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Government responses to COVID-19 and vulnerability in Wales

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Table of Contents

Introduction

This report gives a brief overview of how the pandemic was managed in Wales in terms of public health crisis management, changes in the pandemic responses, the operationalisation of vulnerability, and what lessons were learned. In particular, it is led by considerations of the conditions under which the pandemic policies were drafted, barrier identification and management, and the perspective on vulnerability.

The report is based on Welsh pandemic governance policy documents and publicly available information on Welsh government websites, academic literature, and expert interviews. The experts interviewed include people who have been involved in the development, scrutiny, and implementation of the policies. The interviews were conducted over Zoon or Microsoft Teams, the audio recordings were transcribed, and analysed thematically in NVIVO 12. The interviewees have provided informed consent and quotations of their input has been anonymised. Ethical approval has been provided by the Swansea University College of Science Ethics Board.

The report is part of the larger COVINFORM Deliverable “4.7 Analysis: Government responses to COVID-19 and impact assessment – update M32” and COVINFORM Deliverable “4.8 Synthesis and lessons learnt on governmental responses and impacts – update M33”.

The Welsh government prior to the COVID-19 pandemic

Wales is a devolved nation within the United Kingdom since 1998. Devolution granted the National Assembly for Wales the power to decide how the Westminster government's budget for Wales is spent and administered. In 2006, the National Assembly for Wales was given legislative powers, resulting in the creation of a Welsh Parliament and a Welsh Assembly Government, comprising of a Prime Minister for Wales (currently Mark Drakeford), Welsh ministers and deputy ministers. From May 2020 onward the National Assembly for Wales is called the Welsh Parliament in English and Senedd Cymru in Welsh.

Wales has its own National Health Service (NHS Wales). NHS Wales now delivers services through seven Local Health Boards and three NHS Trusts in Wales. The seven Local Health Boards (LHBs) in Wales now plan, secure and deliver healthcare services in their areas. The 3 NHS Trusts operate in Wales alongside the Local Health Boards are the Welsh Ambulance Services Trust, Velindre NHS Trust, and Public Health Wales (PHW).

In the UK, COBR (Cabinet Office Briefing Rooms) meetings started on January 24th, 2020, and although the participants of these meetings are not made public, they comprise of key ministers and officials. COBR is a crisis management facility that is activated in events of national significance; it is a crisis management component as authorities come together to identify appropriate responses to a crisis. The UK-wide Scientific Advisory Group for Emergencies (SAGE) is led by the government chief scientific adviser (GCSA), Sir Patrick Vallance, and the chief medical officer (CMO), Chris Whitty. SAGE is an ad hoc committee that brings together government scientists and officials with external experts.

In March 2020, COBR was the main forum for decision making in relation to COVID in the UK and included the devolved nations in these meetings from early March (Haddon and Ittoo, 2020). SAGE meetings were also held during that time and served to inform and advise all devolved nations. While SAGE meetings provide scientific advice to guide policy and regulations, in practice, authorities agree on the best approach to handle the pandemic during COBR meetings. SAGE meetings therefore inform decisions taken during COBR meetings and between January 22nd, 2020 and February 25th, 2021, SAGE held 82 meetings[1].

The Wales Resilience Forum is the highest authority for crisis management and emergency planning in Wales and works in cooperation with local resilience forums and other agencies. Wales as a devolved nation follows advice from their Chief Medical Officer (Frank Atherton in Wales) and Chief Scientific Adviser (Rob Orford in Wales). The Chief Medical Officer works with the Welsh Government on policy for public health[2], and the Chief Scientific Adviser advises the Welsh Government on matters related to health science[3].

On March 18, 2020, Wales initiated its own health protection regulations. In Wales, the Coronavirus Restrictions were approved by the Welsh Parliament on March 25th, giving Wales the power to manage the pandemic independently of the other British nations. The Welsh Government is comprised of several departments, with Public Health Wales that manages health emergencies. Emergency planning in Wales is consistent with the United Kingdom's Civil Contingencies Act 2004, but it includes the Welsh Government's involvement and the participation of operating organisations unique to Wales.

As addition to the UK-wide SAGE group, Wales created a Technical Advisory Cell (TAC) and a Technical Advisory Group (TAG) to support SAGE in advising the Welsh Government and Public

[1] https://www.gov.uk/government/collections/scientific-evidence-supporting-the-government-response-to-coronavirus-covid-19
[2] https://gov.wales/dr-frank-atherton
[3] https://gov.wales/dr-rob-orford

Health Wales[4]. TAG – SAGE experts, alongside the Chief Scientific Adviser for Health Rob Orford met three times a week to discuss the progress of the pandemic. TAG-SAGE experts inform the ministers, which in turn present changes to the regulations to the Welsh Cabinet for consideration. The Cabinet makes the final decision which is communicated to the ministers.

The Welsh pre-pandemic preparedness strategy is aligned to the overarching UK-wide strategy. The main Welsh document that resembles a pandemic response plan or strategy is the *Wales Framework for Managing Infectious Disease Emergencies 2005*. It "sets out national arrangements for managing major infectious disease emergencies, including national co-ordination, operational responsibilities of NHS organisations and the role of partner agencies" (Welsh Assembly Government 2007: 3). Wales also has a more pandemic-specific response plan; the 2007 *Pandemic Influenza Guidance Planning* was established before the 2009 influenza pandemic. For emergencies in general, Wales has the *Pan-Wales Response Plan*, that entails the "command, control and co-ordination urgent response structure for national emergencies and includes activation levels and multi-agency responsibilities" (Welsh Government, 2021: p2).

[4] https://gov.wales/technical-advisory-cell/terms-reference

Changes and other developments throughout the COVID-19 pandemic

Prior to the pandemic Wales had a different approach to the implementation of law than England, which allowed more different kinds of measures to be imposed in Wales, whereas they were absent in England. Therefore, interviewed MP1[5] who represents a Swansea City Region constituency reminds us that:

> *"In Wales, you can actually use force of law. And then in terms of traveling around – as mentioned earlier – in Wales, they said, you can only – the advice, that strong guidance, 'you should only be traveling as far as five kilometres', but in England, it was like unlimited. So, there were spectacles of Bournemouth, that's 10,000 people, averaging. 'How could I know that everyone was going to turn up on a very sunny day in Bournemouth?'. So thanks to devolution, we're able to have a more cautious approach."* (South-Wales MP1)

He argues in favour of the multiple ways in which the Welsh government could respond to the pandemic and that this level of governmental freedom has been helpful in keeping numbers down in comparison to England; in particular in the first year when Wales made use of more protective measures than England. In addition to the 5-mile rule that was in place in Wales during the first wave (stretching further in remote places where shops, GP surgeries, and pharmacies are sparse).

Wales differs from England on socio-political and economic terms as well, which merited a different approach to the pandemic, as interviewed MP2 explains:

> *"What's interesting about Wales compared to England, is that the demography of Wales is essentially – you look at the numbers – of an older, sicker, poorer population. And so therefore, other things being equal, you just thought that the death rate would be higher. But the last rates I heard – and you do need to confirm and check these rates – were that the death rates over the five-year average in Wales was 13%, over the five-year average, and in England, it was 20% over. And that is a sort of testimony to the more cautious approach Wales took and specifically, we're talking about years, the legislation for two-meter social distancing as opposed to the guidance of one-meter social distancing."* (South-Wales MP2)

The MP's statement thus suggests how the Welsh Government took population-level statistics into account about how to adopt the pandemic mitigation recommendations from the WHO.

[5] MP = Member of Parliament; they represent their local constituency before the UK Government in the House of Commons

In Autumn 2020 Wales as only UK nation had a 'firebreak' lockdown. This lockdown was announced shortly before it began on 6pm on Friday 23 October and had a planned end date on Monday 9 November, which differentiated from other lockdowns in as not being open-ended, avoid a surge in infections with the Kent variant, and was shorter than other lockdowns[6]. No other devolved countries employed this form of lockdown at any time during the pandemic, and it was criticised heavily by the UK government and in the UK media as well. MP1 explains:

> *"Boris Johnson obviously likes to be popular and had previously proclaimed that he wanted to push forward with herd immunity. And the strategy – as you remember – was to infect as many people as possible in order to give them immunity, which was assumed that they get immunity from this particular virus. As it goes like flu, the variants are changing, subject to the NHS not being overwhelmed. So what was happening is, is that allow that virus to grow and come back all the time, and keep the NHS a nearly breaking point, that was the UK strategy, which obviously is farcical."* (South-Wales MP1)

The firebreak lockdown went against the ideology that underpinned the policy approach from the UK, and reflects Wales' more cautious approach, heeding public health preventative principles more strongly than the UK government.

Regarding change of COVID responses, Wales only ever did one Firebreak lockdown, however, as did it only implement the 5-mile rule once. With the expansion of vaccine uptake in Wales, the Welsh government more or less stopped implementing unique measures, and more regularly replicated the UK-wide policies, albeit often for longer periods, for instance, mask-wearing in public transport and testing commercially after having come back to Wales from international travel.

Later in the pandemic response phase that entailed protective measures requiring the general public to comply with, the cautious approach Wales had taken became more difficult to uphold. A national politician from an opposition party remarked that the Welsh government was scrutinised heavily for maintaining the pandemic measures that were considered for abandonment in England. He recalled a moment that this approach was not necessarily offered to the public in genuine sense:

> *"[Government official] would look at the graph [displaying infection and hospital rates over a period] and was like; 'see, things are as bad as we predicted' And I went, 'No, that's not what that graph says'. And I was right. We were we were coming out of the Omicron wave quicker than government was telling us. We were, and they were they were playing the 'let's keep on scaring the public'-hand a little bit too hard on that occasion."* (Politician at the national level)

As a result, in the spring of 2022, Wales changed its set of regulations from relatively strict in the UK context to none at all over a short time. This was mainly due to the combination of hitting a mark on vaccination degree of the Welsh population or number of doses administered, the Omicron variant emerging as less likely fatal after infection than earlier variants, and the likelihood of better weather[7].

[6] https://www.gov.wales/national-coronavirus-fire-break-to-be-introduced-in-wales-on-friday
[7] https://www.gov.wales/coronavirus-regulations-to-end-in-wales

Much can be said about the ways in which the public in Wales reacted to the crisis management and its changes in the regulations. The public in Wales seemed to adhere well to the requirements the Welsh government implemented. MP2, who also represents a Swansea City Region constituency, argues that this can be explained by the social histories of the mining and steelwork industries and their enforced closure in the 1980's. He noticed the difference particularly evidently when crossing the border between England and Wales in January 2022:

> *"But yesterday, coming back from London, I had a mask on, and nobody had a mask on. And then they did say something over the tannoid like 'wear a mask' and a couple of people started wearing a mask. And when you got into Wales more people were wearing masks. So it's just a matter of telling people what to do and policing it and providing social pressures."*
> (South-Wales MP2)

Nonetheless, MP1 remarks that arguments against restrictive pandemic measures entailed the supposed encroachment of the human rights of the individual. Both MP1 and MP2 are wary of this line of argument for its easy applicability to a wide variety of situations. Both mention the proposals for COVID passes and check at the door of hospitality establishments (e.g. pubs and restaurants) being shot down for being pitted against the right of individuals not to get vaccinated or not to show medical information to be allowed access to a place:

> *"The discussion on human rights has been so hijacked (…) And, to a certain extent, this is imported from the far right in the United States. And it appears to be done in a sort of random way, but it's being done in this systematic way to undermine things. (…) One way of course of undermining human rights is claiming that you've got human rights. We don't have them, in particular – "my right to go to the pub, without a mask without a vaccine. I've got this right. It doesn't matter about your health. I don't believe you've got that right."*
> (South-Wales MP1)

Members of the public in Wales who do not want to comply with the regulations seem to use the arguments for state-based rights for protection against the virus that are underpinned by collective notions for arguments for rights based on individualised notions of protection. The latter seems misplaced in the eyes of this interviewee and others; also because prioritising the rights of the individual over the collective sets a precedent for normalising the individualisation of the pandemic response.

Other changes in the crisis response included new ways to pre-empt different virus variants and vaccine hesitancy to consider where and how vaccine fatigue would occur and in what kind of communities. A senior policymaker explained the following:

> *"So we have the UK health security agency that tracks global trends. (…) So they may look at variants circulating in some of the countries with surveillance mechanisms. Obviously, you'd be sure of countries with advanced surveillance systems. So looking at what was coming over the hill, in terms of variants is really important. I think another thing is social insight work with your populations back home. So that you know that perhaps this vaccine fatigue or perhaps, you know, the antivaxx movement is affecting certain parts of the population more than others. You might find that, you know, parents are actually put off from it. If a parent has become very anti in their stance to vaccination themselves. And, you know, we do see it sometimes with certain groups of people. So certain groups of people who are more anti-establishment. So they made to say that perfectly great educational system, the Steiner Schools, very creative, very artistic, very led by the child. (…) So, mistrust of government and systems and poor experience, maybe as well. And then, you know, you will find that, you know, some communities will have much lower levels of uptake. (…) And they tend to be intelligent people, you know, so they've read a lot, but they can read a lot of misinformation as well. And so what we're worried about as well is whether an anti-vaccine sentiment would spill over into people denying their baby say, diphtheria, tetanus, polio injections."* (Senior health policy makers in the Welsh Government)

Whilst the senior pandemic policymaker did say that they looked for new variants, the advice did not necessarily change accordingly; the 2-meter distance remained at the same reach, even though the Delta variant was clearly more infectious, which would perhaps have warranted 3 meters distance. At the time of the interview, Omicron had not yet emerged. Also, remarkable from the quotation is the concern that this intelligent parent group that did not want the vaccine would also change their mind about other infectious diseases. Elsewhere in the interview she mentions measles having returned to Wales, likely because of these parent groups. As such, they "kept tabs" on these groups to address them specifically if a groups was found to underperform in the stats.

Furthermore, addressing the many unknowns and uncertainties required an ethical view on the situation. A retired top policymaker explained how the different viewpoints of the different ideologies, moral frameworks, and cultural backgrounds that typify Wales were brought together in an ethics panel. She explains the origin and reasons for this governmental ethics advisory panel:

> *"So there wasn't the evidence, the evidence developed, and as it as it came forward, you're able to make better and better clinical decisions. (…) So lots of the clinical stuff got thrashed out by the Chief Medical Officers, either in their discrete group, because they would then advise the Health Ministers directly or in this collaborative group that I was involved in. And then, you know, it would be cascaded within the country. But in Wales, we had some particular concerns about how come more Black, Asian and Minority Ethnic workers were dying? And should we be doing something to protect them, and often, people from that background in society are in lower paid jobs which have higher contact. We were concerned about Do Not Resuscitate orders. (…) So the Minister agreed that we set up a particular panel, it was chaired by one of the doctors within the Welsh Government. And they pulled in experts from outside, so that there was a proper debate. I did not sit on that committee, I've merely sort of was asked questions to feed into it. (…) So you actually had a group of people you could go to, with ethical and moral dilemmas and issues. And it was from their group, that they developed a tool to actually help with the safety of workers. So the evidence, which was showing that if you had certain factors, so if you came from a Black or Asian background, you were overweight, you were male, you're an older age, you had heart disease or something, you can rank it and put a scoring on a chart, and it said, if you got to a certain level, you should not be having close contact with people with COVID, you should actually be moved to a different type of working environment."* (Former lead health policy maker)

The tool this top advisor speaks of was a calculation of a combination of the characteristics of people's bodies (age, disease presence, etc) and their job (working with others present, possibility to keep a distance from others, possibility to work from home, etc). It had thresholds that related to the need to protect workers. As such, this ethical advisory panel was successful in bringing in new connections between the population and clinical information that could be used to differentiate the pandemic responses for different social groups in Welsh society.

Vulnerability in the governmental health crisis management

Vulnerability seemed to be a straightforward categorical concept to determine the differential likelihood of infected people to suffer more severe illness and have a higher chance to be hospitalised or die than the average person. The principles that determined what was understood and operationalised as vulnerability that ended up in the pandemic response policy documents reflect this apparent simplicity. However, the reasoning behind these principles seem to be much more nuanced and intricate as appears from the interviews. An important decision maker on healthcare policy in the Welsh government explained how the pandemic changed the way policies were made to address people differently:

> *"We think of people and then we think pathways don't really think oh, yeah, the cardiovascular groups, and then diabetic people. And we don't really stratify people in other groups. But I think in the pandemic, we started to stratify people for vulnerability, what were their social vulnerabilities? What were their mental health vulnerabilities? What were the physical vulnerabilities? And, and the policy started to be developed in that manner, which was the first time I've seen that sort of emergence of thinking, which is quite a maturation in a system, which I think what I assumed was mature in the sort of national scale thinking before, this was a different type of idea. And what it showed us in the population is that those with social deprivation, those that have the social determinants, that impact with social terms are not as positive and will impact health, people have far more vulnerabilities and those vulnerabilities are not one, they will come in a mass."* (Lead health policy maker)

Clearly, the concept of vulnerability in the way she explained it to be used to guide pandemic responses rooted in biomedical categorisations. However, she argued that different forms of vulnerability, including social vulnerability, became rapidly part of the governmental debates on how to keep the infection, illness, hospital bed occupation, and death rates down. This focus was corroborated by another senior policymaker in the Welsh pandemic response. She explained that she was recruited into the Welsh Government for her specialism in equality matters:

> *"So inequalities was, was something that I was very interested in. Within three months of being in Welsh Government, the pandemic had been announced. (…) The anxiety at the end of December (2019) and by January (2020), we're in it. So I was put fulltime onto supporting the response for the initial wave. (…) In the sort of May-June (2020) time, I felt that, you know, we really needed now to have somebody an advance party, if you like, looking at the vaccinations, making links with foreign nations partners here in the UK. And so I went fully over to the vaccination program in July (2020). (…) And then we basically got together and established a program board with all of the health boards on it. And with a stakeholder group with many of the third sector partners on it, representing groups that would be interested in the vaccinations. And also a kind of the lens of the third sector for homelessness, asylum seekers and refugees, people whose mother tongue was not English, people who had a learning disability, or any disability. So it was a very broad ranging stakeholder group."* (Senior health policy maker)

Her experience remarks on the early active engagements with different marginalised people in Welsh society who were considered vulnerable in the context of the pandemic. A return to social group based thinking around vulnerability does come through in the equity efforts in the vaccination strategy development, which is potentially unavoidable in a representative democracy, such as Wales. Such efforts revolve around the experience in healthcare provision that certain social groups are not addressed in ways that encourage them to take up vaccines, which requires the development of a vaccination strategy that addresses all rather than the dominant social groups efficiently. Examples of such efforts in Wales include information in multiple languages, spoken information on websites, discrete vaccination booths with female staff, and vaccines being offered and administered at the place of work for sex workers in the evening. With time passing, the development of the vaccination equity strategy changed with more social groups being added that had particular issues in accessing the vaccine.

How the measures created new vulnerable groups was monitored via statistics and representative of certain occupations and unions that raised alarms with the Welsh government. A senior pandemic policy advisor gave an example of a new vulnerable group that they addressed with their vaccination strategy:

> *"And the other thing is using community voices, if you have somebody who has died of COVID, you know, amongst the taxi drivers in Merthyr Tydfil, as they did, that you use the other taxi drivers to spread the word through their work colleagues, that the vaccine is safe is effective, you know, because many people were not respecting wearing masks in cars, or these people need to make a living; they can't insist too much, because people will say, 'don't bother, and I'll get the next one, I'll get the next taxi', they're a bit more understanding. People who are drunk might not be taking the best precautions, they may have gone out, even though they're feeling unwell, because it was a party or whatever, they're young; it's not really going to affect them badly. But we did lose taxi drivers in Merthyr Tydfil. And we had representations from the Transport Workers Union; 'could we prioritize them as an occupational group?', but we couldn't prioritize the police or the fire people or anybody, because the age parameter for prioritization had been decided nationally. And that was what we had to stick to."* (Senior health policy maker)

She argues that it was impossible to prioritise occupational groups as they were bound to UK-level regulations set by the Joint Committee on Vaccination and Immunization. Therefore, it seemed like the more cautious approach in Wales that sought to further differentiate its responses amongst particularly vulnerable social groups could not be delivered in the way the Welsh Government wanted to.

Conclusion: lessons learnt

Several lessons can be learnt from the main findings in the previous sections. Firstly, the way the Welsh pandemic response defined vulnerability and was organised around addressing the needs of vulnerable people may have set it up for failure. Employing vulnerability as characteristic of a group of people on the grounds of shared biological potential for the virus to wreak havoc on is problematic without committing to intervene in all social processes that could lead to infection. Following from the interviews, MP1 notes how the precautionary principles were unlikely to work adequately in the government's attempts to separate vulnerable people from the virus:

> *"From the start, it was like 'we haven't got concrete evidence on this'. And they don't take the precautionary principle which is rather dull. It was very self-evident that obviously if you get all the children to school, they're going to be back to the transmitters. And they're going to go home to grandma or whatever and kiss her. Pretty obvious stuff really"* (South Wales MP1)

The lesson from this could entail that treating social groups as bodies with particular characteristics (e.g. age, sex, clinical conditions) decontextualises them and likely left gaps in the pandemic response. In effect, such a focus loses sight of the social processes in which these people are embedded. Therefore, pandemic measures that had a stronger focus on social processes, for instance households mingling over religious celebrations (e.g. Christmas or Eid) complementing body-based rules would have addressed the spread of the virus more thoroughly.

Secondly, whilst the protective pandemic measures that restricted people's possibilities of contact with others were not particularly differentiated between different social groups aside from shielders and non-shielders, other aspects of the pandemic response; in particular the Welsh vaccination programme did. It seems that offering people something new or encourage them to adopt the COVID-19 vaccines as something new in their lives requires the vaccine to be specifically tailored to people's lives. Measures that take away from people's lives, such as testing to travel by boat or plane, picking up one's children in a specific timeslot at the local primary school, or restricted access and freedom of movement in supermarkets more strongly reflect the requirements of the institutions, organisations, and businesses involved. Indeed, these restrictions are much less adapted to social difference and do not reflect people's lives. Fostering a higher level of compliance and a less distressing pandemic experience could have been achieved by explanations and regulations that fits better around people's lives.

Thirdly, a lesson learnt from the arguments presented by people who resisted the pandemic regulations is to take care of the potential for the measures to sound unreasonable from the perspective of individual human rights. Providing explanations for these measures that ensure no human rights are harmed could have accompanied these measures. In addition, powerful explanations of the benefit to human collectives at different scales could have accompanied the measures.

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