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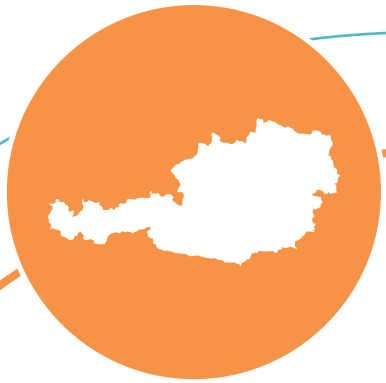

Management and Responses of the Covid-19 Pandemic: Austria in Focus

Authors

Vanessa Moser & Neda Deneva
SYNYO GmbH

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Introduction

The EU-funded COVINFORM project employs intersectionality theory and complex systems analysis to examine COVID-19 responses at government, public health, community, and information and communication levels. The project includes empirical research and community-based case studies to assess responses to COVID-19. COVINFORM draws on cross-disciplinary approaches (social epidemiology, the sociology of migration, philosophy, etc.) to investigate different aspects of vulnerability in the context of the pandemic. Based on the project findings, the consortium will develop an online portal and visual toolkit for stakeholders in government, public health, and civil society integrating data streams, indices and indicators, maps, risk assessment models, primary research and case study findings, and empirically grounded policy guidance.

The country report on Austria provides an overview of how the COVID-19 pandemic was managed from the perspective of government, public health, community responses, and crisis communication in Austria. It focuses in particular on how vulnerability was operationalized and acknowledged, and the different measures taken to include and address vulnerable groups. The report follows the COVINFORM temporal framework and is based on three different time frames: pandemic preparedness before the crisis hit in 2019, the early stages of the pandemic in 2020, and how did the response and measures evolve after vaccination rollout and the occurrence of Omicron variant after mid-2021. The report is based on analysis of governance policy documents, secondary statistical sources, academic literature, institutional analysis, and expert interviews. The expert interviews were conducted for each dimension, respectively with governance officials, public health experts and general practitioners, representatives of civil society organizations, and communication experts and government communicators. The report summarizes the updated analysis on Austria provided for deliverables D4.7, D5.7., D6.7, and D7.7.

Pandemic preparedness

Austria has a federal system of government, with considerable autonomy for the nine federal states or provinces. The Austrian parliament consists of two chambers: the National Assembly (Nationalrat) and the Federal Council (Bundesrat). The National Assembly is the main legislative body, while legislative functions are shared between the federal and provincial levels. The Bundesrat represents the interests of the provinces, while the Provincial Assemblies (Landtage) represent the citizens of the provinces. Each federal state has its own provincial government, headed by a provincial governor (Landeshauptmann) elected by the respective provincial assembly.

Responsibility for pandemic management lies with the Ministry of Health and the Health Minister. They lead and coordinate health authorities nationwide during a crisis. They are also responsible for strategic decisions such as testing and vaccination strategies, the provision of protective equipment and the development of public health measures. Instructions from the Ministry of Health must be followed by the governors of Austria's nine federal provinces.

Austria also has a crisis and disaster task force (SKKM) within the Ministry of the Interior. This task force operates exclusively in emergency situations and acts as a coordinating body for the actions of the provinces, which are responsible for crisis and disaster management. The legal basis for dealing with such situations is the Katastrophenhilfegesetz (law regulating catastrophes) and, specifically for the COVID-19 pandemic, the Epidemic Act, last updated in 1950. Prior to the COVID-19 pandemic, Austria did not have an overarching crisis management plan, but did have an influenza pandemic plan from 2006, which is still in use, to guide the country's response to the influenza virus.

Austria's federal government is primarily responsible for the regulation of state affairs, with Vienna serving as the federal capital and the seat of the highest federal authorities. Vienna is also a state in its own right and therefore plays a prominent role in Austria's federal system. It has its own municipal government and is also the seat of the national government. Vienna's diverse demographic landscape is characterised by a population with a migration background, which will account for 42.6% of the population in 2022. Economically, Vienna is a powerhouse in Austria, contributing more than a quarter of the country's economic output. The city's economic strength is driven by the service sector and trade-related services. As member of the European Union since 1995, Austria's political landscape includes five major parties: the Austrian People's Party (ÖVP), the Social Democratic Party of Austria (SPÖ), the Austrian Freedom Party (FPÖ), the Green Party and the NEOS. All political institutions derive their authority from secret, personal and equal elections.

The country's public health system involves many actors, including federal ministries responsible for health policy in general and public health protection in particular. Especially the Ministry of Health drafts legislation and acts as a decision-maker, supervisory authority and coordinator between the main actors in the health system. In the hospital sector, legislative and executive powers lie with the individual provinces, which makes them responsible for hospitals and other public health facilities. Health insurance funds and agencies, such as ÖGK, cover almost 99% of the population. Other key actors are the Agency for Health and Food Safety (AGES), which controls and regulates the spread of infectious diseases, the use of medicines, etc., and the Oberste Sanitätsrat, which is an advisory body to the Ministry. In addition, a National Vaccination Committee, composed of medical experts and representatives of the national and provincial administrations, advised on the use and safety of vaccines.

At the onset of the pandemic, Austria also established a Corona Task Force, composed of Ministry of Health staff, representatives of the Austrian Red Cross, medical professionals, scientists, and various public health stakeholders. The Austrian Red Cross played an important role in crisis communication and information campaigns, closely coordinated with the Ministry of Health. Expert resources such as the European Commission, the European Medical Agency, and the World Health Organisation (WHO) also played a crucial role.

Crisis management and measures implementation throughout the COVID-19 pandemic

Austria's pandemic management was led by the Ministry of Health under the direction of the Austrian Minister of Health. Notably, Austria did not have an independent public health authority with decision-making powers during the COVID-19 pandemic. Instead, management was a collaborative effort involving various government agencies.

The Crisis Management System (SKKM) played a central role in Austria's COVID-19 management. It served as a platform for the various COVID-19 advisory councils set up in different ministries and institutions to collaborate and exchange information. However, in addition to the Ministry of Health, several other actors at the federal and provincial levels played an important role in pandemic management.

Key federal actors included the Federal Chancellery of the Republic of Austria, the Ministry of Finance, and the Ministry of the Interior. Decisions that fell within the competence of ministries other than the Ministry of Health were often coordinated among members of the federal government. The involvement of the Federal Chancellery, headed by the Austrian Chancellor, was crucial for the implementation of certain decisions, as it ensured effective cooperation between the Chancellor, who came from the People's Party, and the Minister of Health, who belonged to the Green Party, a coalition partner. The cooperation and agreement between these two figures were crucial in the decision-making process.

In the early stages of the pandemic, Austria's COVID-19 response was mainly governed by the Epidemic Act. However, as the pandemic progressed, several COVID-19 laws were enacted, the first and most comprehensive of which was passed on 15 March 2020. These COVID-19 Acts amended and expanded the Epidemic Act. The first law established the COVID-19 Crisis Management Fund and interim measures to prevent the spread of COVID-19. In addition, it included statutory provisional budget provisions, financial framework laws and various other legislative measures empowering the Minister of Health to manage the health crisis by ordinance.

The first lockdown in Austria started on 16 March 2020. This decision was based on the newly adopted COVID-19 Act, which also regulated measures to contain the spread of COVID-19. The restrictions in public spaces were enforced by the police, with administrative fines of up to 3,600 euros under the COVID-19 law, and in certain cases administrative fines of up to 30,000 euros. Additional measures to contain the virus included social distancing rules and public health advice to keep 1.5-2 metres from others, and individuals were only allowed outdoors with members of their household.

In April, mandatory masks were introduced in shops. The first closure ended at the end of April, but the mask-wearing rules were extended and then relaxed in mid-June. Testing, initially only available to those already ill, was made available free of charge to people returning from holidays in August. In September 2020, the 'Corona Ampel', a tool to visualise the epidemiological situation at a local level, was introduced.

The government provided support for people who lost their jobs due to the pandemic through various financial measures, including a €38 billion first aid package to mitigate the economic impact. This package included measures such as the short-time work scheme, a financial hardship fund for small businesses and one-person companies, a Corona fund, and a fixed cost subsidy programme.

Due to the increasing number of COVID-19 cases, Austria implemented a "light lockdown" from 3 November to 16 November, followed by a "hard lockdown" from 17 November to 6 December. This was followed by a "soft lockdown" from 7 to 23 December, followed by another "hard lockdown" from 26 December to 18 January 2021. The lockdown was extended until 7 February 2021, with these measures accompanied by extensive testing. After the lockdown, FFP2 masks became mandatory in shops, hospitals, and public transport. A night-

time curfew from 8pm to 6am, introduced on 3 November 2020, remained in place, but people were allowed to meet with others from different households during the day.

Shortly before Easter, Austria's eastern states declared another lockdown due to high hospital admissions and concerns about overloading the health system. From 19 May to 30 June 2021, Austria began the first phase of reopening, including hospitality until midnight, events with reduced capacity, and a reduction of social distance rules to 1 metre.

However, on 15 November, the government imposed a lockdown on unvaccinated people, requiring a positive green pass to enter various places such as bars and restaurants. At the end of November, Austria recorded its first case of omicron. A week later, a general lockdown was imposed until 12 December 2021. In early February, over 200,000 Austrians had their green passports expire, leading to the gradual end of the lockdown for the unvaccinated in February 2022. Austria fully opened in June 2022, when the last COVID-19 measures, including mandatory masks in supermarkets and public transport, ended. Vienna was an exception, with mandatory masks extended until the end of April 2023.

With the appointment of the new Minister of Health, Johannes Rauch, in March, there was a noticeable shift in Austria's pandemic management strategy. The strategy shifted from relying on lockdowns to a strategy of 'living with the virus'. This shift reflected the strategies of other European countries. In addition, two other factors contributed to this change in strategy: growing public dissatisfaction with pandemic management and the introduction of vaccines.

In 2021, the Federal Ministry of Social Services, Health, Care and Consumer Protection published a guidance document entitled "The COVID-19 Pandemic: Stocktaking and Framework for Action". The Minister of Health updated this document in April 2022, outlining pandemic planning and management for the COVID-19 pandemic, based in particular on the lessons learnt during the first year of the pandemic.

According to the Court, the Minister of Health did not make full use of available legal instruments, such as decrees, regulations and directives, to make the necessary changes and amendments to the existing Epidemic Act. This in turn affected contact tracing and the monitoring process of isolation measures through the Epidemiological Reporting System (EMS). Questions were raised about the surveillance response and its alignment with fundamental human rights. Data protection issues were evident throughout the process, starting with the registration and reporting of infected individuals to the authorities. In addition, the contact tracing process involved the sharing of data on contacts, and the compulsory quarantine of infected persons affected freedom of movement.

Social distancing measures, including school closures, restrictions on public places and religious services, restricted several fundamental rights. These measures affected not only freedom of movement but also data protection rights.

In interviews with government stakeholders, two key issues emerged as challenges to pandemic management: the slow decision-making process in the Austrian democratic system and the federal structure. The relative inertia of the democratic system led to a less dynamic crisis response, and the federal system led to a complex set of rules and regulations in the different Austrian states. The role of the provincial governments in making decisions in areas under their jurisdiction increased over time, influenced by different political leadership and different epidemiological developments.

As already mentioned, the Austrian Minister of Health had legal responsibility for crisis management under the Epidemic Act during the COVID-19 pandemic. However, the crisis response was carried out in collaboration with key figures in the federal government, including the Chancellor, the Minister of the Interior, and the Vice-Chancellor. This group was often referred to as the "virological quartet". The government's crisis communication was multifaceted and included several key components:

- **Press conferences:** The government held regular press conferences, particularly between March and May 2020, to announce new measures and provide updates on the situation. The frequency of these conferences varied over time.
- **Government websites:** Information was regularly updated on government websites and dashboards, with data provided by the Austrian Agency for Health and Food Safety (AGES).
- **Corona traffic light system**: An early warning system was implemented, indicating both the risk of the virus spreading and the systemic risk.
- **Information campaigns:** Notable campaigns included "Look at me, look at you", which was launched in March 2020 to raise awareness of the risks of COVID-19 and provide actionable advice. The "baby elephant" metaphor was used to emphasise the importance of maintaining a safe distance.
- **Social media:** Hashtags such as #schauaufdich and #StayAtHome were used on social media to communicate key messages.
- **Hotlines:** The government repurposed the existing 1450 health hotline and introduced new hotlines to create two-way communication channels.

Austria experienced several changes in the leadership of the federal government during the pandemic, including changes in the roles of the Chancellor and the Minister of Health. These transitions had a notable impact on crisis communication. Chancellor Sebastian Kurz played a prominent role in crisis communication, and the personal communication styles of different health ministers influenced the overall approach. In addition, the involvement of political parties within the government in pandemic communication led to an increased politicisation of crisis management.

The effectiveness of Austria's initial one-size-fits-all approach to communication waned as the pandemic progressed. The government observed a decline in public acceptance of the measures, which led to a shift towards more tailored communication strategies. Instead of trying to convince the entire population to be vaccinated, the focus shifted to providing fact-based information to undecided individuals.

However, a significant shift occurred with the announcement of mandatory vaccination in autumn 2021, followed by the adoption of the Federal Law on Mandatory Vaccination against COVID-19 in January 2022. This decision was met with resistance from both the public and the political opposition. Austria's populist parties, including the Freedom Party of Austria (FPÖ) and the newly formed MFG Austria, contributed to anti-government and anti-vaccination rhetoric and influenced national communication.

Austria's crisis communication faced various challenges. The politicization of measures and conflicts within the government contributed to a decline in public trust. A lack of transparency in decision-making and communication complicated the crisis response. Complex issues and the involvement of different stakeholders made it challenging to convey clear and accessible messages to the public. Language barriers played a role, particularly in communicating with migrant populations.

There was confusion regarding vaccine effectiveness, partly due to unclear media communication, causing frustration and undermining public trust in pandemic measures. The abrupt removal of decision-making power from the public and the implementation of strict measures without clear explanations also contributed to confusion and uncertainty among the population.

CSOs were not directly involved in the government's crisis management but played a crucial role in supporting vulnerable communities. The pandemic impacted their operations, causing interruptions and requiring adaptations. Three key challenges faced by CSOs were:

- **Interruption of CSO activities:** During the initial phase of the pandemic, all three CSOs experienced interruptions in their activities. Two of the CSOs had to switch to remote work and support their clients by phone or email. This resulted in a lack of direct contact with clients and challenges in adapting to new forms of communication.
- **Financial vulnerability and structural disadvantage:** CSOs' clients, particularly migrant women and the financially disadvantaged, faced additional challenges during the pandemic. Language barriers, social exclusion, and difficulties navigating Austrian bureaucracy were reported. Migrant women's lack of German language skills hindered their access to important services and support.
- **Limited support for certain groups:** Some groups, such as students and asylum-seekers, were excluded from receiving support from certain aid organizations. This created gaps in the governmental response, leaving these vulnerable populations without adequate support.
- **Limited access to essential services:** The closure of health and social services during the lockdowns had a significant impact on vulnerable groups, including individuals experiencing homelessness or housing instability. Many services, including food banks, stopped providing services, leaving people in need without access to food or medical care.
- **Language barriers and compliance:** Language barriers were a challenge in communicating important information about the pandemic and public health measures to diverse populations. The lack of clear and accessible information led to lower compliance with public health measures among some migrant groups.
- **Vulnerability of CSO employees:** CSO employees were themselves vulnerable during the pandemic. They experienced the crisis while supporting their target groups in the same crisis. The lack of protective equipment such as masks and the inability to work from home were cited as problems.

A significant gap in government interventions was the closure of essential services and limited support for specific groups, which left vulnerable populations without assistance. Community-driven initiatives and CSOs stepped in to fill these gaps, offering support and connecting people in need with volunteers.

Acknowledging and addressing vulnerability in crisis communication management

The Austrian government defined vulnerable groups as those who are at higher risk of suffering from severe symptoms and to whom the disease could potentially be life-threatening: these are people aged over 65 years as well as people with (chronic) pre-existing conditions of all ages (ref). The most important document in relation to this is the so called COVID-19 Risikogruppen-Verordnung (COVID-19 risk order). The order itself was updated but never extended beyond health vulnerabilities. As a government representative point out, the focus was on medical indicators:

The other important document in relation to defining vulnerability in Austria is the document that outlined the prioritisation for the COVID-19 vaccination, established by the NIG (Nationales Impfgremium/National Vaccination Committee). This was the roadmap to Austria's vaccination program[1]

The document outlines, on the one hand, health risks like chronic disease or pre-existing conditions and, on the other hand, exposure to the virus (in a work setting). The focus on exposure adds a different layer to the definition of vulnerability: it moves beyond a focus on health status towards the likelihood of getting infected due to exposure during work. Nonetheless, the focus on health outcomes remained. However, focusing on exposure meant that teachers or health care staff were recommended for early vaccination. In Austria, these are often professions with lower income and a high percentage of women in the workforce. As such, the focus shifted, to some extent, to groups who felt the negative social impact of COVID-19 more strongly.

The protection of high-risk groups was regulated through the social insurance law (Sozialversicherungsgesetz).[2] The measures taken to protect these groups encompass home office, paid leave, protective gear and so on. However, these measures are not mandatory for employers and there is no right to home office in Austria. Another health-related measure aimed at protecting pregnant women from the risk of infection at their workplace. They had the right to premature maternity leave.[3] Similarly, employees got granted additional four weeks of paid time off work between the 1st of November 2020 and the 9th of July 2021 if they have caretaking responsibilities towards children under 14 or people living with disability or relatives in need of care. However, once schools reopened for supervision, special care taking allowance was no longer possible. To mitigate economic vulnerabilities the government temporarily increased the social support for people out of work who are no longer eligible for unemployment money due to the ongoing COVID-19 crisis.[4] Additionally, already in March 2020, the Austrian government provided a first aid package (€38 Billion) to battle the negative economic outcome of the Corona virus and related lockdown as well as other measures. This included the short work scheme where employers remove employees from their payroll and have their wages subsidised by the government, financial hardship fund (Härtefallfond) for small enterprises and one person companies, a Corona fund, and a fixed expenses subsidy program (IHS 2020 May, Desson 2020). The Härtefallfond ended in May 2022 and the fixed expenses subsidy program already ran out in August 2021.

[1] https://www.aekktn.at/documents/e031f3c0-4066-11eb-a558-5254009ad2fe/Empfehlung%20des%20Nationalen%20Impfgremiums%20zur%20Priorisierung%20von%20COVID-19-Impfungendocx.pdf,
[2] https://www.ris.bka.gv.at/Dokumente/Bundesnormen/NOR40223704/NOR40223704.html
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[5] https://www.sozialministerium.at/dam/jcr:5f807a53-5dce-4395-8981-682b5f1dc23b/BMSGPK_Analyse-der-sozialen-Lage.pdf

We could only identify one analysis of vulnerability conducted by the Ministry of Health.[5] The document primarily engages with people at risk of poverty and social exclusion. It also discusses people disabilities, single parents, children, older people, and people in need of care as vulnerable groups. Other dimensions such as race, ethnicity, sexuality, legal status found little attention in government documents. While also other stakeholders involved in the pandemic response acknowledged the negative impact of COVID-19 on socially vulnerable groups, no mitigation strategies were introduced to address these vulnerabilities by the government.

Over time, children became part of the public discourse as a vulnerable group due to school closures. The Ministry of Education addressed the extent of school closures, deciding that restrictions would be reduced to an absolute minimum and would be in line with regulations in other areas of life. The goal is to ensure continuous attendance classes and, depending on the risk situation, to implement targeted security and prevention measures at individual school locations. Finally, many stakeholders acknowledged the negative secondary effects such as loneliness that were created through lockdowns and social distancing measures. These effects were considered in the pandemic management, particularly after the second COVID-19 wave by trying to avoid lockdowns as much as possible.

A best practice by the Austrian and the Viennese government were the multiple communication channels they used to communicate with the population in order to reach various groups. This was inclusive and well planned from the early days on. One of the first activities to make communication more accessible was to include sign language interpreters in press conferences early on. In addition, non-profit organisations such as the Austrian Red Cross, the Caritas, the Volkshilfe or the Arbeiter-Samariter-Bund used their internal structures to communicate to vulnerable groups of both kinds. However, for example during the vaccination campaigns, a government communicated *(WP7_SYNYO_2)* efforts to reach particularly vulnerable groups such as immunosuppressed people to raise awareness.

Conclusion: Lessons Learnt

In the case of Austria, general pandemic planning documents to deal with health emergencies were not adequate to allow flexibility, provide direction or translate to unknown crisis. In fact, Austria faced challenges due to an outdated epidemic act, which lacked definitions and regulations for handling infectious diseases. Crisis management focused on introducing necessary measures and policies to curb the spread of the COVID-19 virus. This included the introduction of new COVID-19 Laws, implementation of Test and Trace, creation of COVID-19 vaccine certificates, new committees, new taskforces, new ministers, creation of passes to access business and services, execution of lockdowns as well as and mandatory COVID-19 testing in workplaces.

The COVID-19 pandemic affected acknowledged vulnerable groups. Addressing existing and new vulnerabilities was not ignored, and necessary support measures were put in place to help address the specific needs that vulnerable groups required to get through the pandemic. COVID-19 measures such as lockdowns contributed towards heightened loneliness and put victims of domestic abuse, homelessness, and those with disabilities in precarious situations. The pandemic created also new vulnerabilities. Examples include heightened loneliness, deterioration of mental health, negative effects on education attainment/educational inequalities, poverty, food insecurity, financial difficulties, and overcrowding.

The influence of social and cultural factors on public health responses is evident in the varying levels of public acceptance, compliance, and adherence to measures. Factors such as socioeconomic status, living conditions, access to resources, and cultural norms shape individuals' ability and willingness to comply with guidelines. Trust in public health authorities and the government, clear and consistent communication from trusted sources, and community solidarity also emerged as important factors in shaping public behaviour.

In Austria initial public reactions to government measures showed support and perceived solidarity among the population. However, over time, satisfaction with measures decreased, and there was a rising perception of excessive measures and frustration among segments of the population. Trust in public institutions, such as parliament or government, varied and sometimes declined, influenced by factors such as party-political preferences, educational background, and changes in communication. In addition, Austria has faced challenges regarding vaccination, particularly with compulsory vaccination, which outlined discrepancies between federal levels and institutions.

The COVID-19 pandemic has had significant impact on healthcare workers worldwide. Healthcare workers in Austria faced increased workloads, longer working hours, and heightened risks of exposure to the virus. They experienced physical and emotional stress, shortages of personal protective equipment, and challenges in managing the demands of COVID-19 patients. Burnout, mental health issues, and financial problems were prevalent among healthcare workers, highlighting the strain they faced during the pandemic. Delays in necessary operations and treatment were observed due to the overloaded medical system.

Lessons learnt in relation to participatory practices include the active engagement of citizens in a variety of solidarity activities aimed to mitigate the negative socio-economic consequences of COVID-19. In Austria, CSOs and citizen initiatives helped fill the gaps in governmental responses, particularly via active engagement with target groups in information and awareness raising, provision of goods and hygiene items, and provision of services. Insufficient involvement of various population groups in crisis management was another issue. Additionally, complex data discouraged citizens from closely following the pandemic situation. Therefore, Austria chose not to overwhelm the public with complex issues. Collaboration with civil society organizations and local representatives who had direct contact with vulnerable groups was a proactive approach. These local teams played an essential role in decision-making and advice formation for culturally fitting measures within marginalized groups. Key persons or influencers, such as community leaders, celebrities, and experts, were employed to target specific groups. Multilingual information campaigns

and sign language usage were adopted to reach non-native speakers and those with hearing impairments.

Austria utilized various communication strategies. Many relied on government media like official ministry websites and social media channels to disseminate information and counter misinformation. Health hotlines were reactivated or newly established. Mobile phone applications for contact tracing and alerts were also developed. These varied approaches and practices highlight the importance of adapting crisis communication and management to the specific needs and challenges of different populations, with lessons learnt from both positive and negative experiences. A noteworthy, good practice, observed in Austria, was the active collaboration with group representatives and organizations working with vulnerable populations. These collaborations aimed to tailor communication strategies to the specific needs of these groups. Channels such as websites, social media, television, radio, newspapers, leaflets, posters, and phone lines were employed to disseminate pandemic-related information. However, a shortcoming was the absence of clear communication strategy in Austria's crisis preparedness plan. Negative practices were also identified, often linked to political upheavals or inconsistencies in government actions. Austria, for instance, experienced political scandals and government changes that eroded public trust. Inconsistent policies, such as the initial announcement of mandatory vaccination followed by its cancellation, caused confusion and frustration among citizens.

Lessons learnt in the field of crisis communication included the importance of strong leadership, collaboration between different actors, and effective crisis communication strategies. There are some groups that cannot be reached through governmental communication or via mass media. Even with posters or personalised letters it is impossible to create narratives that reach these groups. One way to address this challenge was to work with keypersons, who are active in certain spheres and work with particular target groups. For example, the Muslims Youth of Austria organization assisted with translating in relevant languages. Another best practice for the future, is immediately involving CSOs working with various vulnerable groups in order to reach these groups in a more effective way through their channels. For example, CSOs who work with different groups of migrants, with care workers, especially hard-to-reach groups like live-in caseworkers, with seasonal workers, with homeless people, with elderly people etc.

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Contact

office@covinform.eu
www.covinform.eu
@covinform.eu
covinform-project
@covinform

Consortium

SYNYO GmbH (SYNYO), Austria

Magen David Adom in Israel (MDA), Israel

Samur Proteccion Civil (SAMUR), Spain

Universita Cattolica del Sacro Cuore (UCSC), Italy

SINUS Markt- und Sozialforschung GmbH (SINUS), Germany

Trilateral Research LTD (TRI UK), UK

Trilateral Research LTD (TRI IE), Ireland

Kentro Meleton Asfaleias – Center for Security Studies (KEMEA), Greece

Factor Social Consultoria em Psicossociologia e Ambiente LDA (FS), Portugal

Austrian Red Cross (AUTRC), Austria

Media Diversity Institute (MDI), UK

Societatea Națională de Cruce Rosie Din România – Romanian Red Cross (SNCRR), Romania

University of Antwerp (UANTWERPEN), Belgium

Sapienza University of Rome (SAPIENZA), Italy

University Rey Juan Carlos (URJC), Spain

Swansea University (SU), UK

Gotenborg University (UGOT), Sweden

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