional and local politicians, members of national opposition parties, and others with decision making powers during the pandemic. These interviewees were mainly public figures who were identified through governmental webpages, news stories that mentioned their names. Some have been recruited through snowballing recruitment techniques in which one interviewee puts the research team in touch with a relevant colleague.

2.3 Data collection: interviews

Following the interview topic guide that was the same for all COVINFORM partners, interviews were conducted with a semi-structured approach. Semi-structured interviews allowed the interviewee to elaborate on specific procedures, decision making and interactions into governments' responses to the pandemic. The have a more informal 'feel' than fully structured interviews and encourage the interviewee to add (personal) experiences that they think are relevant to the study. Interview topic guides were provided to the partners, who adapted the list to make it as relevant as possible to capture the experiences of their interviewees. The interviews lasted for up to an hour. All interviews were held

over a video-conferencing app or in person (taking necessary precautions into account), they have been audio-recorded, transcribed, and translated in the case the interview was conducted in another language than English. All English transcripts were sent to KEMEA, the work package leader, who made them available to the partners involved in writing the analysis.

2.4 Privacy and confidentiality

Before agreeing to be interviewed, potential interviewees were provided with an information sheet that explained the study, the research activities, and the treatment of confidentiality and data management. Interviewees were provided a pseudonym code that makes them non-traceable in accordance with the consent forms. They were also asked to fill in a survey with generic questions about their personal living conditions. Some expert interviewees consented to the usage of their institution, commensurate job role, and relation with vulnerable groups in a given country; other did not. In this case more abstract descriptions of their institutions and role are provided.

2.5 Analysis method

The interview transcripts were compared and subjected to a discourse analysis – an analysis method of interpreting text in relation to the social context of the interviewee's situation of relevance to the interview. This allowed for identifying how the everyday experiences of the people working with the pandemic public health policies suggested how they were understood, used, and operationalized. This provides insights into how these policies addressed pre-existing and new vulnerabilities and contributed to the way the pandemic unfolded in the different countries.

2.6 Limitations

The research methodology employed in the analysis underpinning this Deliverable has several limitations. With any research that takes place in different countries, languages (also pertaining to translations of transcripts), cultures, histories, and value systems, what is remarked as important will vary between research partners. Such variations can be regarded a limitation as it makes comparability challenging (if not impossible), but they can also be seen as reflecting a more varied understanding of what happened, which makes the analysis more faithful to these differing situations and understandings.

Most importantly, perhaps, the subject that is studied has not 'stabilized' yet, in other words; the pandemic has not ended yet. Therefore, new insights about what has been relevant about what happened in early stages continues to change, as are feelings and anxieties about this. Therefore, the interviews are a product of the moment they were recorded, and the interviewee may have changed their opinion about certain experiences by the time the analysis takes place. Although this is not uncommon for qualitative interview-based research, the current study might be more susceptible to major changes. In addition, the researchers' understanding of the pandemic and its various significant moments continues to change with hindsight, which informs the interpretation of the interview data and thus the findings and ultimately recommendations.

3 Synthesis and lessons learnt on governmental responses and impacts

3.1 Governmental Structure per country and adaptations for COVID-19: As of January 2020, until March 2021

The following section outlines a short, summarized analysis of the governmental structure, vulnerability, socio-economic, legal, culture and educational factors taken into consideration for measure implementation, communication and the adaptations observed after the outbreak of COVID-19 crisis, coving the period of January 2020 (first identified COVID-19 case in Europe) until March 2021. Relevant data are based on and drawn from D.4.1 Baseline report: Governmental responses, that extensively elaborate on of each of the participating countries.

Based on the analysis of participant countries conducted on D.4.1 Baseline report: Governmental responses, it can be observed that in spite having different **governmental structures**, thus subsequently administrative differences, all countries emphasized on nationalized point of authority for pandemic management. In most cases that would be the national government, in cooperation with semi-autonomous regions in some cases such as Germany, Austria and Belgium. All target countries appear to have partially or fully depend on pre-existing crisis mechanisms, whereas most activated and implemented additional bodies that included the contribution of the scientific community expressed through specialized scientific committees while relevant ministries would lead task forces to manage, combat and mitigate the consequences, impact and effects of the pandemic. In certain cases, such as Switzerland and Spain that adapted the national government influence to a regional level as the pandemic evolved, while countries such as Italy, Greece, Israel and Romania did not proceed in altering their administrative structure. All countries that participate in this study, decided to adopt similar COVID-19 related measures immediately to restrict the impact of the pandemic. These measures are regional, local or national lockdowns, physical distancing, whereas several countries such as Italy, Ireland, Greece, Israel, Portugal, Spain and Switzerland declared a state of emergency, taking into consideration legislative national and international parameters regarding human rights, which are protected under the Constitution. Countries such as Belgium, Austria and Germany did not proceed to such declaration. In all target countries, the final decision-making actor was the national government, while in countries with a more decentralized governance structure system, such as Austria, Germany and Belgium, municipalities, region and counties had the authority to implement additional measures conduct small adaptations within the area of jurisdiction, particularly on issues revolving around education, elderly care and public health.

As it is further elaborated in D.4.1 Baseline report: Governmental responses, **socio-economic, legal and cultural factors** were taken into consideration which influenced governmental decisions and responses. Particularly, from a social standpoint, measures emphasizing in movement restriction and implementation of lockdowns, were adopted to contain and mitigate infection spread rate among the citizens. Health, social and economic effect are determined to be the most crucial factors taken into consideration by the governments. Several countries, such as Greece, Cyprus, Spain focused on protecting the elderly citizens, through prioritizing vaccination and tailored communication campaigns.

All countries with the exception of Switzerland have implemented a public healthcare insurance coverage system, based on D.4.1 Baseline report findings, in a structured effort to simultaneously

support the health system and facilities both financially and with asset allocation, thus, reducing the severe workload that intensive care units (ICU) and hospitals have been forced to shoulder. All countries, despite controversies, have highlighted how important physical distancing and movement restriction measures are in order to contain the spread of COVID-19, while keeping a balance in respecting individual freedom and human rights. Regarding cultural considerations, most countries, such as Austria, Belgium and Greece, have opted-in for measures particularly during holiday periods such as Christmas and Ramadan, whilst restricted the number of attendees to religious worship places during religious events. Moreover, most countries implemented the provision of support to their citizens in cases where mental health issues were developed and presented due to the impact and effects of the pandemic, regardless if the citizens were considered to belong in a vulnerable group. From an economic standpoint, due to the abrupt cease of business continuity and operation, enhanced economic measures and benefits were implemented, which ensured that businesses on the brink of bankruptcy and those that witnessed a significant reduction in their annual revenue, would be financially secured. Several countries such as Portugal, Austria, Greece and Cyprus that heavily rely on tourism, emphasized significantly in financial support of the relative industry, employees and businesses. All countries implemented short and long-term financial support programs which were aimed at economic recovery for business thus ensuring continuity.

The interpretation of vulnerability was addressed by all countries, nevertheless, specific countries such as Belgium and Austria, would not examine *vulnerability* per se but rather "groups at risk". All countries adopted similar criteria and parameters to determine vulnerability and vulnerable groups, setting the categories of health, social and economic vulnerabilities. The most frequently mentioned vulnerable group has been the elderly, citizens with disabilities and chronic diseases, which had an immense rate of influence on governmental policies and measures. Following those, minors, children and teenagers closely followed based on a variety of educational obstacles imposed by COVID-19 and the impact on psychological and mental well-being due to movement restriction.

Gender was also an important factor that was considered, due to a significant increase of domestic violence cases, particularly against women during the lockdown, whereas in countries such as Italy, UK, Greece, Cyprus and Ireland among other countries, migrant and minorities were considered to be vulnerable populations due to their social status and living conditions, thus efforts were made to accommodate their needs, albeit somewhat delayed in a number of circumstances. Most countries also invested in supporting healthcare workers and first line practitioners due to their high viral exposure and immense workload throughout all pandemic phases. All countries adopted and adapted their prevention policies in relation to COVID-19 and relevant measures, in accordance with the pandemic fluctuation and evolution, thus, minimizing and mitigating the effects and impact to the relevant groups of citizens. Regarding communication strategies, primary analysis conducted on D.4.1 Baseline report, demonstrated differentiated degree of success in each case. The main underlying reason was the various involved actors in each case and the level of public trust towards the COVID-19-related focal point figure. Consistency, transparency and timing of information dissemination are all factors that contributed to the success rate of each case. In most countries, the main communication strategies would be carried out by governmental bodies, particularly by ministers, prime ministers, well-known healthcare scientists, whereas in several cases these efforts were supported by non-governmental organizations such as the Red-Cross. Moreover, communication strategies emphasized on raising awareness on social distancing and good hygiene practices, whereas it has been observed that efforts focused on vulnerable populations often lacked a tailored approach,

that however became more structured towards later stages. COVINFORM target countries that adopted successful communication strategies are observed to have common characteristics such as consistency and timely communication since early 2020, where based on the cooperation of both private and public actors, would utilize both digital (websites, applications, social media etc.) and traditional means (printed material, newspapers, TV, Radio etc.). The analysis conducted on D.4.1 Baseline report determined that daily briefings and press conferences of governmental officials and respected health experts are identified as the most effective communication method. Concluding, COVID-19 dedicated official governmental websites and the utilization of targeted communication campaigns on social distancing, hygiene practices, vaccination campaign would be employed by all countries, whereas simultaneously disseminate information in a variety of languages (including sign language) in order to address all educational, social and cultural needs of every citizen. For instance, these targeted campaigns would also include visualizations and videos to address the needs illiterate citizens. Based on the findings of the initial analysis conducted on D.4.1 Baseline report, participant countries have shared valuable input on how COVID-19 pandemic crisis has been managed and countered by the respective governmental and non-governmental mechanisms. Further empirical research that includes the interaction between main actors and related experts, illustrating the pivotal role of governmental entities shall follow in the next section.

3.2 Analysis: Government responses to COVID-19 and impact assessment: As of March 2021 – April 2022

This section similarly outlines a short, summarized analysis of the governmental structure, vulnerability, socio-economic, legal, culture and educational factors taken into consideration for measure implementation, communication and the adaptations observed after the outbreak of COVID-19 crisis, covering the period of March 2021 until April 2022. Relevant data are based on and drawn from D.4.3 Baseline report: Governmental responses, that extensively elaborate on each of the participating countries, is based on empirical analysis, primary data drawn from expert interviews of decision makers, policy makers and stakeholders.

Based on the analysis of the target countries conducted on D.4.3 Analysis: Government responses to COVID-19 and impact assessment, it can be observed that each country adhered to their response path, which was based on pre-existing and newly implemented strategies and bodies. National governments were taken by surprise regarding the intensity, infection rate spread and impact of the pandemic, thus, countries established a centralized authority system and founded new bodies, working groups and task forces, particularly emphasizing on maintaining a close relation with the healthcare scientific community. In accordance with Chapter 4 of D.4.3 Analysis: Governmental responses to COVID-19 and impact assessment, it has been determined that national governments, despite the healthcare expert advice and recommendations, have proceeded in conclusive decisions which would often generate confusion and controversy between both general public and pandemic management stakeholders. Taking into consideration that the assessment determined task forces and newly established bodies had a very positive impact, it was particularly due to healthcare and pandemic management expert support and knowledge provision towards governmental entities, simultaneously being assigned to leadership roles such as acting as the main focal points in communication campaigns, advisory and consulting roles, findings also present that crisis management strategies that pre-existed prior to COVID-19 in participant countries were mostly insufficient and

there was an imperative need for supplementation and readjustment on COVID-19's pandemic characteristics.

Chapter 5 emphasized on the governmental approaches regarding the identification and in what ways "vulnerability" should be addressed in relation to COVID-19. As expected, governmental structures in target countries would identify and address vulnerability in relation to multidimensional variables which include health, socio-economic and cultural factors. It is rather safe to state that elderly citizens, non-native language speakers, asylum seekers, migrants, children, single-parent families and employees working in the healthcare sector as well as the tourist and hospitality industries are to be considered highly vulnerable. The effects and impact that the COVID-19 pandemic has on these groups is significant due to long-term healthcare related diseases and mobility issues, systemic and social isolation, lack of equipment provision intended to facilitate via-distance education particularly for young students, immense exposure to COVID-19 due to working environment conditions and abrupt cease of all business activities which would result in permanent business closure and high unemployment rates. The findings of the previous deliverable (D.4.3) suggest that not every country implemented a tailored approach due to different interpretations of vulnerability and/or "at risk groups", whereas some countries identified vulnerability and addressed the needs of citizens in a more encompassing way, thus, providing psychological and economic support. Findings suggest that vulnerability is determined and influenced based on the sociodemographic characteristic of each group in each social context they reside. The phenomenon of vulnerability pre-existed COVID-19, that in turn highlighted emphatically socio-economical and health-related social inefficiencies and systemic weaknesses on daily issues that vulnerable groups face, thus, introducing additional challenges, increasing their exposure, signaling the imperative need to address these issues.

Therefore, vulnerability is not just a condition related to the pandemic; instead, the pandemic exacerbated pre-existing vulnerabilities and touched upon longstanding everyday challenges. Notwithstanding some positive experiences across the countries, local communities and vulnerable groups had levels of distrust towards governments. In addition, higher government levels do not always engage with other government levels and with local communities, so understanding local needs is challenging for them.

The following section, Chapter 6, focused on the multi-level responses of governance and governmental structures. The study identified a significant research gap despite the relatively homogeneous research sample, which will be discussed further on the following sections of this deliverable. The next chapter, Chapter 7, emphasized on the socio-economic measures, highlighting the various implemented measures in a series of EU target countries, indicating organized governmental efforts in mitigating the effects of the pandemic on businesses and vulnerable groups, whereas simultaneously actively working toward economic recovery. Particularly, governmental entities have developed and proceeded with the provision of targeted economic support to the businesses stricken by the pandemic, such as the hospitality industry and implemented several social welfare-related responses to support families, unemployed citizens among other vulnerable citizens, ensuring the continuity of the domestic labor market. Chapter 8 of the report emphasized on the ethical, legal, social and political factors that have influenced the governmental preparedness, decision-making and response mechanisms. The findings of D.4.3 suggest that in some countries legal and ethical challenges were highlighted due to restrictive measure implementation, contact tracing and surveillance, whereas in some other target countries, the degree of controversy was by far of a lesser rate. The study suggests that the status quo of living in the ever-evolving COVID-19 pandemic

era has provided fruitful ground of enhanced risk of creating discrimination among European populations, distrust towards among citizens, towards governmental entities and stakeholders.

The empirical research and research findings have highlighted several limitations, research gaps and topics that could be academically examined and explored even further. The main objective of this deliverable is to synthesize and interpret the findings, conducting a concise comparative analysis of the data collected from D4.1 – D4.3 from an interdisciplinary and intersectional perspective. Moreover, this deliverable will furthermore develop policy and practice recommendations to be delivered to policymakers at WP8.

4 Interpretation of findings

In this chapter we are going to address the main policies designed to deal with the COVID-19 pandemic and implemented across the target countries. We will focus also on the practices carried out by the stakeholders during the management of the pandemic to analyse the context they faced and how they dealt with the pandemic from their position. According to the information available on D4.1: Baseline report: Governmental responses and D4.3: Analysis: Government responses and impact assessment, we focus on policies and practices pointing to the countries only when a deviation of common patterns is observed; or when there is no pattern at all.

The structure of this chapter starts with the policies (5.1), dividing them in contention policies (5.1.1) and compensatory policies (5.1.2). Then, we present the main contexts that explain the practices reported by interviewed stakeholders in Chapter 6. We conclude with the main findings in the summary of the aforementioned sections, trying to propose hypothesis to explain common and different patterns observed across countries.

5 State responses against the impact of COVID-19: Policies and Practices

5.1 Policies

5.1.1 Restrictive policies to control COVID-19 transmission.

As stated, in this section we attempt to compile and group some of the most relevant measures made by governments and other institutions to respond the health emergency caused by the COVID-19. Therefore, we will present each policy according to the available information[2]:

[2] The body of evidence presented and analysed in this text is mainly drawn from the following sources: CIDOB (2020). Medidas de contención y desescalada adoptadas por los gobiernos europeos en la primera ola del coronavirus (enero-julio 2020) Consulted on March 7th. Retrieved from: [https://www.cidob.org/biografias_lideres_politicos/organismos/union_europea/covid_19_la_respuesta_de_europa_contra_la_pandemia_2020]; and Teslya A, Pham TM, Godijk NG, Kretzschmar ME, Bootsma MCJ, Rozhnova G (2020) Impact of self-imposed prevention measures and short-term government-imposed social distancing on mitigating and delaying a COVID-19 epidemic: A modelling study. PLoS Med 17(7): e1003166. https://doi.org/10.1371/journal.pmed.1003166.

5.1.2 Recommendations of extreme caution in everyday life

Due to the characteristics of the virus, governments urged and in certain cases[3] enforced their citizens to adopt some behaviors: minimize social contacts and practice hygiene (e.g., sanitize and wash hand). Throughout all the target countries, citizens were urged to minimize contact with others and to exercise extreme caution in interpersonal contact. The message was that no one should touch except when strictly necessary. The degree to which this physical distancing took place varied from country to country. The objective of the public measures and policies that were adopted since February 2018 had a shared goal: to minimize the impact on citizens' health, limit the spread of the virus and protect national health systems (Teslya et al. 2020).

While in some countries, such as Spain and Italy, governments adopted States of Alarm and Emergency that allowed the limitation of citizens' freedoms. These mechanisms established a framework in which obligatory distancing was legally sanctioned. It was compulsory by law to stay at home and have no contact with anyone. Sweden is the opposite to this model of crisis governance as it advocated leaving individual and collective responsibility for stopping the pandemic to its citizens (see Deliverable 4.1. Baseline report: Governmental responses, pp. 23-36). Between these two extremes of control and ubiquity of power lie the countries of the consortium. The WHO (2022) encouraged individuals to take care of their own health and protect others. It was suggested that traditional greetings of our cultures would be replaced by new, more aseptic gestures. Heightened awareness to hand washing was recommended, i.e., when entering a building. The hydroalcoholic gels that ended up becoming familiar for all began to become popular in late February and early March. Since there has been insufficient studies to clarify the rate of contagion, the means of transmission of the virus and its survival on surfaces (Teysla et al. 2020). As the knowledge about the coronavirus improved, some of those measures have been relaxed and physical contact has gradually returned to our lives (BBC, 2022)[4].

5.1.3 Legal framework and legislative tools to manage the Covid-19 crisis

The D4.3, COVINFORM report Analysis*: Government responses to COVID-19 and impact assessment* found that, independently from political and structural differences of each country, the management of the crisis caused by the pandemic was carried out using a top-down approach. The national governments were who assumed the greatest responsibility to lead the response against the coronavirus spreading and became the most important central actor.

> *"To specify, in countries that adhered to the federal political system, like Belgium, Austria, Germany and UK (Wales and England), decisions were made on both national and regional levels, with local institutions being involved in both the conceptualization and application of the policies. On the other hand, in countries whose political system is a parliamentary democracy or republic, it was the central government that organized and strategized the appropriate response plans, while municipalities and regions had a supporting role, especially in the implementation of the measures" (D. 4.3. Government responses to COVID-19 and impact assessment, pp. 16-22).*

All countries as mentioned in D4.3 (pp. 16-22) relied on their established previous authorities and governmental structures to tackle the crisis. However, they also created new entities to manage the

[3] Based on following observations.

[4] Given the time related differences across countries, the main sources to order when and how measures have been relaxed are often journalistic. See for instance: https://www.bbc.com/news/explainers-52575313.

situation such as *Coronas Tasks Forces* or *Experts' roundtables* that acted as scientific committees to assess government's policies.

5.1.4 Exceptional tools: Enhanced Governmental Powers

Some of the countries that declared the State of Emergency/Alert for managing the pandemic were: the state of alarm, Greece, Israel, Italy, and Spain; the state of emergency, Romania and Switzerland and UK; and, finally, Portugal declared first the State of Alert, then the State of Emergency and then the State of Calamity (D.4.1. Baseline report: Governmental responses, pp. 23-36). These countries resorted to emergency legislative tools, foreseen in constitutional institutional design for periods of emergency, alarm or crisis (Stefan and Chun Luk, 2021). The *State of Alarm* also named as *State of Emergency* or *State of Alert,* depending on the country, is a legal instrument conceived to give exceptional powers to national governments to respond critical events (from natural disasters to political, economic or social crisis). Depending on the countries' constitutions and related legal framework, the State of Emergency allows governments to assume decisions that they are unable to make in normal circumstances. In some countries such as Israel or Italy, it permitted the restriction of fundamental rights; in other such as Spain or Switzerland, in addition, it allowed to transform the governmental structure, conferring national governments extra powers for coordinating regional and local administrations. Under this new exceptional regime, countries were able to restrict the freedom of movement, air traffic, requisitions of some goods, and other measures such as countrywide curfews, cancellations of large events, or mandatory quarantines for travelers entering the country (D.4.1. Baseline report: Governmental responses, pp. 23-36 and D.4.3: Government responses to COVID-19 and impact assessment, pp. 22-26). Those changes in governmental structures that allowed the restriction of freedoms had two objectives. Firstly, creating formal mechanisms to ease decision-making procedures since governmental interventions required to act fast. Time was revealed as a key variable in the fight against the virus (D.4.3: Government responses to COVID-19 and impact assessment, p. 69). Given the exceptional character of this legislation, states of emergency have a limited duration, that varies from country to country, and they must be renewed periodically (Stefan and Chun Luk 2021).

Citizens' response to those restrictive measures was different across countries. Even if there were protest in almost all countries, how many citizens ended up supporting demonstrations and protests, sometimes violent ones, widely differ. While in some countries the conflict around the COVID-19 increased a lot, as Germany, The Netherlands, Belgium or France; in other countries demonstrations and public protests against the measures had less support, as it was the case of Greece, Italy, Portugal or Spain (Newmayer, Pfaff and Plümper, 2021)[5].

5.1.5 Non-exceptional legislative tools

Some countries' responses relied on pre-existing laws for emergencies and regulations in Austria, Germany, Belgium, Cyprus, Ireland and Sweden. Governments decided to deal with the pandemic using pre-existing legislation that allowed their governments to make measures to reduce the spreading of the coronavirus without approving exceptional tools. Laws on emergencies allowed

[5] More information about the context in press. See: https://www.bbc.com/news/world-europe-59363256 , https://www.dw.com/en/germany-thousands-protest-against-covid-measures-across-country/a-60181181, https://www.euronews.com/2022/01/24/thousands-protest-covid-measures-in-washington-brussels-and-barcelona.

governments to pass emergency public policies that were also highly restrictive, sometimes requiring the approval or ratification of courts (D.4.1. D.4.1. Baseline report: Governmental responses, pp. 23-36 and D.4.3: Government responses to COVID-19 and impact assessment, pp. 42-68).

5.1.6 National quarantine and home confinement

One of the first measures adopted by the governments of most Western countries, with the exception of Sweden, was to confine people at their homes in order to minimize social interaction and personal contacts. This measure was linked to the dramatic increase of infection and death rates. The risk of hospital collapse determined the approval of this strict measure. Despite many countries imposed quarantines to control the spread of the virus, the intensity of these lockdowns varied substantially from country to country. The following subsection intends to illustrate the main differences between them as they have been observed through the empirical analysis.

5.1.7 Countries that have resorted to lockdowns

Full-scope quarantines included prohibiting citizens from leaving their homes except for major reasons, such as purchasing food or medicine, going to those workplaces declared essential, receiving medical care, and aiding the elderly and disabled. The following countries took the measure of strict confinement as key a control measure (D.4.3: Government responses to COVID-19 and impact assessment, 22-25):

- *Austria* from March 16, 2020, to April 14, 2020. It lasted 29 days. The first of the five deconfinement stages began on 20 April which was scheduled to end on 8 June. From April 30, meetings of groups up to ten people were allowed. On 15 November 2021, the Austrian government approved a containment for those who had not been vaccinated. It was not until February 2022 that this measure was lifted. This was implemented as a means of extra pressure to people who were not willing to get vaccinated and as an effort to mitigate the consequences of the anti-vaccine movement (Henley, 2022).
- *Cyprus* from March 24, 2020 to May 21, 2020. In 2021 Cyprus Government had to return to house lockdown because of the increasing number of positive cases in the republic. This time it lasted two weeks from the end of April to May 10th, 2020 (Ganot, 2022).
- *Spain* from March 14 2020 to May 4 2020. Spanish confinement lasted 50 days. The Spanish government decreed a State of Alarm that only allowed essential activities such as visits to supermarkets, pharmacies, veterinary care, health services (Andrino et al., 2021). Only those who work in these areas were allowed to go out. It was one of the strictest lockdowns worldwide. At some point the situation was so worrying there was a two-week paralysis of non-essential productive activities. The de-escalation plan foresaw four phases (0, 1, 2, and 3) to be implemented over a period of six to eight weeks.
- *Greece* from March 23 2020 to May 4 2020. Greek lockdown began in March and was extended until May 4 when a three-phase de-escalation plan began. It was expected that this plan lasted until mid-June, always depending on the evolution of the disease. They reviewed each measure every 24 hours in case they needed to be corrected (Bathia et al, 2022). Until May 4, citizens were required to carry a QR code explaining why they were leaving their homes.
- *Israel* was the first developed country to re-impose a general lockdown during the second wave of the COVID-19 (Last, 2020). During the first lockdown people were able to go a maximum of 100 meters from their place of residence. One month later the government tried to impulse a gradual de-confinement because of the risk of having to apply a third lockdown.

The prompt implementation of the first de-confinement measures aimed to reactivate the national economy which was negatively impacted from the strict restrictions.

- *Italy* from March 9, 2020 to May 3, 2020. Italian lockdown lasted for 55 days. Italy imposed containment measures 37 days after they noticed the first COVID-19 positive case (Euronews, 2021). Italy was one of the first entry points of the virus into Europe. Once the State of Emergency was declared, the borders were closed, and the population was completely confined. Non-essential non-economic activities as well as schools and universities were paralyzed. Nonetheless some shops were allowed to open again such as bookshops, children's clothing shops and some forestry services. Italian citizens were allowed to engage in outdoor activities close to home.
- *Romania* from March 25, 2020 to May 23, 2020. The state of emergency in Romania provided for the closure of borders and shops, as well as road, rail, sea and air traffic. Cultural, religious and artistic activities were also suspended (Romania-insider, 2020). From 6 a.m. to 10 p.m., trips could only be made for business purposes, for the purchase of basic household goods, for medical care and for short trips close from home for physical activity.
- *United Kingdom, England,* from March 23, 2020, to May 13, 2020 (the responses to the pandemic in Wales, England, Scotland and Northern Ireland were very different and not necessarily coordinated as it can be seen at D.4.3. Government responses to the COVID-19 and impact assessment (p. 22)). Boris Johnson's Government was committed to a strategy of herd immunity. They were reluctant to impose containment measures at the start of the pandemic. However, on March 23, 2020 they imposed lockdown measures until May. In the UK, citizens were allowed to go out once a day for exercise. British de-escalation plan was divided into three phases, which lasted until July. From May 13, workers in sectors such as production or construction could go to their workplace, always with distancing and protection measures. From June 1, gatherings of up to six people were allowed in public spaces and also in private gardens, always with a distance of two meters. (Institute for Government, 2022). From June 13, the government allowed adults to create a "social bubble" which meant to have contact with people in a dwelling other than their residence without security measures
- *Ireland* from March 27, 2020 to May 18, 2020 (Irish Mirror, 2021). Although the Irish Government set May 5 as the kick-off date for de-escalation, lockdown had to be extended until May 18. The Irish de-escalation consisted of five phases of three weeks each that were planned to last until August 10, if their national forecasts were positive (Brennan, 2021). Before the lockdown, Ireland cancelled all non-essential travel within the country and ordered the closure of nightclubs, gyms, hairdressers, schools, and universities.

5.1.8 Countries that did impose strict lockdowns

On the other hand, there is a group of countries, as presented below, which did not impose such strict lockdowns and relied on other tools to control the spread of the virus. Partial quarantines may include mobility restrictions, such as prohibition of travelling outside the municipality of residence and limiting street activities, but they are not strict house lockdown measures. Indeed, in almost all countries, meeting restrictions and social distancing were either mandatory or recommended. These are the countries which imposed partial quarantines to the population:

- *Belgium:* March 18, 2020 to May 10, 2020. Belgium began its deconfinement on March 18, although it was characterized by its laxity, as sport and outdoor walks were allowed with no time slots and minimal distance limitations (D4.3: Government responses to COVID-19 and

impact assessment, p. 16). The de-escalation plan in Belgium was organized in four phases: Phase 1 (May 4), Phase 1b (May 11), Phase 2 (May 18) and Phase 3 (June 8) for the time being. Belgian Government assured that even though the de-escalation process had begun, measures such as social distance, limiting person-to-person contact, and good hygiene practices remained in force. It also started to develop a contact tracing model that was initiated during the first phase of deconfinement. From May 18, private meetings at people's homes were allowed. Families were allowed to invite friends or relatives to come over, but from May 10 families were allowed to receive visits from four people as long as they were always the same ones.

- *Portugal*: April 9, 2020, to May 2, 2020; Portugal lifts the State of Emergency on May 2 and switched to a State of Calamity that relaxed restrictions (D4.3: Government responses to COVID-19 and impact assessment, p. 20). Portuguese de-escalation plan had three phases and dates: May 4, May 18 and June 1. Portuguese government wanted to get its economy back on track at this time. However, at the end of 2021, Portuguese Government declared the State of Calamity, the highest State of Emergency provided by law for a catastrophic event. Portugal started 2022 with one lockdown to face the consequences of the Omicron COVID-19 variant[3] spreading (Hosteltur, 2021).
- *Switzerland:* March 16, 2020 to April 27, 2020. Switzerland was one of the first countries to close bars, schools, and non-essential activities, although it did not impose citizens' mandatory confinement. On February 28, activities with more than 1,000 people were banned. The government approved a three-phase de-escalation plan, starting on April 27, continuing on May 11 and with further last measures on June 8th. Switzerland declared the end of the state of emergency on June 19 , 2022 (Swissinfo, 2022)
- *Germany:* German Government did not resort to a strict lockdown (D4.3: Government responses to COVID-19 and impact assessment, p. 43), but from March 23, it was obliged to reduce contacts and maintain a social distance of 1.5 meters. People could walk or play sports in small groups with the people they live with. However non-essential activity did stop, German Government closed bars and restaurants and shut down manufacturing, such as the car industry. On May 6, Germany relaxed these restrictions by extending the possibility of walking together up to two families, even if they do not live together. Angela Merkel declined to coordinate de-escalation at the national level. It was up to the Länders to relax restrictions, regarding some common rules: if a district or city had more than 50 cases per 100,000 inhabitants over seven days, it had to introduce restrictive measures.
- *Sweden* is one of the few countries that did not adopt lockdown as a strategy to prevent the spread of the pandemic to a strict lockdown (D4.3: Government responses to COVID-19 and impact assessment, p. 25, and pp. 43-45). Swedish Prime Minister Stefan Löfven called on March 22 for individual citizen responsibility in dealing with the coronavirus crisis. Schools, kindergartens, bars, and restaurants were not closed, although they had restrictions on their activity and recommendations were made to keep safe social distance, work from home and isolation for elderly.

5.1.9 Curfews and mobility restrictions

Once the hardest stage of the pandemic was overcome, and scientific evidence supported a gradual return to normality, lockdown was substituted by other policies (Powel, Molina & Martínez, 2021). Most countries began to implement their de-escalation plans, generally endorsed by health and

pandemic experts (D.4.3. Analysis: Government responses to COVID-19 and impact assessment, pp. 16-22). These plans tended to identify different phases, which grouped several measures that became more permissive in each phase. However, as restrictions were gradually relaxed and life gradually returned to normal, a second wave of contagions followed. In a context when citizens and productive life was beginning to recover, a return to confinement would have been unacceptable for many citizens, and hard to apply for its economic cost. Therefore, policymakers preferred to adopt more selective forms of control to minimize social interactions, such the curfews. Curfews consist in the prohibition of staying in public places from one hour to the next, usually during the night. It applies to individuals but also to economic activities D.4.3. Analysis: Government responses to COVID-19 and impact assessment, ibid).

In general, curfews were enforced from an hour after the end of working hours, and everyone was required to return to their place of residence. The aim was to allow people to go out on the streets and to revive the economy progressively (Ayuso, 2020). It was understood that nightlife could be a very clear source of contagion. During the second wave of the pandemic, curfews were applied to prevent congregations in bars and restaurants, rather than just restrictions on capacity (D.4.3. Government responses to COVID-19 and impact assessment, ibid).

The *French* curfew was imposed from 9 p.m. to 6 a.m. and other countries such as *Switzerland* and *Belgium* followed this policy (García, 2021). The Austrian government enforced a curfew from 8 p.m. to 6 a.m. *Germany* also imposed a curfew from 10 p.m. to 5 a.m. (El Mundo, 2021). *Belgian* curfew started at 10 p.m. one hour later. In the *UK* they followed this model of applying a curfew only to pubs and bars (El País, 2021). Ireland for its part applied their curfew to hospitality and nightlife while citizens were allowed to leave their homes, but pubs and restaurants were closed. The Irish curfew was activated at 8 p.m. In *Romania*, no one was allowed to go out on the streets from 10 p.m. to 6 a.m. unless individuals hold an authorization (El País, ibid).

Southern European countries applied a more sensitive curfew regarding the daily life of their citizens and their culture (El Mundo, 2021). In *Spain,* a national curfew was declared, and the Autonomous Communities were given the power to reserve or delay the curfew by one hour according to pandemic data. The Spanish curfew was first 11 p.m. and then from 12 p.m. to 6 am. In *Italy* the curfew was from 11 p.m. to 5 a.m. *Cyprus* also applied a curfew from 9 p.m. to 6 a.m. *Greece* also applied a curfew from 11 p.m. to 5 a.m. only to the most affected areas, among which were the cities of Athens and Salonica. *Portugal* also imposed a curfew from 11 a.m. to 5 p.m. Finally, there were countries such as *Sweden* that did not impose a curfew on their citizens (D. 4.3 Analysis: Government responses to COVID-19 and impact assessment, pp. 67-68).

5.1.10 Border closures

European Council members agreed on March 17, 2020 to apply a temporary restriction on non-essential travels from third countries to the European Union and associated Schengen countries. The goal was to limit the spread of the virus globally, member states agreed to reinforce our external borders by applying a coordinated temporary restriction of non-essential travel to the EU for a period of 30 days, based on the approach proposed by the European Commission (European Council, 2020) Any individual from a third country could not enter to the European countries to protect national public health, unless he/she belongs to one of the following categories (BOE, 2020):

- Residents of the European Union or Schengen Associated States, travelling directly to their place of residence.

- Holders of a long-stay visa issued by a Member State or Schengen Associated State, on their ways to that Member State or Schengen Associated State.
- Cross-border workers.
- Healthcare and elderly care workers on their way to work.
- Transporters of goods and supplies in the course of their employment and aircrews required to carry out commercial air transport activities.
- Diplomatic, consular, international organizations, military and humanitarian organizations personnel, in the exercise of their duties.
- People travelling for duly accredited imperative family reasons.
- People who provide documentary proof of force majeure or necessity, or whose entry is permitted for humanitarian reasons.

In general, countries closed their borders very strictly during the first months of the crisis, except for reasons of *force majeure* (Eurocontrol, 2020). Subsequently, air traffic was progressively and selectively re-established. It was the available infection data for each country that led governments to decide whether to open borders. For some time now, however, since the vaccine reached adequate uptake in the population (variable but typically over 70-80%) in 2021, travelling between countries has been permitted under some requirements. Countries required either the EU digital COVID Certificate or recent negative PCR or antigen tests. Some stricter countries such as *Germany* have required a quarantine for a few days for all visitors. In *Spain,* for example, a compulsory quarantine of ten days was imposed for people coming from: Brazil, South Africa, Botswana, Comoros, Ghana, Kenya, Zimbabwe, Mozambique, Tanzania, Zambia, Zimbabwe, Peru and Colombia (BOE, 2020). *Israel* has been one of the countries that has closed its borders to foreign visitors for the longest time. During this time only Israelis themselves were allowed to return to the country. It opened its borders for the first time since the pandemic in 2022 to non-Israeli passport holders yet imposed a two-week quarantine on those arriving (D.4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 69). Those requirements have varied depending on the pandemic context, becoming strict when the virus spreads and being more flexible when circumstances improve.

5.1.11 Suspension of some economic activities: shop closing and re-opening

Previous responses to stop COVID-19 spreading were mainly aimed at reducing residential mobility. By these movement restrictions citizens' contacts would be almost minimal and therefore the rate of contagion could be controlled. However, those actions also had negative consequences for economic activity. All businesses or establishments declared non-essential had to stop their activity, leaving employers and workers with no income for a slightly long period, depending on each country. The stoppage in daily life and production was considered necessary to avoid the collapse of the health services, but it could not be prolonged indefinitely because its high negative socioeconomic impacts.

The European Council (2020) considered it a priority to secure countries' supplies. "We need to ensure passage of medicines, food and goods and our citizens must be able to travel to their home countries". The UK also declared some services essential, but those services are not different from the ones regulated by the European Union[6]. Therefore, we will present the mandates of the European Council,

[6] The specific information for UK is available here: https://news.sky.com/story/covid-19-list-of-sectors-where-workers-may-be-exempt-from-isolation-revealed-12361169.

the common denominator of the services declared as essential in a similar way in the countries studied are:

- Transport of supplies and o goods (energy, food, medical...etc.).
- Services involved in the supply chain: producers, supermarkets, distributors.
- Shops selling necessities (hardware stores etc.).
- Hospitals and health centres.
- Non-economic services: police, army, justice workers.
- Funeral homes.
- Gas stations.
- Veterinary clinics.
- Prisons, civil protection, maritime rescue, rescue and fire prevention and extinguishing, mine safety, traffic and road safety services.
- Private security companies.
- Press and media sales services and publicly and privately owned media or news agencies.
- Financial services companies.
- Those that provide services related to the protection and care of victims of gender-based violence.
- Those working as lawyers, solicitors, translators, interpreters and psychologists.
- Those providing services related to cleaning, maintenance, emergency repairs and surveillance, as well as those providing services related to the collection, management and treatment of hazardous waste.
- Those who work in Refugee Reception Centres and Temporary Stay Centres for Immigrants and entities of International Protection and Humanitarian Attention.
- Those who work in water supply, purification, conduction, portabilization and sanitation activities.
- Those essential for the provision of meteorological forecasting and observation services and the associated maintenance, monitoring and control of operational processes.
- Those of the operator designated by the State to provide the universal postal service, in order to provide collection, admission, transport, sorting, distribution and delivery services for the sole purpose of guaranteeing this universal postal service.
- Those offering home delivery services.

After a period of total or partial paralysis, which as we have seen in previous lines, a process of reopening society began. A few months after the pandemic started, governments considered it imperative to maintain a positive trade-off between protecting citizens' health and recover material, social and mental well-being (D.4.3: Government responses to COVID-19 and impact assessment, pp. 59-66).

The de-escalation process implied the reopening of non-essential shops and stores, even if they had to incorporate the hygienic measures of hand-cleaning and respect social distance. *Sweden* was an exception to this measure as they did not close their non-essential shops at any time. De-escalation processes have varied from country to country. Countries such as Italy, Israel, Spain, UK (England and Wales) Ireland, Belgium and Greece have had de-escalation processes that have lasted longer. Other countries such as Germany, or Switzerland have had faster de-escalation procedures. The first to be able to open their non-essential shops were Switzerland, which started to open on April 27th and *Germany,* which started to open them on April 20 when it was left to the discretion of the Landers to

decide whether or not to allow stores of up to 800 square meters in area to open. May was the month when shops reopened in most countries. *Italy* opened all its shops on May 18, *Switzerland* opened the shops that remained closed on May 11, *Portugal* opened its shops on May 18, *Belgium* and *Greece* which opened their shops on May 11. In *Spain*, shops also started opening in May. Spain proposed a de-escalation based on four phases. These phases were conceptualized according to epidemiological criteria: number of cases, infection rate per 100,000 inhabitants, occupancy of the ICUs, and the number of patients per 100,000 inhabitants. It was a progressive procedure, in three phases according to some demographic and health indicators open with less or more restriction for the commerce's.

Last countries to start opening their shops were the *UK countries (England, Northern Ireland and Wales)* which opened in June, whereas Northern Ireland in particular, which finished this opening procedure in July. Initially, the shops had less capacity to admit all clients according to its space and capacities to assure the respect of social distance. However, this limitation was gradually changed depending on the evolution of the COVID-19 indicators. The reductions in space or capacity were designed to keep the establishments open but to avoid any proliferation that could increase the rate of contagion. The EU digital COVID certificate regulation came into force on July 1, 2021. EU citizens and residents were able to obtain and submit their digital COVID certificates for verification throughout the EU. The certificate confirms that they have been vaccinated against COVID-19, tested negative, or you have recovered from COVID-19 (European Commission, 2022). Later on, once vaccines became more available to all citizens, regardless of their status, the governments of the countries decided that in order to enter certain establishments such as bars, museums or cafes, the person would have to show his or her complete vaccination schedule. It was the case of France, UK in Scotland and Wales, Italy, Ireland, Germany, Austria, Cyprus, Portugal, and some regions of Spain[7].

In *Austria*, entry to restaurants, theatres, hotels, sports facilities, and places of personal hygiene requires proof of vaccination, a negative test or a COVID-19 recovery certificate. Anyone visiting indoor hospitality in *Cyprus* must have a Coronapass, also known as a Safe Pass, documenting proof of vaccination or a negative test (Binder et al; 2020). This is a separate application from the EUDCC and is used separately. Restrictions vary from state to state in *Germany*, but it is widely accepted that customers must present a negative test result or proof of vaccination to be admitted to indoor hospitality. As of August 6, 2021 a COVID-19 green pass will be required in Italy to visit the interior of all hospitality establishments. The green pass will show that the holder has received at least one dose of vaccine, recovered from the virus or tested negative within the previous 48 hours. In *Portugal* more than 60 high- and very high-risk municipalities - including the cities of Lisbon and Porto - require a COVID vaccination test or a negative result on Friday evenings after 7:00 pm and on weekends. This does not apply to children under 12 years of age. Ireland

The *Irish* government passed a law that allowed pubs, cafes and restaurants to serve vaccinated persons indoors from July 26, 2021. In Spain it is up to each Autonomous Community Government whether to apply this measure or not. In Catalonia for example was mandatory to show your COVID-19 vaccination passport to access enclosed spaces while in Madrid such measure was never applied (Castro, 2020).

[7] See both https://english.elpais.com/usa/2021-12-01/covid-passports-which-countries-require-them-and-for-what.html and https://english.elpais.com/society/2021-11-25/catalan-high-court-approves-use-of-covid-passport-in-bars-restaurants-and-gyms.html.

5.2 Suspension of some economic activities: catering, hospitality, and touristic sector

5.2.1 Bars and restaurants

In a context of a general economic slowdown in the country, but also of a general distancing of citizens from their family, work and friendship networks, the tertiary sector, the hotel and catering industry, suffered greatly. The touristic ecosystem has been hit hard by the restrictions on movement and travel following the pandemic. To get it back on track, on 13 May 2020, the Commission presented a package of guidelines and recommendations to help Member States safely resume travel and gradually reboot Europe's tourism (D.4.3. Government responses to COVID-19 and impact assessment, p. 62).

In May 2021, Member States began removing non-core travel restrictions for vaccinated third-country nationals (European Commission, 2020). At least 14 days before the date of arrival, travelers should have received the last dose of: (a) a vaccine approved by the European Medicines Association (EMA) or, (b) a vaccine approved by WHO for emergency use (if permitted by the Member State).

Now, we are going to summarize restrictions related to the touristic sector, specially to the sector related to the mass tourism. According to CIDOB (2020) the main restrictions are:

- As well as non-essential businesses, bars and restaurants had to suspend their activity during the worst months of the pandemic. From July 2020, they saw their capacity reduced, depending on the country, and curfews forced them to close earlier than they normally did. In *Sweden*, bars and restaurants have always been open, although new rules were introduced on March 24 2020 to avoid overcrowding[8].
- In *Portugal* bars, terraces and restaurants re-opened on May 18 2020, with capacity limited at 50 percent. Restaurants and cafés had to leave two meters between tables and disinfect six times a day. In the beginning only customers who live together daily were allowed to sit at the same table. The self-service system was prohibited, and payment would be preferably electronic. Both employees and consumers must wear masks, which must be removed only at the time of food/drink consumption.
- In *Germany* most bars and restaurants could open from May 16 with security measures and 1.5 meters of distance between customers. Until that day, they could only serve take-away food. It was up to the Länder to set the specific rules for reopening.
- In each of the countries of the UK both bars and accommodation sector reopened from July 2020 onwards. Northern Ireland for example allowed restaurants and cafés to start using their facilities from June 29, 2020 in Phase 3 of de-escalation process assuring social distance. Bars, pubs and discotheques resumed their activity last, in Phase 5, on August 10, 2020.
- In *Belgium* restaurants, bars and cafés were not expected to open until June 8 once they were at Phase 3. In Belgium restaurants, bars and cafés resumed business from June 1 if they would have space for consumers to sit outside and safety distances are respected. Campsites opened on June 1, 2020.
- In *Italy* bars and restaurants opened from May 4, 2020, but only to buy food to take home or to work. It was on June 1, 2020 when the government opened the rest of bars and restaurants but with special measures regarding capacity, hygiene, and social distance: one-meter distance between tables, dividing barrier if this distance is not possible, the use of masks until the food is served, ban on buffets etc.

[8] See https://www.reuters.com/article/us-health-coronavirus-sweden-stockholm-idUSKCN2262AX.

- *Switzerland* was one of the countries that maintained restrictions on bars and restaurants for the longest time. Restaurants, bars and discotheques were banned from opening. However, take-away restaurants, workplace canteens and hotel canteens were allowed to open.
- In *Austria*, gastronomic establishments could reopen from May 15. Catering establishments were able to reopen from May 29. Opening hours would be from 6 a.m. to 11 p.m. There was a maximum of four adult diners per table.
- In *Spain* bars and restaurants reopened in on May 4, but only delivered takeaway food by appointment. There were approved a set of indicators to relax the restrictions according to the spreading of the virus. Firstly, there had to be a separation marked with barriers between employees and customers and a two meters' minimum distance between customers. As the data improved, terraces open, but their maximum occupancy was limited to 50%. Two meters between tables and a maximum of ten occupants were also imposed. When the virus seemed under control, this was extended to 75% and up to 20 people. There were other recommendations and security measures like the following: tables and chairs on the terraces must be disinfected between one customer and the next, and the use of single-use materials will be prioritized. Nightclubs and late-night bars opened with a maximum capacity of one-third and without the possibility of using the dance floor, which can be used for tables.

5.2.2 Accommodation: hotels and touristic apartments

Once travelling between countries started to be reactivated, the rules and guidelines implemented by the EU were based on the country of origin of the traveler. Depending on the country of origin and based on the epidemiological situation of the country, the person could face certain restrictions or others. Initially, these were the criteria governing movements between countries. Before vaccination campaigns reached a higher coverage, the main criterion for applying one or the other restrictions was the country of origin (European Commission, 2022)

In May 2021, Member States began removing non-core travel restrictions for vaccinated third-country nationals. The EU uses a traffic light mapping system to identify risk areas. Recommendations for travel restrictions within Europe are based on this color-coded classification (ETIAS, 2022):

- Green zone: no restrictions.
- Orange zone: Member States may request a rapid antigen or PCR test.
- Red zone: Member States could require travelers without a COVID test result to comply with quarantine on arrival.
- Dark red zone: testing and quarantine requirements. Non-essential travel is discouraged

Each EU country makes its own decision on travel requirements. Essential travelers were defined according to:

- EU citizens returning to their countries of residence.
- Health care workers, such as doctors and nurses.
- Members of the scientific community working on solutions to this health crisis.
- Members of the scientific community working on solutions to this health crisis.
- Citizens who commute to the borders (e.g., workers who need to provide services on both sides of the border).

Because of the progression of vaccination campaigns in the EU and worldwide, the Commission has proposed the progressive implementation of a person-centered approach. Justice Commissioner

Didier Reynders said in an EU press release: "Based on our common tool, the digital EU COVID Certificate, which has become a real standard, we are moving towards a 'person-based' approach. Our main objective is to avoid divergent measures across the EU. As of February 1, 2022, Member States only allow entry of vaccinated, recovered or essential travellers from outside the EU if: at least 14 days before the date of arrival, travellers should have received the last dose of: (a) a vaccine approved by the European Medicines Association (EMA) or (b) a vaccine approved by the WHO for emergency use (if permitted by the Member State).

Regarding the regulations for hosting and hotels, countries approved a set of measures that had to be applied by hotels and touristic apartments. They are hard to systematize since they changed from time to time. According to the available data (ONU, 2020), during the first months of 2020, international tourist arrivals decreased in 56 per cent and, by May, they had fallen by 98 percent. In economic terms, that can be translated into the loss of nearly 320 billion in exports, more than triple what was lost during the entire global economic the entire global economic crisis of 2009 (ONU, 2020). Therefore, hotels remained closed or had to pay attention to some regulations: In *Spain* hotels and tourist accommodations reopened in May 2020, with some limitations as the prohibition on using common areas. In *Greece* seasonal hotels open from June 15th for domestic holidaymakers and campsites were able to open on June 1st. *Italy* notably implemented security measures such as wearing masks permanently in hotels, controlling the capacity of common rooms and allowing only a group of people who travel together to use lifts. In *Austria* at the end of May hotels could started to open. In *Germany* tourist establishments opened from May 23rd, with capacity limits of 50-60 percent, among other restrictions. In the *UK* they started allowing hostels and hotels to open in July[9].

5.2.3 Adaptation of education during the crisis: suspension and online teaching.

One of the first decisions made by governments consisted in suspend the activity in schools, colleges, or universities according to some suggestions of Public Health experts. Any educational centre brings together people from different areas of the country and the city daily. Therefore, they were considered relevant vectors of contagion. However, this statement has been finally questioned as the evidence of the pandemic improved.

The most common pattern consisted in suspending attendance to the school, that is suspending face-to-face teaching until, in some cases, September 2020. Educative centres moved to online activity in a few weeks in March 2020.

This *online-attendance* has implied the aggravation of educational inequalities that were already present before the spreading of the Covid-19. The digital gap, the need of space within family houses to attend online classes, and the caring of children that educative services indirectly offer, were key contributors that explain the impact on social equality. In the following lines, we summarise what response in most of the target countries:

- In *Austria,* regular classes started with the new academic year 2020-2021. Depending on the situation, it was envisaged that schools opened from May 18, 2020 (Reuters, 2020).
- In *Germany,* the Länders set the rules for reopening. Secondary schools in several Länder also resumed their activities to allow pupils to prepare for their final exams, and schools gradually reopened again in those Länder with a low incidence of COVID-19 from May 4th.

[9] We have journalistic sources about this information, but we prevent readers about the provisional nature that they have. See https://www.rtve.es/noticias/comparador-desescalada-coronavirus-paises/.

- In *Belgium*, schools were made available to parents who could not telework and remained open. Kindergartens will remain closed until further notice. Schools resumed classes on May 18th, if they respected the regulation of a maximum of ten pupils per classroom, with a minimum of four square metres per pupil and an additional 8 square metres per teacher.
- In *Italy,* classes resumed in September 2020, but the Italian government proposed that all students should pass the course, although students with failing grades will have to make up the rest of the course next year.
- In *Portugal*, 16- and 17-year-old students resumed face-to-face classes on May 18th. One million primary school pupils did not return to school in 2020 – 2021 and will follow the course through TV classrooms. Another interesting measure adopted by the Portuguese government was to give the possibility to parents who did not want to take their children to kindergartens to keep the financial support they were receiving for two more weeks.
- In *Switzerland,* primary and secondary school pupils were expected to return to school on May 11th, and all other levels, including universities, on June 8th.
- In *Greece* upper secondary schools were able to return to classes from May 11th. Lower grades returned to classes from May 18th.
- In the *UK* the restrictions were longer than elsewhere, but pupils up to the age of 11 could return to school on 1 June. However, not all did. The government opted for conferring flexibility to schools in England (Scotland, Northern Ireland and Wales have their own measures to return to the school) to decide whether they admitted students or did not. The government guaranteed that secondary school students with exams next year would be able to meet with their teachers before the end of the school year and aimed to have them in class for a month before the summer holidays.
- In Spain an interesting measure was the fact that schools only opened, from June 2020, for pupils under 6 years old with both parents working.
- *Swedish* kindergartens and schools were not closed at any time, but high schools and universities were closed since March 18th. High schools reopened on June 15th. Some of Sweden's major universities, such as Stockholm and Uppsala, maintained distance learning until August 10th and reopen in the autumn. Others, such as Gothenburg, have extended online teaching until October 31st, and Malmö until did it until November 8th.

5.2.4 Compulsory wearing of facemasks

The use of masks is seen as a further barrier to the spread of the virus. Masking, space decongestion and social distancing have been some of the best tools to reduce the spreading of the COVID-19 according to the experts. Then, some governments have urged citizens to use them because their use was advisable and useful whereas in other countries, their use was not advisable but compulsory, especially in enclosed spaces. According to the available information, the requirements about masking for each country are[10]:

- In *Austria*, face masks were mandatory in shops and public transport until June 15th. The Austrian government is committed to the citizens' civic discipline and fewer rules.
- In *Germany* the use of face masks is a measure that is expected to last for a longer period, it is compulsory indoors.

[10] To depict the regulation about the use of masks in each country we have used the information from https://masks4all.co/what-countries-require-masks-in-public/.

- In *Belgium* the use of face masks is compulsory at workplaces, in companies; for citizens it is highly recommended but not compulsory.
- In *Italy* it is only recommended outdoors, and the authorities recommend its use if there are many people outdoors. Piedmont and Sicily make it compulsory to wear a mask in the street. The Italian government established a maximum sale price of 0.50 euros per face mask.
- In *Portugal* masks are compulsory in schools, transport and shops. The sale of masks was defined as a priority for the government, and they can be purchased in all supermarkets.
- In the *UK*, the mandatory use of facemasks was announced in 2020 for a short period in markets, shops and transports, but specific regulation is provided by each country.
- In *Spain* it is compulsory in enclosed spaces and on public roads, if personal distance cannot be observed.
- In *Greece* it is compulsory at work and services as well as in transport.
- In *Switzerland,* the use of face masks is recommended, and public respirators are distributed daily in shops, but their widespread use has not been made compulsory. *Sweden* also did not oblige citizens to wear face masks.
- Regarding children, the specific age depends on countries' regulation, civilians with prior health-related issues are usually people and groups who are not obliged to respect the compulsory use of masks.

5.3 Policies to compensate the effects of the measures to reduce the transmission of the COVID-19

The measures depicted along the previous section provoked a huge impact on countries' economy. This impact ended up damaging citizens' welfare and creating a need of public protection both for vulnerable and not vulnerable population. In this subsection, we address the policies adopted to soften the policies that froze the economic activity. As reader can see, although countries adopted different policies, the main goals have a high level of equivalence. Therefore, here we will point to the main policies, explaining which country or countries deviate from the general pattern. Nonetheless, the similarity is the general trend[11].

5.3.1 Keeping essential supplies and services operative

A common decision made by all studied countries was to display a set of policies to keep the essential supplies and services operative. Countries disposed measures to assure the working of police, sustaining of roads, fuel stations, cleaning services and, of course, hospitals and other health-related services. See page 10 of this deliverable and the definition of essential services.

5.3.2 Job protection: online conversion, wage replacements and business protection

One of the most relevant policies to absorb the impact of the restrictions had to do with mechanisms to protect the employment. Those mechanisms were beneficial both from workers and business. Measures can be grouped in:

[11] To depict measures to compensate the economic and social effects of the restrictive policies described before, we have used the following sources: COVINFORM - Deliverable 4.3: Governments responses to Covid-19 and impact assessment (pages 59 to 66).

a) Transition to online working schemes (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 36, 64).

b) Flexibilization of working schemes, like part-time working or flexible working hours (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 65).

c) Policies to assure wage-replacement in case of suspension of economic activity or due to the absence of demand (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 62 and 65).

For some jobs, countries designed new policies to widen unemployment benefits (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p.65). This is the case of *France or Spain*, that made more flexible the requirements to receive wages in a context where working was not possible since economic activities were suspended. And, once recovered, the economic activity had relevant limitations as the capacity of clients (see previous pages). Some countries also designed non-contributory programs, pretended to be universal, for those vulnerable individuals that were not able to get nor wages nor benefits. That was the case of *Spain or Italy*. Those benefits were widened to self-employers in *France and Luxembourg*, that is, self-employers that had no right to be benefited from unemployment schemes were considered eligible for them.

Hence, the mechanisms to keep the jobs and replace wages had, at least, two goals. On the one hand they reduced the economic impact on vulnerable workers; on the other, they had positive outcomes for businesses that could interrupt their activity and opened when situation improved, surviving to the crisis. Of course, the specific design of the policies adopted across countries was different. Some countries stablished direct benefits, other relaxed the requirements for previous unemployment benefits, and others adopted loans and tax reductions.

Finally, some countries underline the relevance of improving workers' abilities and skills to face the challenges of a changing world, especially the skills related to the information technologies. That was the case of *United Kingdom, Belgium, Germany* or *Israel* (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 66).

5.3.3 Business protection: benefits and cut taxes.

Other policies to protect the future of business consisted in benefits that were articulated into direct benefits, loans and cut taxes (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 62 and 66). Regarding policies, the most relevant program has been designed at the European level, disposing incentives to transform countries' economies and promote economic growth, as it is the case of the Next Generation programme[12]. Nonetheless, national governments approved different packages to minimize the economic recession.

5.3.4 Suspension of legal duties

To protect citizens, under certain circumstances, governments extended some deadlines and suspended the execution of some administrative and judicial decisions. The European Union disposed a table to summarize the suspension of activities related to the administrative and judiciary procedurals (see European Commission, Directorate-General Justicia and Consumers, 2020):

[12] https://op.europa.eu/en/publication-detail/-/publication/d3e77637-a963-11eb-9585-01aa75ed71a1/language-en.

- Austria (law on 22/03/2020) from March 22nd to April 30th, deadlines were suspended (exceptions can be found in the quoted law).
- Belgium (measured adopted on April 8th), from the day of its approval to May 3rd and finally postponed to June 3rd 2020, deadlines were suspended for six months except for urgent matters.
- Cyprus: procedural time limits suspended until April 30th 2020.
- France: time limits and deadlines, including limitation periods expiring between March 12th were suspended for two months, covering different procedures during the state of emergency.
- Germany: no limits on civil time deadline, only provisions regarding the longer interruption of criminal proceedings.
- Ireland: no specific legislation on time limits.
- Italy: the limits and deadlines for exercising judicial acts within civil proceedings were initially suspended from March 9th 2020 to March 22, postponed to April 15th and finally postponed to May 11th 2020.
- Luxembourg: deadlines were widened by three months by a law on March 24th 2020.
- The Netherlands: no specific legislation on time limits. Jurisdiction kept on online.
- Portugal: judicial processes deadlines were suspended within a period to be ended by Decree Law of the state of emergency. Limitation periods and prescription periods were also suspended.
- Romania: according to the State of Emergency Decree 195/2020, and its decree of prolongation, limitation and prescription time limits did not commence or they were suspended if they were running during the state of emergency.
- Spain: all terms were suspended and time limits provided for procedural laws for all jurisdictional orders were also suspended and discontinued.
- Sweden: no measures directed at legal proceedings were introduced.
- In UK, England and Wales, there was no suspension of deadlines. Courts and administration kept on working remotely[13].

5.3.5 Other policies: protection of vulnerable population and gender policies

The suspension and reduction of the economic activity intensified some situations of vulnerability. Particularly, the one related to low socioeconomic status (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 27, 67 and 74). Some policies were approved to guarantee acceptable living conditions for people that were experiencing the worst consequences of the crisis caused by the COVID-19, offering them access to housing, schooling, food provision, and job protection (see D4.1. Baseline report: Governmental responses and D4.3. Analysis: Government responses to COVID-19 and impact assessment, pp. 27-28). Those policies are part of the measures to face vulnerability in Belgium, Greece, Portugal, Spain, UK-England, and UK-Wales (see D4.3. Analysis: Government responses to COVID-19 and impact assessment, pp. 29-41).

A specific group considered vulnerable in terms of health issues, related to the COVID-19 spreading, was the elderly population. Old people have developed more and serious symptoms when being infected by the coronavirus. The main policy identified to prevent old people from the infection and illness was the vaccination campaign. In almost all countries, it was a group targeted as a priority.

[13] https://www.judiciary.uk/announcements/review-of-court-arrangements-due-to-covid-19-message-from-the-lord-chief-justice/.

According to the analysis of the interviews, it was the case of Austria, Greece, Italy, Spain and Sweden (see D4.3. Analysis: Government responses to COVID-19 and impact assessment, ibid).

One of the targeted vulnerable people were women, who experienced more job and economic insecurity than men, having more difficulties to get social protection, particularly where social protection depends on contributions to the social security (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 63). This occurred as womens labour trajectories experienced more interruptions, resulting in two significant consequences: lower wages and reduced labour stability (D4.3. Analysis: Government responses to COVID-19 and impact assessment, ibid), and it reduces their capacity to contribute to the social security. They have a less generous protection from the welfare state when needed (Esping-Andersen, 1990) In some countries, such as *Portugal* and *Spain*, targeted programs to protect women from male violence were approved during the strict lock-down that forced citizens to stay at home. In case of women at risk of violence by their partners, staying at home was particularly difficult and some measures of protection were approved, as a phone-line that cannot be found at the invoice (D4.3. Analysis: Government responses to COVID-19 and impact assessment, ibid).

5.3.6 EUs Plan of Recovery

The European Union, and United Kingdom and Switzerland too, has developed an ambitious plan to reactivate the economy through benefits and funds linked to some economic reforms. This is a change of economic policy at the international level, since it implies a major role for public institutions oriented to assure a sustainable economic growth (see D4.3. Analysis: Government responses to Covid-19 and impact assessment, p. 62).

6 Practices

In this subsection, we present the main context in which policies previously described were designed, approved and implemented. We have identified four contexts that explain the main practices regarding the management of the pandemic, according to the information from the interviewed stakeholders: (a) lack of preparedness and how it impacted policymakers and stakeholders; (b) problems of implementation; (c) rigidity of governmental structures; and (d) the tension between experts and politicians in the policymaking process. We have underlined both the context that hindered an efficient response to the pandemic, and the adaptations adopted by the stakeholders to overcome those contextual limitations[14].

6.1 Lack of preparedness

There is a cross-country coincidence about the unexpected impact of the pandemic during the first months of 2020. This has, at least, two consequences for the practices during the policy-making process: (a) decision-makers and stakeholders had to face an impressive amount of work. They were not prepared to be challenged by a serious pandemic that stresses health services. In all countries, from Austria to Spain, stakeholders evidenced fatigue and stress that could end up creating confusion and mistakes. Firstly, the lack of a plan to deal with a pandemic crisis created confusion and lack of

[14] Regarding practices, we have used as evidence the interviews depicted and analysed in Covinform – Deliverable 4.3: Government responses to Covid-19 and impact assessment.

organization, and absence of personnel, in many cases because they became infected by the virus. Secondly, the problems to organise the work implied extenuating hours of works, beyond the legal limits according to what interviewees said. And finally, the feeling of being overcome by the situation, a context they were not able to deal with (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 47). It was clearly the case of Greece, Italy or Spain, UK: England and Wales, according to the evidence we found from the interviews.

Daily routine of stakeholders changed dramatically, and some needed specific training. The other consequence (b) has to do with the lack of transparency of the measures, that were designed in a context when no scientific evidence was enough developed to support the policymaking (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 34, for Italy; p. 45 for Austria; and p. 46 for Belgium).

On the contrary, many stakeholders underlined the flexibility and capacity to adapt the new context, approving emergency measures when needed. Many interviewees underlined the need of reform and improve the institutions that work on public health to get a quick response without ceding quality responses. The informal adaptation was useful to comply the goals during the first stages of the pandemic, but it would need to be reconsidered for future shocking events (D4.3. Analysis: Government responses to COVID-19 and impact assessment, pp. 25, 41-42).

6.2 Problems of implementation

Some stakeholders, for instance the ones from Portugal, explicated that some policies were approved taking into account the governmental capacity to implement them. In some moments of the pandemic, the implementation influenced the policy content. In those times, the governmental capacity to enforce some policies was not enough, so suboptimum policies were applied.

In decentralised countries, such as Belgium, Spain, or United Kingdom, additionally, some requirements of coordination between different policy arenas hindered the efficacy of the responses. In some cases, health is not a national competence but a regional one. Special and emergency packages were approved to allow national government to coordinate some policies even if competences were regional. Stakeholders underlined the relevance of clarifying processes, competences, and coordination mechanisms without the need of approving exceptional legislation as the state of emergency.

6.3 Rigidity of some governmental structures

Some stakeholders pointed to some difficulties to face the pandemic related with the institutional design of some countries. In general, decentralised countries such as *Belgium, Spain, or United Kingdom* shows a special need of coordination between regional, local, and national areas as we have just mentioned (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 46 for Belgium; contrasting with p. 47 for Greece). Sometimes, exceptional regulations, as the State of Emergency, were needed to assure that coordination; others, decision makers opted for informal paths to solve potential conflicts between administrations. On the contrary, countries with a centralised institutional design exhibited a lower range of problems. That is the case of *Greece, Austria, Portugal, Italy or Sweden* where coordination referred to different policy areas (D4.3. Analysis: Government responses to COVID-19 and impact assessment, pp.44-60).

Generally, countries that reinforced intergovernmental cooperation from a top-down approach exhibit a better level of satisfaction on the management of the pandemic. Some stakeholders underline that, precisely, in the case of Italy or Greece where the leadership of the pandemic was clearly defined. Nonetheless, federal or quasi-federal countries also enlighten the intensification of the mechanisms of cooperation between governments, even if this is more conflictive, in political terms, for them.

6.4 Experts versus politicians

The controversy between policymakers and scientific experts is present in some countries, and it determined some practices. That was the case of Romania, United Kingdom, Spain, Italy or Portugal (D4.3. Analysis: Government responses to COVID-19 and impact assessment, p. 74). Interviewed stakeholders pointed to the salience of scientific experts in the policymaking during the pandemic, which implied a confusion between political and scientific logics, being a key difference the accountability. On the one hand, governments led the response to the pandemic, but, on the other, the accountability was mediated by scientific experts that were not politically responsible for their positions. The need of experts and scientists to assess the policies should not imply the displacement of political responsibility of policies finally made.

6.5 Summary

In this section, we have addressed the main policies adopted to fight the pandemic and correct the negative impacts of such responses on citizens' lives. In addition, we have presented the practices developed during the pandemic, focusing on the main difficulties that interviewed stakeholders pointed out (see both D.4.1. Baseline: and D.4.3. Analysis: Government responses and impact assessment).

The comparative description of both policies and practices shows a high range of similarities between countries. In general, countries responded in similar way differing in specifics points within the same policy. For instance, almost all countries have applied lockdowns or restricted the economic activities in bars, restaurants, pubs or hotels; differences are seen when looking at the detailed regulation, specific hours, exceptions and so on. The same can be said about the responses to the COVID-19 crisis that have to be with policies to compensate the consequences of the economic paralysis caused by policies that aimed to limit mobility to reduce contagions. All countries have designed policies to protect new economic vulnerabilities, extending social protection policies to new collectives. However, differences emerge when we go into details: some countries created new policies to prevent citizens from poverty, whereas other countries extended previous programmes to reach new people when needed.

Countries from central and northern Europe have been less restrictive during the pandemic, whereas Southern countries, Portugal, Spain and Italy have adopted stricter policies of restrictions. Lockdowns were more intense there, also because the pandemic hit harder, and the risk of hospital collapse was a reality. The level of strictness contributes to explain the impact of the COVID-19 crisis on countries' economy, and also the policies to reduce the economic impact of the policies designed to stop the COVID-19 spreading.

Regarding practices, evidence is observed to demonstrate that stakeholders are highly satisfied with how their countries have dealt with the pandemic, given the circumstances. In spite of many criticisms that we have covered in this chapter, such as the lack of preparedness, the problematic role of

scientists and politicians, or some problems of coordination between different political arenas, stakeholders state that health service and essential services kept on working, and many citizens got protection against illness and death (D.4.3. Analysis: Government responses to COVID-19 and impact assessment, pp. 42-43). As we have just mentioned, they are mainly critical with the lack of prevision and the amount of work needed to compensate it, but they value also the capacity of citizens, professionals, experts and policymakers to be flexible and adapt the circumstances. A frequent agreement between stakeholders across countries has to do with the governmental structures and how they impact the practices related to the policymaking. In decentralised countries, stakeholders suggest a special need of coordination between policy arenas. This need of coordination delayed some responses to the pandemic, even if they have served to reinforce intergovernmental relations and correct some mechanisms to improve them. Finally, transparency and accountability have to be improved and corrected in further emergencies, if they finally arrive, to assure a democratic and efficient response to those crises (see D4.3. Analysis: Government responses to COVID-19 and impact assessment, ibid).

7 Policy and practice recommendations

The pandemic constitutes an unprecedented challenge for Governments, moreover, the pandemic is still an ongoing crisis, therefore while it is difficult to assess the effects of the policy interventions implemented, it is also important to stress and to understand for future policy making, what has worked and what did not work. The findings of both desk and empirical research conducted within WP4 highlight that the Governments of COVINFORM countries implemented several policies deploying human, financial and technical resources in order to alleviate the effects of the pandemic. These policies encompass public health, economics and the well-being of citizens.

7.1 Policy Recommendations

The first kind of policies that were implemented by governments were containment policies in order to reduce virus transmission. People were recommended to stay at home and to reduce physical contact. These measures are defined as non-pharmaceutical interventions (NPIs). A second fundamental recommendation was related to hygiene measures: people should sanitize their hands and carefully clean objects. While the measures adopted by governments were similar in nature, the restrictiveness of policies varied among different countries. In some countries, during the first months of the pandemic (Winter/Spring 2020) the policies were particularly restrictive: the declaration of the "State of Alarm" provided some governments with the right of limit their citizens' freedoms (of movements, of meetings…). Thus, strict lockdown measures were implemented in some countries (e.g., Austria, Cyprus, Greece, Israel, Italy, Ireland, Spain…) while in other countries (e.g. Belgium, Portugal, Switzerland, Sweden…) did not implement strict lockdown. However, even in countries where strict lockdowns were not implemented, partial mobility restrictions (both internal and international), restrictions to gathering and meetings, and suspension of non-essential economic activities were in charge to limit the spread of the virus. Later on, during the second and following waves, strict lockdowns were replaced in most of the countries by curfews and mobility restrictions. Among the NPIs, border closure was the one that lasted longer. Border closure was however stricter from January to May 2020 when travel bans were issued by all countries around the world. Afterward,

mobility was dependent on the citizenship and on complying with strict health measures (testing, quarantine…) and later on vaccination status (testing, quarantine and/or proof of vaccination).

The resort to lockdowns and similar restrictive measures coupled with public health measures (testing, contact tracing…) was necessary to limit the spread of the virus, to reduce the number of infections and fatalities and to not overwhelm the health systems. However, it has been stressed that these kinds of policies may have a "complex cluster of effects" (Norheim et al. 2021: 10). The first side-effect of those policies is that the limitations of the liberties of the citizens. Other major side-effects of restrictive policies are slow down economic growth, make difficult the access to social services, depress employment, mental well-being and education. Other side-effects that should be taken into account are widening income inequalities (Palomino et al. 2020) and social unrest.

The side-effects of NPIs have been assessed by recent research (Toffolutti et al. 2022, Block et al., 2020); this research has shown that while the mental health of inhabitants of EU countries was severely affected by limitations to travel and to gather, it looks that other NPIs such as working from home did not resort in a negative impact for the mental well-being of people. More harmonized policies at the EU level in term of mobility restrictions may prevent in the future such side-effects. Moreover, social bubbles may also act as a mitigating factor for social isolation.

NPIs negative consequences have been harder for some categories: women and individual living with young children, students, the elderly have suffered from the stay-at-home requirements and school closures. Indeed, working from home and increasing caring burden had a disproportionated impact for women with young children and/or taking care of older parents. Students of all age groups suffered the distance learning setting which lasted more than one year in several countries (especially for college and graduate students). Older people suffered of social isolation from family and friends. NPIs policies negative consequences were also experimented by the so-called essential workers such as medical, paramedical personnel, care workers, farmers, people working in the food processing industry: they were both essential and vulnerable because of the working condition that exposed them to precarity and to the virus. Taking into account that many essential workers are migrants, it should be stressed that NPIs policies had an impact also on migrants "throughout the international migration cycle, starting with departure from countries of origin, entry into transit and destination countries, stay in transit and destination countries, and the return to countries of origin" (McAuliffe et al. 2021). Many countries in order to face labour market shortages in the sectors traditionally occupied by migrants, resorted in "selective border closure", exempting essential workers from mobility restrictions. However, few measures were taken to protect them from the virus as migrants' workers continued living in overcrowded accommodation and working lacking protective equipment. Overall, the pandemic has exacerbated the vulnerabilities of several categories of the population. It is clear that one-size-fits-all policies are not successful while dealing with vulnerability and social inequalities. In the future policies should address the social and economic factors that create and perpetuate vulnerability and inequalities.

Governments should find the right trade-off between pandemic containment measures and the sustainability of those measures for the well-being of the country and of its citizens (Toffolutti et al. 2022). In such context, one of the main "lesson learned" is that most of the countries faced several difficulties to deal with the pandemic because of a *lack of preparedness*. The lack of preparedness was particularly relevant during the first period of the pandemic (and of the analysis conducted in this chapter, i.e., January 2020-March 2021). In this matter, two critical points underlined by the analysis (desk research and interviews with governmental stakeholders) conducted within WP4 are the lack of

preparedness of the health systems and the lack of preparedness of those in charge of risk communication. Even if the systems involved in the management of the crisis re-adapted fast to the new pandemic situation, and the situation was somehow better managed during the second period of the pandemic analysed in this report (March 2021-April 2022), there is still large room for improvement for policy making, especially for future similar shocking events. In this regard, it will be advisable to envisage permanent structures within the governmental institutions in charge of managing ongoing and future pandemics. The *ad hoc* structures should be supported by the scientific committees that have been introduced by several countries to advice governments on the design and implementation of policies to counteract the pandemic. Furthermore, the process of policy making should be perceived by the public as fair and transparent. Thus, it should involve political leaders, experts and all affected parties (Norheim et al. 2021).

Another relevant "lesson learned" so far is the lack of coordination among different governmental levels: it occurred not exclusively in de-centralized countries but also in countries where the national government has the final say on policy making and implementation. This lack of coordination resulted in confusion for the citizens and for the major stakeholders at different governmental level. Ideally, the above-mentioned *ad hoc* structures should be adapted to foster integration and cooperation at different government levels. Indeed, in a period of crisis, it looks like that a top-down approach is better than a multilevel governance because the citizens and the stakeholders need precise and straightforward instructions coming from only one institution instead of several contrasting messages.

7.1.1 Suspension of some economic activities: catering, hospitality, and touristic sector

One of the main findings in our analysis relates to the effectiveness of measures aimed at reducing exposure to the virus through mobility restrictions and workforce management (limiting the number of exposed "key" workers in the critical sectors). Supporting measures that curtailed the movement of people to reduce the transmission of COVID-19, amenities and facilities were closed. In addition to putting pressure on people to stay at home through the lockdowns and curfews seen in many countries, reasons to leave the home or be mobile were also reduced. A hierarchy of services allowed some to cease and others to continue activities. This hierarchy was ostensibly centred around the core aspects of the pandemic; health, food and product distribution and delivery, maintenance, safety and security, and media. However, this selection of services has had differing effects on the lives of people with different relations to this selection. Whilst these closures did reduce the movement of some populations who did not work in these services that remained open and/or could work from home, others who did work in these services were much more exposed to catching the virus. The larger the selection of services a country decided to keep open to the public, the more people were exposed to catching the virus. A smaller group that faced this higher level of exposure keeps local outbreaks relatively small, whilst a larger group significantly increases the chances of catching the virus for all. A study on the Swedish pandemic approach that did not involve lockdowns has condemned the approach for the levels of exposure people in Sweden were subjected to (Brusselaers et al., 2022).

Policy recommendations include increased support and utmost protection for workers at the facilities that remained open, so that these key workers can continue their work. As in many countries key workers are predominantly women: 60% in case of the UK (Farquharson et al., 2020), policy measures should also focus on providing gender-specific care support and recognising that availability of childcare (and elderly care where appropriate) is critical for such workers. Also, these services should be supported financially to help them reimagine the operationalisation of their service to reduce the

levels of exposure to vulnerable workers without it impinging on their pay and working conditions (i.e., no mandatory night shifts when employees were used to, and organised their lives around day shifts).

Another important finding relates to the effectiveness of measures that negotiated co-presence and accessibility within catering, hospitality and tourism sectors. Whilst the closure of amenities and facilities took place on largely similar terms in European countries, opening up procedures differed, which leads to different policy recommendations. Reopening of hospitality venues in particular had different patterns following different peak infection times in the different EU and affiliated countries. These patterns also relied on different levels of State anxiety around mass infection, illness, and death, as well as different economic and other pressures felt by the governments that authorised pandemic measures. Varying reliance of the economy on hospitality venues and the broader touristic sector seemed to have played a role in reopening cafes, bars, and restaurants. This is reflected in the governments' wishes to rapidly downscale at the first opportunity the relatively high financial state support to such venues and other touristic and leisure organisations and businesses in countries such as Greece, Portugal, and Austria (D4.1 Baseline Report Governmental responses).

Concerns for different infection rates in hospitality venues seemed to express in different personal protections of staff and patrons through the different usage of indoor and outdoor spaces. Venues that were already set up with an outdoor space or that were allowed to adopt an outdoor space thus seem to diminish infection rates most strongly. Also, venues that were able to change their functionality by allowing enjoyment of their service offsite (such as through take away) were most likely able to keep infection rates lowest. In effect, hospitality that relies on selling a specific experience in space that is designed for it were least able to adapt to keep infection rates low. For instance, bars and nightclubs, such as those in Spain and Wales, are good examples of businesses that could not readily adapt their service to cater for social distancing and masking requirements. As such, hospitality businesses that could best extend their services away from their core inside service delivery to outdoors or offsite entirely have been recognised to be best able to reduce processes that render people vulnerable to infection. Such extension makes these services more accessible to people who are clinically more vulnerable to serious illness.

Policy recommendations therefore include measures that support and help adapt hospitality services to be consumed in a variety of ways and in many different places to allow for clinically vulnerable people to continue using these services without them becoming less accessible. Key is also to have measures and support systems in place after the pandemic to continue for these businesses to retain a sensitivity towards social difference. Fostering such sensitivity would, in turn, help retain a versatility in their service offer that caters to people with a broader range of backgrounds and circumstances.

The findings from our report also highlight the importance of different scales in providing pandemic responses and avoiding "one size fits all" approach in addressing different pandemic vulnerabilities. Whilst the virus and biomedical understanding of its transmission between bodies would suggest measures at the individual level would be most useful to base reasons on for access to countries from abroad, the governance practices at the scale of the nation-state were used. This allowed countries to continue relations between countries that had been fostered in pre-pandemic geopolitics and economies. It is through this mechanism that national governments and their geopolitical and economic concerns shaped state responses to the pandemic. Otherwise, they would only need to set up isolation regulations and systems for external visitors, resource internal individuals to the extent that they could stay at home without problems, resource the internal healthcare infrastructures, and resource external efforts to develop and distribute vaccines. Therefore, the person-centred approach

of vaccination passports employed in the EU also emerges from the analysis as a potentially fruitful way forward for pandemic policy to ensure vulnerable people are protected from COVID-19 infection and illness, including in touristic contexts.

For many countries of which the economy relied on tourism to a relatively high percentage compared to the European average; predominantly Mediterranean countries as well as individual cities and coastal towns touristic overnight accommodation has been an important aspect of the pandemic measures. Different methods were used to render staying in hotels and apartments safe to a certain, agreeable, extent. Regulations have been aimed at keeping bodies separate as much as possible and reducing the possibility of the virus spreading through the air. Closures have been ordered at peak times and for specific nationality-based groups of people. The combination of (1) the absence of people when infection rates above a threshold posed a risk of infection in these spaces with (2) the material set up of the venue spaces and reduction of people mingling in communal spaces, and (3) behavioural measures of mask wearing (e.g., Greece) to reduce transmission seemed to work well in adapting the business for vulnerable staff and guests. Indeed, the material set up of hotels and possibilities for mask-wearing and severely reducing access to other spaces then guests' own room was successfully used as quarantine practice by a range of countries to reduce the virus travelling between countries. Nonetheless, using a country's infection rates to decide who is welcome to stay in hotels and apartments does not imply useful indications about the likelihood of a guest of a certain country of residence being infectious during their stay. An approach that takes more notice of the circumstances of the individual and derives the likelihood of exposing other guests and staff to the virus could be recommended.

7.1.2 Adaptation of education during the crisis: suspension and online teaching

One of the key findings in our analysis concerns differential treatment of young people in education, which re-defined their vulnerability during the pandemic. Tensions between the pressure to keep educational rhythms going with the idea that missing school in the conventional face-to-face way was considered problematic. In most countries, older children and teenagers of high schools and universities were asked to return to in-person educational settings before younger children in nurseries and primary schools. Concerns for the organisations of education tended to rely strongly on the nature of the job of children's parents. Children of parents in critical occupations, who continued in-person teaching, alongside teaching staff, had higher levels of exposure to infection and illness. In turn, parents in 'essential' jobs (e.g. healthcare, social care, emergency services, transport and food supply) were more likely exposed to infection both due to the nature of their jobs and due to their children's exposure in schools.

The emerging clinical studies of the early variants did not necessarily consider children as a group vulnerable to the virus. Even the emergence of Delta and Omicron variants, which increasingly affected children, did not change the government policies, and vaccines were equally not readily made available for children under the age of 18 in most countries. The vulnerability of children was therefore almost exclusively formulated in social terms, expressed as disruption of their development and learning at school. This limited concern on social (rather than also medical) vulnerability of children was shared across the European countries. As such, children were not seen as a priority group and were more or less organised as a 'buffer' in the family unit that sustain the countries' labour systems.

Policy recommendations include that children who have been continuing in-person education or have been requested to return to in-person schooling with the endings of lockdowns need to be offered (1)

better support for home studies, and (2) more flexible learning possibilities that combine home and school-based education. Even though the educational set-up online and in-person teaching may have been helpful in retaining disruptive effects on the critical job sectors, it has amplified the levels of exposure to infection and illness. This was particularly true for many children and young people who had to keep attending in-person education or were asked to return to schools too quickly, before supportive infrastructure was made available to parents returning to work. Clinically vulnerable adults who worked in education and vulnerable children (especially in 2021 and 2022) were thus much more likely to catch the virus, which worked counterproductive to the job of governments to reduce the exposure to the virus for all inhabitants.

7.1.3 Compulsory wearing of facemasks

Another finding in our study reflects on the use of behavioural prompts, accessibility and affordability of measures designed to combat the spread of the virus, such as wearing facemasks. Masks have been utilised as important method to reduce transmission of the virus between people. Countries differed on the obligatory and recommended enforcement of using them by the vast majority of inhabitants. This is potentially reflective of the dominant political ideology around the relationship between the State and the individual. More communitarian ideologies saw less problems with enforcing people to wear masks in shared spaces then countries with a more individualistic political ideology and culture: Sweden being the epitome of a laissez-fair attitude of the State to its citizens. People who worked in such shared spaces including healthcare settings were thus immediately rendered more or less vulnerable to catching the virus based on legally or morally enforced mask usage.

Some countries (e.g. Italy and Portugal) accessibility of masks for all was prioritised, which will have helped for poor people to organise a reduced chance to become infected by having access to masks. Therefore, policy recommendations include the measures targeting affordability of personal protection equipment, such as extension of price caps on masks, especially in countries that employ recommended mask use. It is difficult to recommend practices as the analysis does not show the mechanisms for ensuring that mask use was followed up on in the shared spaces it was warranted.

7.1.4 Economic activities and labour markets in the pandemic

Economic and social policies in European countries were largely aimed at retaining the pre-pandemic economic activities; wage replacement schemes kept people who could not be paid by companies and organisations in their exact same jobs, and companies were helped with their reduced income through financial support schemes. Governments could have chosen instead to induce targeted change in the labour markets, which would include strategic resource injections for the sectors that had been struggling before and during the pandemic. Furthermore, government interventions can also offer workers in certain sectors opportunities to retrain for other jobs that were relevant for the pandemic conditions, ensuring sustainability of post-pandemic growth and targeting pre-pandemic job inequities. Possibly, with the unfolding of the pandemic the extent to which and the duration of the pandemic was underestimated, and the rapid changes governments needed to make to address immediate issues may have detracted from the possibilities to redesign the internal labour markets.

Policy recommendations would entail pursuing those more fundamental changes to domestic labour markets. Financially struggling people could be resourced to fill a gap in new economic activities. Practice recommendations include that on the level of an organisation or company, changes to the scope of economic activities could also be revised and changes made during the periods of State aid.

State policies can be heralded as helpful in the protection of vulnerable people specifically include wage replacement for people with a low socio-economic status without demanding change to their job or forcing them to take up jobs that would expose them more to the virus then when working outside the home.

7.2 Practice recommendations

In addition to policy recommendations, this section includes several practice recommendations that could lead to smoother governing processes in the face of the ongoing pandemic and potential future health crises. Collaborative organisations between sector departments (e.g. transport and health) as well as between higher and lower administrative and territorial scales that had already been in place between the pandemic seemed to have enabled quicker decision-making and policy implementation processes. However, stakeholders are hesitant to suggest that a centralised governance approach has been a better environment for them to do their job in. Whilst the efficacy of an authoritative approach may have resulted in quicker policy development, this approach was not favoured over a more decentralised governance structure. This was especially apparent in countries where regional actors that had been in charge of health or security leading up to the pandemic had to stand back for national actors to take over (e.g., Belgium, Spain, and the United Kingdom). Indeed, the smoothness of clarifying processes, competences, and coordination mechanisms was said to have been the most crucial for the stakeholders the consortium members interviewed. Therefore, practice recommendations include that regardless of government structure, collaborative communication structures must be in place preceding future (health) crises that can quickly evolve and adapt to newly emerging information on crisis sensitivities.

Collaborations between politicians and medical scientists also provide possibilities for practice recommendations. Accountability has been named a key aspect in the potential differences between positions of scientists and politicians in the creation of pandemic policies. Whilst accountability that sits with politicians distinctly suggests caution as guiding principle to their suggestions for pandemic policies and follow the scientific advice, it may also be used as reason not to. As the previous sections have shown, politicians cited concerns around negative economic consequences of the public health protection measures have been used to prioritise ‘the economy’ over 'health’. Pitting economic concerns against health concerns suggests that not letting caution in terms of health guide pandemic responses is acceptable. In turn, this makes it acceptable for ‘trading in’ measures that allow clinically vulnerable people to utilise facilities and amenities in similar ways as others.

Furthermore, whilst accountability of politicians is theoretically inherently part of the position, in practice, consequences of decisions that publicly perceived as problematic seem to be minor. Brusselaers et al. (2022) argue that decision-making politicians in Sweden have indeed not faced repercussions for the harmful elements of pandemic responses they implemented, and this is replicated in other countries such as England. Recommendations thus include that structures that hold politicians accountable to a set of principles, publicly checking their conduct against this guidance, and have better and more visible systems in place that involve severe consequences for politicians that do not comply with them. For instance, the simultaneous design and development of an inquiry into the conduct of governing agencies and agents to be delivered on regularly during the pandemic and for some years afterward.

In terms of understanding and efficiently contributing to the pandemic responses at different governmental levels, many stakeholders felt underprepared. They argue for the necessity of a more

comprehensive crisis plan to reduce the effects of the pandemic on the residents in their governmental territory, regardless of the specific novelty of COVID-19. The lack of preparedness experienced was shaped by a combination of being faced with many 'unknowns' and drastic changes in the conduct of their work through making extremely long hours for long periods of time and staff absences. Stakeholders feeling that they could have made a better contribution to the pandemic response developments also stated that these responses lacked sufficient reasoning in the absence of scientific data. Simultaneously, with the new working circumstances, new practical possibilities of working emerged that were embraced by many. Practice recommendations therefore entail that more effort ought to be spent on ensuring that governmental agents have better ways of working amidst uncertainty. One such way is development of a crisis action plan in which communication structures are a more strongly developed aspect than what was in place at the beginning of the pandemic.

7.3 Summary

The policy and practice recommendations develops based on the analysis in Chapter 6 and suggests that a renewed understanding of uncertainty is crucial. Firstly, the pandemic policies and the processes that develops them should radically include or centre populations that are not assumed as 'standard citizen' that would be on the receiving end of the policies. Indeed, one-size-fits-all policies can never address social inequalities and associated vulnerabilities. A radically intersectional approach that foregrounds circumstances and perspectives that are usually seen as exceptional in policymaking processes is crucial to distribute the burden of the negative consequences of the measures more equitably. Secondly, pandemic policies as well as the practices to develop them need to provide space for uncertainties to be incorporated rather than reduced and/or eschewed. And thirdly, and relatedly, communication of changes in policies that change everyday life circumstances of countries' inhabitants often seemed to be confusing; in particular, in relation to the distribution of responsibilities between different governmental agents. Therefore, building in more predictability in communication approaches by establishing the guiding ethical-political principles of policy development and the practice of governance is also recommendable. Employing such principles from the start helps order and prioritise uncertainties in governmental processes and procedures for the different agencies.

8 Concluding remarks

The aim of this deliverable was to synthesize the data drawn from the empirical and desktop research realized within WP4. More specifically its aim was to provide a summary and an interpretation of the findings of D4.1 – D4.3 from an interdisciplinary and intersectional perspective, within the theoretical framework established in WP2 and WP3 respectively. Moreover, T4.4 aimed to provide policy and practice recommendations in order to be delivered to policymakers in WP8.

After introducing the aim and the methodology of the deliverable in Chapter 1 and 2 respectively, Chapter 3 has provided a synthesis of governmental responses and impact and on lessons learnt. The baseline analysis (desk research T4.1) conducted during the first period of the pandemic from January 2020 to March 2021, has served as basis for the remaining tasks of WP4. In particular, it has described the governmental structures of COVINFORM partner countries, and the policies adopted by the governments in response to the pandemic (lockdowns, state of emergency, border closure…) according to the pre-existing governmental structure. The desk research conducted during spring 2021

have also highlighted the relevance of socio-economic, legal and cultural factors for policy makers in different contexts. The second part of Chapter 3 is devoted to the governments' responses to COVID-19 during the period March 2021-April 2022. It is based on empirical research conducted within task 4.3, and in particular on data stemming from expert interviews of decision makers, policy makers and stakeholders. The empirical research has revealed the fundamental role played by ad hoc working groups and task forces- implemented in each partner country in the early months of the pandemic and made by experts- in dealing with the pandemic responses. Their role has been important from the point of view of the pandemic management both from the public health and from the communication perspectives. Another important aspect that emerged from the empirical research is the governmental response to the vulnerable populations. From the analysis conducted within D4.3 is clear that vulnerability has been addressed differently in various context. While in some contexts pre-existing vulnerabilities and a multidimensional approach to vulnerabilities have been accounted for by policy makers, in other contexts such aspects were ignored provoking a distrust toward governments by the citizens.

Overall, the empirical research and research findings have highlighted several limitations, research gaps and topics that could be academically examined and explored even further. Therefore, Chapter five and six has been devoted to the interpretation of findings of desk and empirical research. More specifically it has addressed the main policies adopted to fight the pandemic and the practices developed during the pandemic, focusing on the main criticalities that the empirical research has revealed using a comparative perspective among COVINFORM partners' countries.

What has emerged from the comparative analysis of policies and practices is that governments implemented similar policies to fight against the pandemic (e.g. lockdowns, restrictions to non-essential economic activities, border closure…), with different degrees of restrictiveness/openness among them according to the specific context. Economic policies and welfare interventions to compensate the negative effects of those policies addressing public health, have been also similar among countries. Also in this case, government adapted pre-existing policy settings or provided brand new policies.

Regarding practices, stakeholders were in general satisfied with the response to the pandemic implemented in their countries, given the circumstances. Many critical issues emerged during the expert interviews such as the lack of preparedness, the problematic role of scientists and politicians, or some problems of coordination between different political arenas. Nevertheless, the stakeholders found that the governments did their best to assure the continuity of basic needs to their citizens such as to assure the provision of health services and essential services. They have also appreciated the response and the flexibility of citizens, professionals, experts and policymakers. Overall, stakeholders found some criticalities in the governmental structures especially in decentralised countries, where there is a need of coordination between policy arenas. Finally, transparency and accountability must be improved and corrected in further emergencies to assure a democratic and efficient response to those crises. The last chapter of this deliverable is devoted to policies and practices recommendations.

8.1 Policy recommendations

Containment policies *(lockdown, border closure, curfews…)* i.e., non-pharmaceutical interventions (NPIs) may have several unintended consequences: the limitations of the liberties of the citizens, slow down economic growth, make difficult the access to social services, depress employment, mental well-being and education, widening income inequalities and social unrest. Therefore, governments should

find the right trade-off between pandemic containment measures and the sustainability of those measures for the well-being of the country and of its population. Preparedness should play an important role: it will be advisable to envisage permanent structures within the governmental institutions in charge of managing ongoing and future pandemics. The *ad hoc* structures should be supported by the scientific committees that have been introduced by several countries to advice governments on the design and implementation of policies to counteract the pandemic. Furthermore, the process of policy making should be perceived by the public as fair and transparent. Thus, it should involve political leaders, experts and all affected parties.

Suspension of the economic activities: catering, hospitality, and touristic sector. Policy recommendations include increased support and utmost protection for workers at the facilities that remained open, so that these key workers can continue their work. As in many countries key workers are predominantly women: policy measures should also focus on providing gender-specific care support and recognising that availability of childcare (and elderly care where appropriate) is critical for such workers. Also, these services should be supported financially to help them reimagine the operationalisation of their service to reduce the levels of exposure to vulnerable workers without it impinging on their pay and working conditions (i.e., no mandatory night shifts when employees were used to and organised their lives around day shifts). Policy recommendations include measures that support and help adapt hospitality services to be consumed in a variety of ways and in many different places to allow for clinically vulnerable people to continue using these services without them becoming less accessible. Key is also to have measures and support systems in place after the pandemic to continue for these businesses to retain a sensitivity towards social difference. Fostering such sensitivity would, in turn, help retain a versatility in their service offer that caters to people with a broader range of backgrounds and circumstances.

Adaptation of education during the crisis: suspension and online teaching. Policy recommendations include that children who have been continuing in-person education or have been requested to return to in-person schooling with the endings of lockdowns need to be offered (1) better support for home studies, and (2) more flexible learning possibilities that combine home and school-based education.

Compulsory wearing of facemasks. Measures targeting affordability of personal protection equipment, such as extension of price caps on masks, especially in countries that employ recommended mask use.

Economic activities and labour markets in the pandemic. State policies can be heralded as helpful in the protection of vulnerable people specifically include wage replacement for people with a low socio-economic status without demanding change to their job or forcing them to take up jobs that would expose them more to the virus then when working outside the home.

8.2 Practice recommendations

Regardless of government structure, collaborative communication structures must be in place preceding future (health) crises that can quickly evolve and adapt to newly emerging information on crisis sensitivities. More effort ought to be spent on ensuring that governmental agents have better ways of working amidst uncertainty. One such way is development of a crisis action plan in which communication structures are a more strongly developed aspect than what was in place at the beginning of the pandemic.

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