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Introduction

This report summarizes and compares key findings from five studies on health and social vulnerabilities and COVID-19 carried out by academic partners in the SONAR-Global consortium throughout 2021³.

In each of the research sites, the partners implemented COVID-19 Vulnerability Assessments (C-VA) following a standardized, “global” data collection and analysis protocol⁴. The C-VA is a tool that aligns qualitative data collection and analysis across diverse study sites and that therefore allows for comparative- and meta-analyses of larger data sets than those commonly found in qualitative social sciences health research. The principles of the C-VA protocol had been developed by University College London (Napier and Volkmann) prior to the commencement of this study and have been piloted and applied in other multi-site contexts (protocols available upon request to main author).

The C-VA protocol encompasses:

Data Collection	<ol style="list-style-type: none"> 1) 52-point demographic data questionnaire 2) Semi-structured interview guide covering aspects of health, wellbeing, and risk relating to infectious diseases/ COVID-19 (key component) 3) Field summary template to quickly summarize assessments and add some ethnographic observations
Data Analysis	<ol style="list-style-type: none"> 1) A “global” code manual with some key codes to support extracting evidence pertinent to the global research question(s)

To ensure calibration of C-VA implementation across sites, the partners met at least weekly for the duration of the study (see Figure 1).

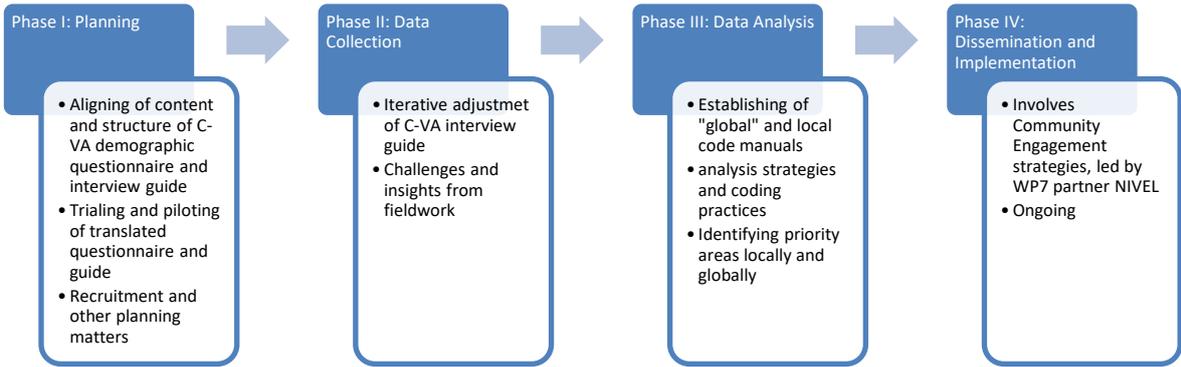


Figure 1 – Key Focus Areas and Coordination Efforts in Partner Meetings for WP7 – C_VA Implementation

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⁴ The SONAR-Global COVID-19 Vulnerability Assessment: a protocol for collecting and analysing qualitative data to understand pandemic dynamics and support just preparedness (forthcoming), Volkmann, Giles-Vernick, Benedikt, Napier.

The country teams translated C-VA materials into respective local languages and dialects relevant to local participant populations⁵, and assessments were then carried out accordingly. Interviews were transcribed, coded, and analyzed by local partners and in ongoing dialogue with the WP7 research group. Key findings have been reported to the EU and constitute the basis of this brief comparative report. The individual reports from those studies can be accessed here: <https://www.sonar-global.eu/vulnerability-assessment/va-reports/>.

Objectives

One of the main goals of the research collaboration between Germany, France, Italy, Malta, and Slovenia was to identify and describe new and existing health and social vulnerabilities particular to the Covid-19 pandemic. We assumed from the beginning that some vulnerabilities would be firmly anchored in country-specific, local contexts, whereas others would be cross-cutting and more universally expressed and experienced.

Because we are interested in shared and divergent insights and learnings from the respective country studies, our objectives for this comparative report are to:

- describe briefly local data collection and analysis processes relevant to contextualizing their respective insights and learnings;
- identify commonalities between research sites in terms of COVID-relevant health and social vulnerabilities and establish cross-cutting themes;
- summarize policy and any other recommendations.

Description of Work

We reviewed the reports made available to us by each research partner (both the brief report submitted to EU as Deliverables 7.2-7.6. and longer reports generated to cover each country study in-depth). We extracted key findings in a first reading; then the first author coded report data according to stated objectives (above) manually and with NVivo⁶.

Main Findings

In this section of our report, we synthesize key findings by our work package partners. For data protection reasons, there are a few cases in which we do not cite the partner in relation to a specific finding but rather make a generalized statement.

Summary of Research Approaches in Partner Sites

As mentioned above, all partner sites (France, Germany, Italy, Malta, and Slovenia) implemented the Vulnerability Assessment protocol developed for WP7. Their shared objectives were to:

- identify local factors that reduce or augment health vulnerabilities;
- develop local case definitions of vulnerability and resilience;
- provide policy recommendations based on local insights;
- and suggest locally meaningful actions and interventions (if applicable, via stakeholder/ community involvement).

Though partners shared a concern with and aligned analysis of all key major themes, minor local variations in priorities steered participant recruitment strategies (see below).

⁵ English, French, German, Italian, Maltese, Persian, Slovenian, Spanish, Turkish, Wolof, Various Local Dialects

⁶ NVivo qualitative data analysis software; QSR International Pty Ltd. Version 12, 2018.

It is notable that across all sites, Covid-19 restrictions made the process of collecting data, especially using qualitative research methods (which favour face-to-face interaction with study participants) very difficult. In the first instance, lockdowns and curfews led to periods during the data collection phase for all partners during which assessments could not be implemented at all, or only implemented remotely via video links or telephone, leading to delays and/or less detailed data than desired. Where it was possible to meet participants in person, hygiene measures frequently meant that establishing a rapport and trust with participants was challenging, and that snowball- and direct recruitment strategies were less successful than in non-pandemic circumstances. On the other hand, there were many instances where participants were relieved to be sharing their stories and experiences, especially after prolonged instances of isolation.

This information is relevant because pandemic conditions had a significant but unavoidable impact on the data collection procedures in each country.

The Study Population in the Five Partner Sites

Participant recruitment using a C-VA protocol stipulates that sampling be iterative and adjustments be made to the data collection tools as the study progressed, to cover a significant variety of demographic features in a given population. In keeping with qualitative investigations, the resulting study population was expected to be heterogeneous and *not* representative of a population as a whole. Recall that primary objectives were to identify cross-cutting factors that shape health and social vulnerabilities and to develop locally meaningful case definitions of vulnerability. To achieve these objectives, the study teams sought to transcend assumed categories of vulnerable populations and to also reach individuals and new social groups whose experiences and circumstances during the COVID-19 pandemic had rendered them at heightened risk to adverse health and social conditions.

Research teams pre-selected populations or individuals with characteristics that plausibly could be associated with health and social vulnerability as starting points for the VA: undocumented migrants and asylum seekers, typically marginalized members of society, those living with chronic disease, for example⁷. As data collection progressed, new definitions and characteristics of vulnerability emerged.

In all sites, there was an effort to sample from both rural and urban areas, based on the widely-evidenced fact that experiences would diverge along a rural-urban divide during Covid-19, as they had in pre-pandemic times.

Importantly, it was not possible to ascertain an exact number of participants across our study sites who had tested positive from COVID-19 and/or were experiencing symptoms; this was largely due to participants not knowing their status as they had more pressing concerns or simply lacked interest, while some were reluctant to disclose it. The same holds true for vaccination status.

⁷ Notably, in Malta the government issued a notice in March 2020 in which the term ‘vulnerable persons’ was legally defined and those deemed to fall under this definition were required to remain segregated in their residence (Baldacchino, Malta).

Table 1 - Overview of Key Demographic Data

	Total Number Participants	Gender			Age Range	Region	
		Female	Male	Non-binary		Urban	Rural
France	154	91	59	4	21-95	111 (Paris)	43 (Vendôme)
Germany	83	45	36	2	19-86	54 (Munich)	29 (Surrounding Area)
Italy	190	99	87	4	18-91	101 (Rome)	89 (Province of Lazio)
Malta	110	59	50	1	20-89	Not applicable	
Slovenia	214	131	81	2	18-91	109 (Ljubljana)	105 (Murska Sobota)
	751	Total Number of Participants					

Key Cross-Cutting Themes

In the process of comparatively evaluating the findings from partner reports, we identified a set of seven cross-cutting themes that are present and relevant in all sites. The themes are interwoven with other, diverse local vulnerability factors – as well as indicators of resilience. It is important to note that in order to synthesize findings for this report we necessarily reduced the nuance and depth found in the work of respective country partners. We, therefore, urge the reader to follow up with those partners for further detail.

Below, we present the cross-cutting themes with an introductory explanation, followed by select partner examples to illustrate the theme, and close each sub-section with a brief reflection on the broader implications.

1. Pre-existing vulnerabilities are exacerbated

The studies confirmed that pre-existing vulnerabilities (e.g., vulnerabilities linked to poverty, chronic illness, social isolation, and so on) were, unsurprisingly, exacerbated in the pandemic across all research sites. Such negative developments were more often than not linked to pandemic control measures, though in some cases they were also due to contracting COVID-19 and being both unwell and socially isolated.

Selected Partner Findings

As in the other sites, researchers in Italy pointed out that the psychological and mental health consequences of Covid-19 are more severe for those already struggling with existing vulnerabilities. The team also highlighted that ‘a greater sense of vulnerability with respect to health is also experienced by chronic patients, both because of the fear of falling ill with COVID and because of the restrictive measures often reduced their access to treatment [...]’. (Vaccarro)

Baldacchino and team (Malta) write that among the 54% of participants that reported living with a chronic illness, and who were considered medically vulnerable, ‘there was a reluctance to approach hospitals to seek care even when this was required’. Thus, fear of infection, promoted by government messaging and communication, led to missed treatment and disease-management opportunities.

Those already socially marginalized but living in institutions (psychiatric hospitals, prisons, asylum homes, residential care homes, etc.) were shouldering the double burden of being at increased risk for infection but also being deprived of important social contacts.

Overall, ‘social support provided to immigrants, the disabled, the elderly, the poor, and families have been severely interrupted’ (Öcek, Germany), but asylum seekers were hit particularly hard: in one research site, persons living in a center were not allowed during lockdown to leave and seek out day-labor jobs, meaning they: a) lost the income they needed to support themselves

in the center; b) felt as if they had been unfairly stigmatized as the source or spreader of contagion, and c) had to endure cramped conditions without outlet relief, meager occupational income, and (mental health) support. Similarly, undocumented migrants were especially affected because they relied on the informal sector for their income. With a halt to all tourist activities, they suffered a catastrophic income loss (Giles-Vernick, France), and the closure of public sites and facilities (such as public toilets and showers) caused severe issues for those relying on them (e.g., the homeless), especially in times of heightened need for access.

Work conditions changed for all participants across the research sites, but the economic impact was, of course, especially hard on those without secure employment and benefits. Social distancing measures meant that informal economies were curbed, if not shut down, and those who relied on access to government resources for housing, food, or other benefits were at times completely cut off and slipped further into poverty. ‘Alongside the new poor, for whom a recovery of their economic and income situation is likely when restrictions come to an end, there was an awareness among the interviewees that the most serious and lasting consequences have affected those [...] who started from weaker positions in the labour market and people with fewer resources, not only economical but also social’ (Vaccarro, Italy).

Conclusion

Together, the studies show that many measures to control the spread of Covid-19 exacerbated vulnerabilities and weakened some existing coping or resilience mechanisms and that the prioritizing of virological and epidemiological knowledge in policy decision-making meant that significant social and psychological impacts were often not sufficiently taken into account in pandemic response planning. At the same time, some valuable pre-existing and pandemic-specific resources remained underutilized (see below, Theme 6).

2. Loss of income, livelihoods, and sense of future

Loss of income and financial instability due to pandemic mitigation measures affected many participants in all of the study sites, though experiences were very diverse within countries. Those who had been living through financial hardship before the pandemic were largely pushed into even worse circumstances (see above), but there were many participants across sites who belonged to the “New Poor” and had not previously faced this level of threat to their livelihoods.

For those that were not in paid employment at the time (students, seniors, those living in institutions), the pandemic had a particularly harsh impact on the perceived loss of future opportunities and potential prosperity, in addition to acute financial hardship. Importantly, classifications by governments of certain work as ‘essential’ (and others as ‘not essential’) contributed to participants’ sense of disillusionment with those in charge and a sense of being devalued and forgotten.

Selected Partner Findings

Findings were generally similar across the research sites. On average, about half of the participants described declines in, or even the complete absences of, regular income due to pandemic measures – often paired with a negative outlook towards the future. In Italy, for example, where 48 % of those assessed experienced a decline in income, almost all of those (43%) believed that their livelihoods would not return to pre-pandemic levels. (Vaccarro, Italy)

In the short term, there were some reports of acute lack of funding to pay for essential medicines and health care services, and the price of medical consultations and treatments could be prohibitively high for those without good medical insurance. Those who found themselves out of work due to pandemic restrictions and without employer-based healthcare were struggling, and access to mental health care was often noted as particularly troublesome. Despite pressing need, ‘several participants explained that they had to stop, reduce, or could not initiate

psychological consultations because of high treatment costs of private practitioners and long waiting lists for public ones’ (Giles-Vernick, France).

In some instances, ‘the few participants that had contracted COVID and experienced long-lasting effects reported the symptoms interfering with their work and even requiring prolonged absences’. (Lipovec Cebon, Slovenia). At the time of data collection, few participants had been recipients of formal support by local or national governments (see below, ‘Access to Care and Support’).

Conclusion

Although countries provided some assistance during the pandemic, wide-ranging population groups nonetheless had to confront declining income losses, which were compounded by losses of health care and other social benefits provided by employers. We have serious concerns about the long-term consequences of reduced incomes due to pandemic measures, especially in combination with the lack of physical activity and rise in mental health concerns during lockdowns/ We urge both national and European authorities to remain attentive to the broader health implications for whole generations of citizens.

3. Age matters

Data across sites also confirms that both young and older people were more affected by pandemic restrictions and by fears of contracting the virus - especially those living alone - than those in middle-age. Students⁸ in particular ‘experienced serious social isolation, often losing a sense of purpose to their studies’ (Giles-Vernick, France). There are likely to be significant, lasting effects on this cohort, which could, in turn, also generate further health and economic vulnerabilities.

Notably, public health messaging to protect the elderly caused worries and anxieties both in the elderly and in younger generations related to or caring for them. The focus of defining those of advanced age as “medically vulnerable” (though factually, of course, true) ignored or lessened the impact of isolation on the younger generations, who were caught between stressful experiences of social isolation and anxieties about their parents, grandparents, and other family members at risk. In many cases, guidelines about contact with potentially vulnerable elderly relatives left many interviewees feeling quite guilty about neglecting family members who depended on them in normal times.

Selected Partner Findings

Vaccarro and team (Italy) stress that ‘the possible future consequences [of the pandemic] in the relationship between generations’ are worrying – as are the ‘possibly negative effects on the future developments of the youngest—victims of the drastic cut in peer relationships, who have not been able to experience some important stages of their growth’. (ibid)

All country reports correlated greater feelings of isolation with worsening mental health conditions⁹, while at the same time living with others, who were often at home during lockdowns and extended periods thereafter, presented other mental health challenges: for example, the fear of transmitting the virus to a vulnerable family member was often greater than the fear of infection itself.

⁸ Children and young adults under the age of 18 were not included in the studies

⁹ However, it is important to note that there were some individuals – particularly but not only those some with pre-existing conditions related to social anxieties and agoraphobic tendencies - that also thrived under the enforced social isolation.

Immediate worries about social isolation and/or potential endangerment of loved ones were further exacerbated in the student population, where ‘uncertainty about in-person classes [...] and ruptures in training can have potentially longer-term consequences on the economic, social, and broader health of this generation.’ (Giles-Vernick, France)

Conclusion

The situation of an entire generation of young adults indicates that governments must pay urgent attention to the needs of those who are not necessarily biologically vulnerable but whose mental health appears now acutely under threat. Offering targeted support to assist young adults in developing or regaining a sense of purpose in their preparations for the future, and possibly substantial mental health intervention programming would be crucial. Making such opportunities open to international students, who often do not enjoy the same rights to support, should also be a priority.

4. Stigmatization, gender, and violence

Stigmatization of certain groups took on new forms during the pandemic, according to study participants across the board. Echoing worrying reports of increased gender-based violence in public discourse during the height of the pandemic, the studies showed that prejudice and discrimination reared their ugly heads quickly in the stressful dynamics created by the pandemic and associated mitigation measures.

Participants described both COVID-related stigmatization and discrimination (e.g., for having contracted the disease, being legally labeled as vulnerable, or, in some circles, being pro- or anti-vaccine, respectively) as well as a noticeable and ongoing increase in violence against traditionally marginalized groups, especially during acute phases of the pandemic.

Selected Partner Findings

‘The German LGBTQ+ community experienced more discrimination, racism, and stigmatization than ever in recent history’, Öcek and team (Germany) noted that historically marginalized people were targeted to a greater degree than before the pandemic.

At the same time, study participants in Malta reported that ‘they felt stigmatized due to being labeled legally ‘vulnerable’ because of mental health conditions, certain chronic illnesses, and disabilities’ (Baldacchino). Health care workers caring for COVID-19 patients could also experience stigmatization, especially in the first year of the pandemic (Giles-Vernick, France).

Frequently, people expressed more prejudice towards ‘foreigners’ who were considered the vectors of the virus (see above, section 1), and levels of xenophobia were demonstrably elevated in many – though not all – research sites. Pandemic migration dynamics—particularly in-country, urban-to-rural migration—led to tensions between local populations and newcomers, especially where resources were already considered to be scarce. Indeed, as Giles-Vernick (France) points out, participants mentioned an absence of solidarity in both urban and rural communities, with those recently having moved finding themselves isolated and without the social networks they had expected.

However, discrimination could, as it does so often, also take on the form of inaction: the lack of targeted efforts to include exactly those populations that needed additional support in staying healthy and well throughout the pandemic was strongly pointed out in all settings: ‘many participants found it very hard or impossible to respect the Covid-19 control measures, as they did not have the ability to do so (e.g., social distancing and staying at home for the homeless or those residing in residential institutions and crowded housing).’ (Lipovec Cebon, Slovenia)

Furthermore, an ‘opacity of administrative procedures’ (Giles-Vernick, France) excluded many who were not already well-versed in negotiating with government institutions and programs

from obtaining the support and aid that they were rightly entitled to, and the requirement for digital literacy and access to technology barred a significant proportion of participants from securing help (see below, ‘Access to Care and Support’). The fact that crucial ‘information around COVID-19 was not tailored to individuals’ different language capacities, learning styles, and living conditions increased the risk of infection’ (Öcek, Germany) for certain populations—in particular, refugees, migrants, and those with learning disabilities.

Lastly, Lipovec Cebon and her team (Slovenia) also emphasized that female participants ‘described a reimposition of traditional gender roles due to long periods of working from home’ and thus faced a double-burden imposed on them during extended pandemic mitigation measures.

Conclusion

Stigmatization and discrimination took on both overt and covert forms during the pandemic, further marginalizing certain social and occupational groups and plausibly contributing to worsening both mental and physical health. It goes without saying that the data provided by participants around overt and active discrimination, stigmatization, and even abuse is particularly disturbing and must be addressed comprehensively and urgently at both local and country levels. However, we would also like to highlight in particular the corrosive effect of covert discrimination, as described briefly above; apart from the human suffering it demonstrably causes, such discrimination renders population-wide pandemic control measures and long-term public health planning less effective. National and European strategies around improving health and social equity must be advanced.

5. Trust

Both the loss of trust and increase in mistrust in official organizations, national governments, certain healthcare providers, and the media had consequences for adherence to public hygiene and pandemic mitigation measures and vaccine uptake. By now, these are well documented and also widely evidenced in our data.

Breathless, continuous reporting of pandemic updates by the media—often with contradictory data (some participants themselves invoked the term *infodemic*)—led to many feeling overwhelmed and unable to differentiate relevant and useful news from ‘noise’. Anxiety, feelings of helplessness, and mistrust in news reports resulted. Importantly, this mistrust spilled over into other areas of life, often exacerbated by pre-existing negative experiences with government institutions and/or the health care system as a whole. In some study sites, simmering mistrust was further fueled by politically volatile situations and a ‘widespread public belief that the government was exploiting the pandemic to introduce undemocratic forms of government’ (Lipovec Cebon, Slovenia).

Selected Partner Findings

Incoherent communication, and seemingly arbitrary public health and restriction measures exacerbated mistrust in national governments (noticeably more so than local ones). Vaccaro and team (Italy) stated that in their study population, a ‘widespread distrust of institutions, combined with information problems and the communication about the pandemic, which was considered contradictory, confusing, and counterproductive, played an important role [in creating health vulnerabilities]’.

Specifically, problematic encounters with the health care system that pre-dated the pandemic had primed many to lower their expectations of conventional medical care providers. Criticism of individual health practitioners was quickly amplified and translated into a general sense of mistrust of conventional biomedical practices, especially for participants who were living with emerging or contested diagnoses or conditions that could not readily be identified. Here, ‘the

consequence was that these patients conducted “their own research” online to identify alternative explanations and treatments for their health problems’ (Giles-Vernick, France), and such (historically successful) strategies were then continued through the confusions of the pandemic.

Alongside increased mistrust in biomedical care, the promotion of alternative remedies and treatments through social media was considered more successful by many. In some instances, ‘people prioritized individual responsibility for health, based on ideas of ‘willpower’, ‘goal setting’, ‘positive outlook’. Notions of health in this regard focused on physical exercise and dietary habits, but people recognized that these were also limited by economic factors’ (Baldacchino, Italy).

Conclusion

The long-term consequences of this loss of trust and increase in mistrust are serious and must be addressed. The research partners’ findings help to explain current mistrust among some social groups of state public health measures, including COVID-19 vaccination and related communications, but they also signal a longer-term mistrust in vaccines generally. There will be future effects of increased mistrust in vaccines that can be attributed both to the ways in which online data sourcing and social media discourse often polarize populations and due to ill-fated modes of public health communication during the pandemic. For many, the excessive profits made by vaccine producers (whose work on vaccine development was in most instances publicly funded) have further fueled their mistrust.

Indeed, our data indicate that serious if not critical damage has been inflicted on trust in public health institutions as a result of the pandemic, and policymakers who ignore or play down public mistrust are jeopardizing not only the prospects of achieving a fair and ‘just recovery’, but also of developing a more ‘just preparedness’ for future public health emergencies. In the coming years, the Health Emergency Preparedness and Response Authority (HERA) could facilitate significant efforts to address *infodemics* and to rebuild trust in the EU and member state authorities.

6. Access to care and support

Across all five countries, although aid and assistance were available from multiple state, municipal, and nongovernmental sources, access could be stymied by multiple factors. Some of these factors have already been described above. But, in terms of access to care and support, the main barriers can be divided into: a) a lack of knowledge about existing resources and/ or how to access them; b) an inability to access resources due to non-eligibility or for technical reasons; c) a sense of not really needing the resources and support, or not being entitled to them; and d) an unwillingness to access resources for fear of stigmatization.

Selected Partner Findings

Many participants stated that they either did not know about assistance programs or did not use them. Baldacchino and colleagues (Italy) found that ‘during the pandemic, the primary source of support that people were aware of was the COVID-19 Helpline and the Free Swabbing Services, notwithstanding that various other initiatives, including at the local level, were available.’

Interviewees also found it challenging to ask for help, at times contending that they did not merit assistance: ‘difficulty asking for help constituted a type of cultural vulnerability, which also constituted a health vulnerability. This difficulty was reflected in some participants’ convictions that they “did not have the right” to request help, that they were not suffering “enough” or came from too privileged a background (notably young women coping with domestic violence or students).’ (Giles-Vernick, France). Thus, pandemic response

programming neglected to address anxieties and other mental health challenges in communicating the reasons and eligibility criteria of certain population groups for assistance.

Further, a plethora of structural problems increased barriers, such as the aforementioned lack of public and emergency housing in France and Germany. To reiterate, researchers had also identified expensive mental health care and the opacity of administrative procedures as barriers to care, while many critical public spaces (healthcare facilities, testing centres, not to mention important cultural institutions) were closed due to the pandemic (see above). ‘Accessing healthcare institutions was very difficult in the case of most non-urgent conditions’ (Lipovec Cebren, Slovenia), and implementation of telehealth efforts was largely non-inclusive and not deemed successful by participants.

Conclusion

Several measures to remedy these barriers could be considered. Clearer and better-publicized explanations of the sources of and reasons for available aid and assistance should be developed, in addition to the need to simplify access procedures, so as to reduce stigmatization for seeking such assistance. In addition, although the European Union has recognized the existence of and funded initiatives to address medical deserts in EU countries, the pandemic has exacerbated these uneven conditions and inequalities. Pandemic response and post-pandemic recovery will heighten the need for action.

7. Institutions and their responsibilities

For beneficiaries and personnel in pedagogical institutions (including universities), as well as users and residents of hospitals, nursing homes, asylum facilities, emergency housing, prisons, and so forth, the pandemic undoubtedly exacerbated health and social vulnerabilities. We have already described the double-burdens of being both at risk for contracting COVID-19, of being isolated and anxious, and of feeling ill-informed.

However, we also found that many of those in the care of institutions had significant difficulties or were even entirely unable to adhere to locally imposed pandemic measures. ‘As preventative and containment procedures were often planned without consulting of key stakeholders in a particular sector or impacting a particular social group, they were in practice impossible to follow and had to be subsequently changed and amended’ (Lipovec Cebren, Slovenia). Thus, the experience of one or several of such negative incidents early on in the pandemic left study participants frustrated and mistrustful and with a sense of being powerless and unable – or unwilling - to comply.

Selected Partner Findings

Those living in institutions shouldered a double-burden of increased risk for COVID-19 infection and of social isolation. Nursing homes left many residents without much-needed social contact, patients ill-informed, and staff overwhelmed with providing additional support for the health and emotional needs of these residents. ‘Institutions, tasked with assisting people, put severe constraints on their agency (the capacity to make their actions felt in their worlds) during the pandemic and as a result, exacerbated their sense of isolation, incertitude, and powerlessness in the short term and may be contributing to reducing their wellbeing and overall health in the long term.’ (Giles-Vernick, France)

In one research site, where there had been a history of ill-treatment of people living with disabilities, residents in a care home voiced the fear that pandemic restrictions were designed to further marginalize them from society, and that they would be targeted for forced sterilizations through medical procedures and vaccines under the guise of pandemic measures. Such fears were elevated by casual (and, in all likelihood, not ill-intended) remarks by staff who were skeptical of vaccines and government-mandated measures.

A lack of coherence in planning and coordination, understandable in the early days of the outbreak, left institutions struggling and impacted both staff and residents for the duration of the pandemic: ‘the institutions responded to the fear of infections spreading in two totally opposing strategies: either locking the residents in and closing of all outside contacts, or a mass ad-hoc (unplanned) release of residents and inmates from institutions (prisons, detention centers, hospitals) without providing support.’ (Lipovec Cebon, Slovenia). Such actions put a considerable strain not only on those immediately affected, such as residents and staff, but also undermined effective community responses and public health measures at a broad scale.

Conclusion

Europe’s population is aging, and the provision of care for the health and wellbeing of its elderly will remain a long-term concern in pandemic and non-pandemic times. Other forms of institutionalized care, whether short, mid-, or long-term have been shaped considerably by the experiences of the past two years, and adjustments for better communication, planning, and preparedness will need to be made.

As more evidence is gathered across countries about the high COVID-19 burden borne by users of public and private institutions, more work will be required by governments, health policymakers, and the private sector to restore trust of vulnerable groups whose faith in the very institutions they depend on may now be seriously challenged.

Synthesis of Country Policy Recommendations

Many country-specific, cross-sectoral recommendations result from the research. We synthesize these recommendations as follows:

- Promote use and availability of existing aid and support structures in communities
 - by ensuring better public understanding of what is available, where services may be accessed, and by whom;
 - by reducing doubts, fears, and stigma; and
 - by being more mindful of the distinction between equality and equity.
- Promote inclusivity, resilience and coherence within and across communities through support for social and cultural activities and economic investments in under-served neighbourhoods (particularly in rural areas which some participants described as a ‘healthcare desert’).
- Provide adequate housing that enables individuals to live in dignity and to follow social distancing rules when implemented. This holds true especially for populations that were de-institutionalised during the pandemic in an effort to ease the burden on prisons, social housing, or other state institutions.
- Develop a robust crisis mitigation plan that makes mental health support a key component.
- Develop coherent and transparent planning of control measures that ensure consultation with critical stakeholders across diverse sectors.
- Move beyond an oversimplified view of ‘vulnerable groups’ based on either pre-existing biological risk factors or stereotypical socio-economic, cultural, or demographic features. Our SoNAR-Global WP7 research shows clearly that both vulnerability and resilience have temporal aspects that are much determined by the fluid social and cultural contexts within which people live.

Summary and Concluding Remarks

This report of the C-VA findings in five European countries has sought to balance the specific and changing nature of the diverse populations and pandemic response initiatives in each site with reporting insights that all study sites share. The qualitative approach of the C-VA has enabled us to identify, in ways that quantitative approaches cannot, the complex processes by which situational and spatial factors create, compound, and augment (or indeed reduce) vulnerabilities in the individuals that participated in the studies.

Our point of departure has always been that health and social vulnerabilities depend on the context in which they emerge; they are neither fixed in time nor rigidly linked to certain demographic characteristics or population groups. While living in poverty and lacking access to resources for example, is clearly and undeniably linked to disadvantage and worse health outcomes throughout the life course, the pandemic has required us to consider other forms of vulnerabilities. Isolation and loneliness, or a loss of trust and increased mistrust, for example, are factors that must be more readily integrated into policy and academic narratives about health and social vulnerabilities.

Although it remains important to distinguish the consequences of COVID-19 disease from the effects of pandemic control measures, much of the research focus across these five European country sites addressed restrictions and mitigation measures intended to reduce transmission.

The lockdowns, mobility restrictions, closures, and social distancing measures have exacerbated a sense of incertitude and powerlessness among participants in all countries in the short term. Although aid and assistance from multiple sources were available, albeit unevenly across the sites, knowledge, structural, and cultural barriers impeded access to help that certain individuals and social groups needed and were entitled to.

Delaying and impeding access to health care and assistance that could enable recipients to lead healthier lives and to enjoy better social integration appears to have had consequences for those whose health and social vulnerabilities were already significant, as well as for those who have been newly made affected by these measures. Unfortunately, informal forms of social solidarity were stymied by pandemic restrictions in times when they could have proven essential.

However, we would insist that we cannot attribute all of these consequences exclusively to pandemic measures. Pre-pandemic relations between European publics, certain social/occupational groups and state institutions, medical professions, the media, and diverse organizations are crucial for understanding cumulative, longer-term erosion of trust and vulnerabilization mechanisms that were already in place before the pandemic.

SoNAR-Global C-VA partners will move forward by continuing to collaborate within the network and by working closely with key stakeholders, authorities, civil society organizations, and beneficiaries of aid and assistance to develop effective policy responses at both national and local levels. This work will continue through the end of the project, but continued multi-sectoral, multi-scalar community engagement will be essential, not only for long-term recovery from this pandemic but also for 'just preparedness' for future ones.

The European Union can also lead the way in modeling a more integrated approach to health and wellbeing among European member states. Such an integrated approach would not only focus on health but incorporate social, cultural, psychological, economic, and environmental programs that would assist Europe and its member countries to meet future public health challenges more effectively.

Facilitating exchanges within Europe and other parts of the world that already have deep experience and expertise in managing epidemic diseases will assist member countries in developing more effective and adaptive epidemic preparedness and response initiatives.