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Social Considerations in the COVID19 Emergency in Italy

Dr Luisa Enria (University of Bath)
Dr Serena Masino (University of Westminster)

1. Introduction

On the 20th of February, a 38-year old man from Codogno, a small town in the Lombardia region of Italy, was the first in the country to officially test positive for COVID19. In the weeks that followed, the country's epidemic has grown exponentially, recording the highest European number of cases and the highest numbers of deaths after China. On the 16th of March 2020, recorded cases reached 27,980 and 2,158 deaths. On the 8th of March the Italian government began introducing a series of emergency measures, initially locking down a number of particularly affected "red zones" in the Northern regions. The 'lockdown' was then quickly extended to the rest of Italy, putting in place restrictions on movement between '*comuni*', that is local municipal areas, and encouraging people to stay home. On the 11th of March a further decree required the closure until at least the 25th of March of all restaurants, bars and all shops excluding groceries and pharmacies. Punitive measures in the form of fines or potential jail terms up to three months are in place to regulate violation of the decrees. While some have defined such measures as draconian, the Italian government has deemed them necessary to halt the spread of an epidemic, which is rapidly depleting the national health system's capacity.

It is increasingly recognised that, when organising outbreak responses, there is a need to also take into account the social, political and economic dimensions of epidemics (Bardosh et al. 2019; Abramowitz 2017; Sams and Desclaux 2017). This includes an understanding of how socio-cultural dynamics affect transmission, the circulation of information, and the ability to put in place effective responses. Such dynamics differ across social and geographical contexts because social practices, political economies and historical trajectories have significant effects on different countries and communities' experiences.

In this briefing, we use personal stories and testimonies that we are collecting across the country as a starting point to highlight particular social, economic and political factors that we deem relevant for understanding the on-going COVID19 outbreak in Italy. This is with a view to identifying challenges and opportunities that should be taken into consideration by national and international response interventions. We complemented these with media monitoring and background research. The framing is based on cumulative social science evidence from previous epidemics across the world, and the authors' experience working in and studying emergencies like the West African Ebola response.

The briefing has three aims:

- To bear witness to the situation in Italy and individual experiences, keeping a record of how the epidemic and associated responses are affecting the health system; social, economic, and political relations; as well as individual lives.
- To support an understanding of the current situation that takes into account Italy's particular socio-political context.

- To identify recommendations for interventions aimed at responding to the outbreak and to mitigate its social costs.

This document will continue to be updated as we receive further testimonies and as the emergency develops. We hope that Italy's experience will also provide lessons for outbreak response efforts in other countries around the world.

Summary of Main Points

- The Italian health-care system is rapidly becoming overwhelmed and whilst the focus has been on the North, migration to the South following the announcement of a lockdown has brought the outbreak to regions with less well-resourced health systems
- Health-care workers (HCWs) across the country are over stretched, lack essential equipment, ICU beds and face increasingly critical shortages of protective masks. There is widespread concern regarding staff shortages as key personnel gets ill or enters quarantine
- At-risk groups do not only include those with pre-existing health conditions and the elderly. For example, people living in low-income neighbourhoods, those in overcrowded migrant centres, prisons, and in abusive relationships face specific challenges in relation to the outbreak and its response, for example due to the obstacles to and implications of self-isolation.
- The Italian government has passed significant economic measures to support workers during the emergency, including extraordinary efforts to support precarious workers and freelancers. Factory workers, migrant and irregular workers however continue to face particular risk.
- E-learning options have allowed for education to continue, but there are challenges in the availability of material and the inclusion of marginalised children (e.g. migrants)
- Health-care workers, as well as many citizens in isolation and those who already experienced less extreme forms of isolation prior to the outbreak, are reporting serious mental health challenges. These will likely have serious long-term consequences.
- Latent social conflicts have in some cases resulted in violence, for example in recent prison riots, attacks on migrants and foreigners, and sporadic attacks in some A&E units.
- Communication has at times been confusing and contradictory, especially at the start of the epidemic, damaging trust in the response in a context where trust in institutions is already low.
- Strong community-led mobilisation and government efforts have been significant in strengthening national solidarity and cohesion.

Key Recommendations

1. Develop coherent and coordinated communication and targeted community engagement strategies.
2. Expand understanding of who is "at risk" and develop specific guidance for all vulnerable groups, including alternative self-isolation options.
3. Continue developing support for different categories of workers, including considerations for those in the informal economy.
4. Deliver psycho-social support to those in self-isolation, in at-risk groups, and for health-care workers.
5. Consider deploying regional or municipal task forces with several pillars to include a wider range of competences.
6. Continue monitoring changing socio-economic dimensions of the outbreak.
7. Lobby for international coordination of political response and relief activities.

2. Effects of COVID-19 on the Health System

21. Regional Considerations

The rapid onset of the Novel Coronavirus (COVID19) epidemic in Italy followed a delay in recognising and detecting the spread of the virus in January 2020. This allowed the contagion to progress unchecked for weeks and to grow exponentially in the Lombardia region of Italy. As work-related movements are frequent, the disease was quick to spread to all other regions too within a matter of weeks.

However, while Lombardia, and more in general the North of Italy, has a well-resourced health system and one among the best in the world, the same cannot be said of the rest of the country. Italy has in fact for decades experienced divided dual-speed growth with the industrialised high-income areas in the North scoring far ahead in terms of living conditions than the impoverished South. Migration from southern to northern regions also adds to the drain of human capital.

Against this background, the potential for sustained contagion in the rest of the country is particularly worrying, given that even the well-resourced Lombardia health system is buckling under the pressure of exponentially growing new cases needing hospitalisation and in particular admission to intensive care units (ICUs). Yet, to date, most of the media attention has focused on northern Italy – understandably as that is where the bulk of cases and deaths has been recorded. However, concerns about the spread of COVID19 to less well-resourced parts of Italy have increased following the initial announcement on 8th of March to enforce a lock-down in Lombardia and some surrounding areas. This prompted the controversial decision by scores of residents to board trains and buses, literally overnight, to leave the areas, directed towards the South. These are mostly people from the South, who live, study and work in the North. Not surprisingly, many of them had knowingly or unknowingly been infected at the time of travelling, which translated into higher numbers of cases in the Southern regions targeted by the reverse migration influx. As a family doctor from Naples, in Campania region, explained:

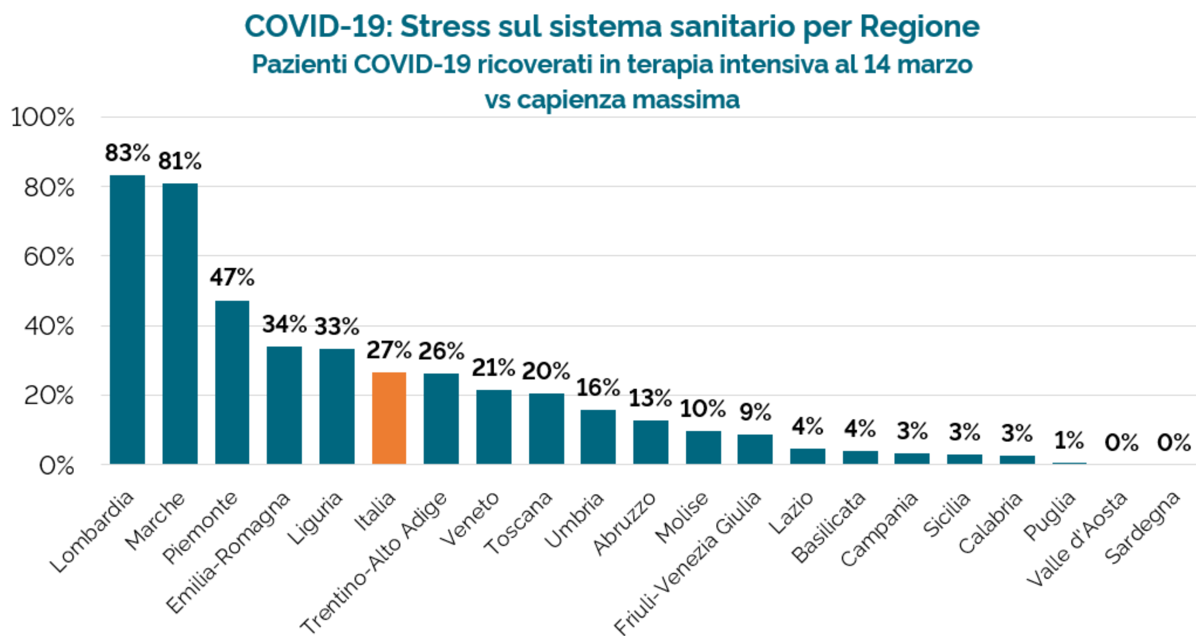
> "we saw a spike of new cases in correspondence with the descent of these 'barbarians'. I have not had cases to refer myself, but from the Whatsapp group chat of all doctors in my district, I could see that many were reporting new suspected cases of people who had recently returned from up North. Not all could be traced and quarantined as some hid themselves, they did not want to comply with mandatory quarantine measures. For example, once a man from Reggio Emilia came to my practice asking for advice; my secretary who received him asked him to wait in the waiting area as he had to inform me of the visit. By the time, I went out to meet him, he had left without warning. It is clear that if he was presenting symptoms, he went on to infect others".

Other regions in Italy also recorded increases in case associated with returnees from the North. Currently the incubation period of COVID19 is thought to be up to 14 days (WHO 2020), so the full scale of such reverse migration impact should soon be clear. Local institutions fear that over the following weeks, cases could rapidly multiply.

Under-resourced hospitals and Health-Care Workers

The infection from Covid-19 has relatively long recovery times, currently estimated to be between 15 and 20 days on average. This means that beds are not freeing up at pace with new severe case numbers. When summing private and public capacity for intensive care therapy, Lombardia has over 600 spaces, which have rapidly almost filled up entirely as of mid-March 2020. Other regions in Italy have only a fraction of those spaces, particularly in the South of the country. In spite of the recent efforts to convert facilities and expand ICUs capacity, the risk is that, if the spread of the disease reaches similar proportions, entire regions will be completely unable to provide ventilation, resuscitation, and on-going care for critical COVID19 patients, so the health crisis could rapidly aggravate. Such possibility is all but remote considering a number of concomitant risk factors, and indeed it has already given rise to controversies around the eventual necessity of triage to prioritise intensive care for younger patients or those more likely to recover from the disease. According to a number of reports, such difficult decisions already had to be implemented in the most affected areas of the North.

Analysis from Matteo Villa of ISPI (Istituto per gli Studi di Politica Internazionale), using Civil Protection data, in the graph below shows the current ratio of COVID19 patients in ICUs against maximum capacity as of the 14th of March. It is clear that the Lombardia and Marche regions are already close to collapse.



A coroner from Lombardia pointed to the fact that the suspension of funerals as part of the ordinances has meant that morgues are struggling. Autopsies have been reduced to twice a week in the Milan area for lack of equipment such as gloves and coats. In the province of Bergamo, a particularly affected area, the recent death of a mayor was accompanied by the distressing news that burials in Val Seriana were happening “every half hour”.

Another risk factor is associated with the availability of health-care workers and their protection. Alarmingly, we have received reports of scarcity, or outright lack, of protective equipment for the first tier of health-care workers, that is family doctors, in under-resourced Southern regions. As family doctors are considered self-employed professionals, there has been a delay, or some say unwillingness, to step up the provision of personal protective equipment such as goggles, face masks, and gloves. Unfortunately, supplies in shops and pharmacies very rapidly depleted, which means that family doctors have been carrying out their duties for weeks now, without any adequate protection. Their concerns have heightened following growing evidence of asymptomatic transmission, especially as most health-care workers were initially only encouraged to wear a mask when coming in contact with symptomatic patients.

While a system of telephone-based triage was rapidly phased in, it took time before visits to practices diminished. In the words of a family doctor in Naples:

"I had to scare them to convince them to stop coming to the practice in person. But it is important that I protect myself too as we have been given nothing by the regional government. And when you try and purchase masks and gloves yourself, it also is impossible because stock has virtually run out everywhere. I am lucky to have received two surgical masks, mind you not even the proper type, from a pharmacy where my patients normally go for their prescriptions; but that is just because the pharmacy wanted to show me solidarity and appreciation as I provide their clients".

Another family doctor from Reggio Calabria also explained:

"We have received an official communication yesterday *(10th March)*, telling us to go and collect our protective equipment, but up to now we have had to work without; even though I had some myself as I also work in hospitals. But it really does depend on individual doctors."

On the 16th of March, doctors in Naples and Reggio Calabria alerted us of critical shortages on protective masks, as they expected their supply to finish within two days with no clarity on when they would be able to access more.

Even for hospitals, where equipment was made more readily available, issues with staff numbers are increasingly arising. Nurses and doctors are working long shifts, abandoning their annual leave, and even then shortages are common. In addition, unprotected contacts with infected patients can lead to further shortages as personnel need to enter a quarantine period. In relation to this, controversy was sparked by the government's decision on the 9th of March, which asked all health-care staff to resume their duties immediately if they did not display symptoms, even if they had had contacts with potentially infected patients. The decree that mandated such new duties was meant to stem the loss of further precious personnel resources. At the same time, this created protests among family and hospital doctors and nurses given that it has the potential to fuel contagion even further; leaving aside the risk it creates to health-care personnel who are constantly exposed to infectious patients. To date, dozens of health-care staff have been infected and unfortunately various deaths have also been reported. In addition, asymptomatic health-care staff can transmit the disease to patients they come into contact with, risking to rapidly transforming hospitals into clusters of nosocomial transmission. In this respect, the WHO has recently changed its guidelines to encourage countries to step up its testing efforts in an attempt to stem transmission by targeting asymptomatic cases. In addition, several petitions are circulating in a number of

European countries, such as Italy and the UK, to request that all health-care staff is tested regardless of their symptoms.

It is, therefore, clear that shortages of both personnel, protective equipment, intensive care infrastructure, and testing kits and resources are major obstacles at the moment and that the response to the crisis could be severely affected by them.

Co-morbidity and Effect on non-COVID Health Services

Outbreaks inevitably have both direct and indirect effects on uptake and availability of other health services, with case counts often obscuring the broader effects on those suffering from other diseases. Regions across Italy have been suspending all non-urgent hospital admissions, only guaranteeing the service of haemato-oncologic patients and other cardiac emergencies. All planned procedures and A&E clinics of non-urgent nature have been suspended to free up resources for the COVID19 emergency. Other sectors, including psychiatry departments for example, have suffered significant repercussions. In the worst hit regions, many departments were converted to COVID units and follow-up appointments with psychiatric patients had to be reduced or moved online.

Another main concern beyond the epidemic of COVID19 *per se* is co-morbidity. Italy has an ageing population, indeed 22% of the population are over 65. This makes the threat from co-morbidities particularly serious for a number of reasons. Firstly, elderly patients and those with pre-existing respiratory or cardiac conditions, or chronic conditions such as diabetes, are at higher risk of developing complications from the virus; we know that such conditions are relatively more present among the elderly population. In addition, more generally, an elderly population presents more medical conditions on all fronts. The elderly are therefore more likely to suffer both directly and indirectly from the epidemic. But younger individuals may also suffer if bed capacity gets filled up so quickly that those suffering serious respiratory complications from COVID19 infection are unable to access emergency treatment in ICUs.

An additional element to consider is that medical conditions, especially those of chronic nature, may be more prevalent among the low-income sections of the population given their impaired or diminished access to adequate health. This, combined with the living and working conditions that do not allow for effective social distancing, as described below, make this part of the population particularly vulnerable. Additional resources and layouts are urgently needed to provide safety nets to all these vulnerable sections of the population, to avoid catastrophic short and long-term impacts.

Poverty and Living conditions

As mentioned in the previous section, there are particular segments of the population that are especially vulnerable and require particular attention. A story from Naples is particularly indicative. On 8th March, Luca Franzese – an actor in the internationally acclaimed TV Series Gomorrah -took to the media to report his 47-year-old epileptic sister's death as a consequence of Covid-19 infection. A video circulated widely on social media showing Teresa's body abandoned in their family house for over 24 hours awaiting confirmation of a Coronavirus diagnosis. Teresa Franzese reportedly caught the disease from a friend and neighbour who lived with family members also suffering from the disease. No one had

received a formal diagnosis up until the unexpected death of the 47-year-old woman, nor had they sought one prior to that; in spite of a relentless media campaign to sensitise people.

Living conditions in the area of Naples where Teresa lived with her family make it almost impossible for social distancing and containment measures mandated by central and regional governments to work. Eight members of Luca and Teresa's family were in the house while the woman's body awaited collection by a specialised team. The whole area is host to mostly low-income households and has very high population density levels, with the poorest often co-habiting in a one-room open space. Up to eight people can be found living in such basement or ground floor dwellings, known as "bassi". In these places, self-isolation is simply not possible.

A similar concern is being raised in relation to migrant centres. Italy has a significant migrant population and the social tensions around migration have been well documented. When migrants first arrive to Italy there are a number of different centres that they can go through: starting at first aid centres then moving to centres where they can apply for asylum and in some cases in detention centres. The centres can be overcrowded, for example volunteers with experience in Rome's "*centri di accoglienza*" (migrant centres) told us that there are up to six people to a room and in some cases migrants are not allowed to cook their own food, waiting for it to be shipped in. This could be particularly problematic if those channels are cut off and in the event of a need to put people in individual or collective quarantine. This is already no longer a hypothetical concern, as on the 16th March the first COVID19 case was recorded in a migrant centre in Milan. Prisons, furthermore, are known to be at high risk of contagion, and as discussed below this has resulted in tensions and escalated to riots in some of the country's prisons.

4. Work, Education and The Economy

The effects of COVID19 on the global economy and on the Italian economy in particular are inevitably significant, but the full effects cannot yet be estimated. On the 6th of March, Moody's revised its predictions for growth in the coming year to -0.5% or -0.7% in case of a longer impact of the COVID19 emergency (ANSA 2020).

There are on-going debates about whether productive activities can go on during this kind of emergency, with the government encouraging factories not to close down but to ensure the health of their workers. The CEO of Leonardo, the country's top manufacturing firm in the aerospace, defence and security sectors, for example said in a newspaper interview: "health comes first but Leonardo cannot stop". A number of initiatives are being put in place to make it possible to continue working whilst complying with the new ordinances. Public and private employers have made efforts to facilitate working from home, and a government-led "digital solidarity" initiative is making available online collaborative working platforms (known in Italian as '*smart working*'). However, the current emergency is exposing significant differences between the ability to protect blue collar and white-collar workers. As the coordinator of a private sector consortium in the North noted: "those who work on the factory floor can't do '*smart work*'". In some cases, these tensions have resulted in strikes and contestations in those factories that have remained open. *La Repubblica* reported the protest of factory workers in Brescia who said: '*non siamo carne da macello'* (we are not meat for slaughter). Giuseppe Civati, the leader of the opposition party *Possibile,* highlighted that this is particularly troubling for people who work illegally in these factories and have no formal protection. On the 14th of March, following consultations with trade unions, the government

published a protocol that outlines measures to protect workers, including ensuring that they are provided with protective equipment, in an attempt to encourage companies to stay open and limit economic damages. The ability and willingness of different companies to comply with these measures remains to be seen, and *Possibile* continue to receive complaints from workers who say they are not being protected and who express concern about being asked to keep working.

Larger companies that rely on international investments and therefore have more stringent regulations have been quicker to respond, as they activated already well-developed preparedness plans. However, Italy's industrial structure is such that the majority of the private sector is made of small and medium size businesses. Many of these businesses have had to react quickly and develop their own internal policies to protect workers and to be in line with government decrees. A businessman from Varese told us that they allowed all of their employees to stay home, but, for those who have to come in, they have asked them to try to have only one person per office, to wear masks if they come into contact with others, while all communal areas were closed. Some factories across the North have established fixed working groups of approximately six workers, with staggered entry, while others are purchasing individual insurance for their workers.

Certain sectors and social groups are more likely to experience a disproportionately high economic cost of social distancing and other response measures and need to be particularly protected. Italy's entertainment and tourism sectors have unsurprisingly taken a significant hit. Owners of bars and restaurants, who "live by the cashier", risk immediate bankruptcy. As in other parts of Europe, precarious work has risen steadily in Italy in the last thirty years. A number of laws (e.g. the Biagi Law in 2003) increased flexibility in the labour market but with the consequence of also increasing precarious working conditions, especially for younger generations. These workers along with freelancers ('*partita IVA'*) are a particularly at-risk group.

For example: M. from a Northern town teaches in a gym and her boyfriend owns a bar, both had to shut leaving them with no income. As the lockdown was announced they had no information from the government regarding possible support for their specific situation. L. a 30 year old who also teaches yoga said that:

> "Without any clear provision from the government I tried to keep working until the last minute, also taking some risks, but once the decree came in I had to stop and close my business. This means not only that I am giving up any form of income, but I also have to keep paying to rent the place where I teach. If this goes on for much longer, I am not sure how I will keep going, I hope the government will put something in place".

In the week of 15th March, there have been a series of wide-ranging and unprecedentedgovernment measures to alleviate the economic effects of the outbreak. This includes offering sick pay for people in quarantine, suspension of taxes and mortgages, reduction of utility bills for the whole of 2020 and a possible transfer of 600 euros to people working independently which would go some way to addressing the particular challenges faced by freelancers.

A significant proportion of people work in the informal or 'unobserved' economy ('*in nero'*), including, as discussed below, carers and migrant workers. Italy's main statistics agency (ISTAT) calculated in 2016 that the 'unobserved economy' amounted for around 12.4% of

GDP. It will be important to continue monitoring changes in these economies, to consider alternative avenues for supporting those who are severely affected but 'off the books' as well as precarious workers, freelancers and small business owners.

With regards to the education sector, the closure of schools and universities was one of the first measures to be adopted, first by particularly hard hit regions then by the whole country.

Schools across the country have been developing distance learning efforts, including through the Classroom Google app. Aside from the significant challenges for parents who are either working from home or are still required to work, there are also significant technical challenges with e-learning infrastructure. One teacher from a Northern town said that she was having to spend 8 hours a day on the phone to give technical support to students. As a consequence, most teachers are resorting to sharing homework on WhatsApp. University students are also struggling to access the books they need and graduations and Viva-voce examinations will be delayed.

Significantly, migrant students are bearing the highest costs. Those who arrived recently to Italy have not been uniformly added onto the e-learning platforms and struggle with language barriers. Some teachers are volunteering to do Italian lessons with them separately on the phone. However, in migrant centres, language teachers and cultural mediators have had to suspend all activities. S. for example was worried about whether she would be entitled to paid leave whilst also expressing concern about how to deal with the 'social tensions' that were emerging within the centres. They were planning online classes but were receiving little support.

5. Psychosocial impact on HCWs and quarantined isolated people

The immediate and long-term psychosocial impact of epidemics is well documented from previous outbreaks (Kingori and McGowan 2016; Van Bortel et al. 2016; Robertson et al. 2004). The focus is often, and rightly so, on the experience of health-care workers who during emergencies tend to be overwhelmed with work, taking significant risks and in some cases also stigmatised in their communities for fears that they are carrying the disease. The kinds of challenges faced by the Italian health sector as described above, will inevitably have significant repercussions. In recent days, media reports have also been emerging of doctors expressing their anguish in having to isolate themselves from their loved ones, in an attempt to keep them safe.

It is also, however, important to consider the mental health effects on individuals and families in lockdown, quarantine, and self-isolation as well as that of survivors and the families of those who are sick. A., a university student, and her sister for example spoke of feeling aimless, "inept" and "unable to react". There is also significant anxiety related to elderly relatives. One of our interlocutors in her 70s lived on her own following the death of her husband last year, she was worried about going out for shopping as she had no mask or sanitiser and relied on a shop-owner bringing some food to her house every couple of days. She felt "scared and isolated most of the time". F. from Rome instead explained how she struggled with her 80 year old father's unwillingness to self-isolate because he said: "we are in the hands of God, I don't want to just survive, I want to live".

6. Social Care

As mentioned above, Italy has an ageing population among the largest in the world. This is having immediate effects on the experience of the epidemic in the country, as the elderly are an at-risk group. In addition, the role of family-based care of the elderly in Italy has significant implications for the set of measures most appropriate to protect the vulnerable and the specific design of social distancing measures. Italy's welfare system is "characterised by its familialistic orientation", and, in relation to elderly care, family members take the primary role and are the main recipient of welfare support (Mazzola et al. 2016). The elderly either live at home with younger relatives or rely on their regular visits to get support with buying food and other necessities. This familialistic welfare system also means that grandparents are often the primary providers of childcare. In addition, "a large number of families privately [employ] eldercare assistants" known as *badanti* (ibid). These are often migrant workers with irregular contracts. Such arrangements have consequences for transmission dynamics. Three points are especially crucial. Firstly, the protection of the elderly is particularly challenging and requires specific guidance for families to assist them in providing care relatives. Secondly, the effects of school closures on the protection of elderly people who provide childcare need to be addressed. Thirdly, the protection of irregular migrant workers in this sector, as noted above, though difficult from the government's perspective, needs to be given further consideration.

7. Trust, Communication and Social Conflict

In recent epidemics, including the Ebola outbreaks in West Africa, challenges in the implementation of outbreak response measures have highlighted the central role of trust. Our research in Sierra Leone for example has shown that a history of eroded trust in institutions and external intervention set the stage for suspicion of the Ebola response, the spread of rumours about the epidemic and, in some instances, rejection of containment measures (Enria 2015; Enria et al. 2016; see also Wilkinson and Leach 2015; Benton and Dionne 2015).

In Italy, trust in institutions has historically been low. A Eurobarometer survey in 2018 showed for example that 66% of the population tended not to trust the government. Volatile governments, regular corruption accusations and significant political divisions have contributed to this in recent years. Whilst an analysis of the current political situation in Italy is beyond the scope of this briefing, it is worth noting that the current government is a coalition between the Democratic Party (PD) and the Five Star Movement (M5S), a party that initially emerged in explicit contestation of what they perceived as a corrupt political elite. The M5S itself has however not been able to avoid corruption scandals since it initially entered Parliament in 2016 in coalition with the far-right Lega (their coalition broke down in August 2019).

A context of mistrust is relevant for understanding initial concerns around compliance with government regulations. In the first weeks of the emergency, there were for example reports of people escaping quarantines from Northern lock-down areas. Rumours also circulated widely on traditional and social media that mischaracterised and underplayed the epidemic comparing it any other ordinary flu; or, in other cases, spread false information leading to panic. In other areas in the South of Italy, many did not buy into alarming messages regarding a new epidemic originating in China and affecting the distant and rich northern part of the country, and were initially reluctant to receive and comply with official advice on prevention.

To counteract these risks, many especially among the wealthier classes, repeatedly asked for the army to intervene in order to force everyone into quarantine. They worried about the broader consequences resulting from the reluctance to comply with regulations on the part of the youth and all those who lacked adequate information or sense of community belonging. However, a militarised response in the context of Italy raises a series of concerns especially in Southern regions where structural violence is associated with the long-standing presence of organised crime. Territorial ties with organised crime are typically associated with both strained relationships with authorities and low sense of belonging to any national identity. This results in low levels of compliance with government-mandated provisions, mostly because the State is often absent from the socio-economic relations of people living in areas where the presence of organised crime is rife. Naturally, a sudden pervasive intervention such as a territorial lock-down is unlikely to elicit spontaneous compliance in these circumstances. Were the government to choose a militarised response, there could be a number of negative consequences. As has been documented, militarisation strains state-society relations in an already tense context of emergency (Enria 2019; Benton 2017). The forceful containment of certain sections of the population can have longer-term repercussions for civil rights and social cohesion. At worst, the presence of the military in certain regions where violence and mistrust are already high and structural as some parts of the South and areas with sginificant organised crime presence, would risk an escalation of violence. This would add civil strife to a health crisis.

A significant challenge for building trust in the national response has been around the perception of confused, or even contradictory, communication, at least in the first weeks of the epidemic. This is both in terms of "vertical" communication between different tiers of the institutional hierarchy and external communication from the government to the public. For example, there have been on-going tensions around COVID19 testing where local health centres (ASL: Azienda Sanitaria Locale) were receiving contradictory protocols around whether to do 'blanket testing' or test only those who were symptomatic, so they were not sure which protocols to follow. Disagreements continue in this regard, paralleling international debates about appropriate testing measures. In Italy these have played out quite publicly (e.g. on social media debates between public health specialists) in ways that may result confusing and counterproductive for the public. A second example of communication problems that had a negative effect on the outbreak response was a leak of the ordinance relating to the lock-down of a number of Northern regions. The decree was published in full in a major national newspaper before the government announced it, contributing to tens of thousands of people escaping to return to the South, as previously described, and potentially contributing to a further spread of the disease in Southern regions.

Some of our testimonies focus on the perception of contradictions in the ordinances (for example on-going debates on social media on whether it is possible to go for a walk or not) and a wish for more accountability and meaningful engagement with citizens when communicating facts around the epidemic. This was not necessarily in terms of a lack of information but rather due to "too much information", with TV talk shows, newspapers and social media rife with debates and disagreements between different kinds of experts and non-experts but a dearth of explanation about the decisions behind specific response measures. For some, daily press conferences that simply report case and death numbers give a sense of lack of accountability and that the government has given up after imposing the lockdown.

Other information campaigns and social mobilisation efforts have had more success. These include for example the sharing of guidance on hand washing and symptoms through

accessible FAQs, the establishment of the viral hashtag #iorestoacasa (‘*I am staying home’*), the use of megaphones to encourage people within neighbourhoods to stay home, the engagement of celebrities in the sharing of public health messaging and community-led musical ‘flash-mobs’ from people’s windows and balconies to strengthen a sense of national solidarity during the lock-down.

Questions of trust and social cohesion must also take into account the potential for latent and emerging social conflicts. Migration for example has been a particularly contentious topic in Italy in recent years, in particular under the Lega-M5S government that presided over the criminalisation of any support to migrants and the blocking of migrant boats in the Mediterranean. Especially in the early days of the epidemic, cases of violent attacks against migrants, and particularly those of Chinese origins, were reported. Other episodes of violence have been recorded throughout Italy with serial revolts in several national prisons, sparked by the ban on visits as part of the ordinance on social distancing measures. Violence was also reportedly sparked by inmates’ fear of contagion in a setting where they worried they would not be cared for; chiefly due to the endemic overcrowding and under-resourcing of Italian prisons. The media have also reported a number of instances of violence against health-care staff in Campania, where generalised panic and frustration translated into attacks at the triage point of care or in A&Es departments. Finally, national women’s groups are highlighting the need to protect women from domestic abuse during the lock-down. This is of particular concern in Italy where women’s groups have been campaigning for legislative change to address the country’s high rates of ‘femicides’ and domestic abuse, for the most part committed by domestic partners.

Recommendations

1. Equipment and protection of HCWs

The most immediate need is support for the health system across Italy. As regions like Lombardia edge closer to collapse and the outbreak spreads across the country, it is vital that all regions are prepared. This includes support in terms of personnel, ICUs machinery and essential protective equipment for health-care staff. The Chinese and Cuban governments already took some steps in this direction, agreeing to provide supplies of personal protective equipment. MSF has also urged European Members States to “demonstrate solidarity beyond their national borders” in a collective effort to protect health workers.

2. Regional Task Forces, Expanded Pillars and International Support

The organisational element of the institutional response to the outbreak should not be underestimated. Indeed, it is likely that the effectiveness of the response is affected by the type of stakeholders sitting at the table when the response is devised. More specifically, task forces should be inspired by an extended pillars principle and include competencies from different sectors of society; beyond political representatives. Of course, the presence of scientific and medical professionals is key, but that of local communities representatives, psychotherapeutic professionals, cultural mediators, communication experts, and social scientists is also crucial.

Finally, given the shortages highlighted above, it has become clear that national capacity is at the moment limited and strained. There is urgent need for an expanded international response to support national efforts, both from the physical and human capital point of view.

3. Protecting At-Risk Groups

In the context of the current emergency, it will be important to expand our understanding of "at-risk groups" and to consider context-specific transmission dynamics. We therefore suggest that specific guidance is provided for example on:

- How to continue family care of the elderly whilst keeping them safe
- Alternative self-isolation arrangements for those living in overcrowded accommodation, prisons and migrant centres. These arrangements need to take into account the psycho-social needs of individuals and communities and could learn lessons and adapt models from Community Care Centres established in previous epidemics.
- How to protect women, children and others from domestic abuse during lockdowns and quarantines

4. Support for workers

The government's announced economic measures show extraordinary commitment to support workers and to react to specific challenges including those faced by freelance workers. It will be essential to continue the national dialogue about how on-going industrial activities affect factory workers, especially in sectors with fewer protections. It will also remain important to monitor economic effects on vulnerable categories as the emergency develops and to consider how to protect groups that may fall through the cracks, such as those working in the informal economy.

5. Psychosocial Interventions

The psychological and social toll of this emergency will need to be monitored as the outbreak continues, as protracted isolation is likely to have long-term repercussions. We also need to continue gathering information on the psycho-social needs of health-care workers. WHO recommendations on psychosocial considerations during outbreaks, and for COVID19 in particular, need to be effectively integrated as a standalone pillar in national responses and supported by international partners intervening in Italy.

6. Communication and Community Engagement

Prior epidemics have shown the importance of clear and coherent community engagement and risk communication in supporting campaigns to increase the acceptability of outbreak responses. Learning lessons from previous epidemics suggests that:

- Communication must be context specific, that is, it needs to reflect local concerns and understanding. In Italy this might also mean considering developing regionally specific communication campaigns to divulge nationally coordinated campaigns in ways that are locally relevant.
- Communication efforts should continue to identify and make use of different forms of communications including social media.
- Response task forces should consult latest guidance on meaningful community engagement and develop initiatives relevant to the Italian context to encourage participation at national and local level.
- Engaging communities effectively requires valuing local leadership and using different channels to communicate and encourage two-way dialogues. This means

identifying social networks that are trusted and have wide reach, for example local social movements, football associations or parent groups.
- Identifying latent or explicit social conflicts and marginalised groups to develop targeted messaging and dialogue to avoid tension and protect the vulnerable (e.g. disseminating domestic abuse hotlines, sensitisation around discrimination against migrants, care for the elderly etc).

7. Continued monitoring of social dimensions of the emergency

The situation will continue to change rapidly with different effects on Italy's social, political and economic life and varied repercussions for different groups of people. We recommend continued analysis of these dynamics to closely support the development of tailored communication other outbreak response measures.

Luisa Enria is a Lecturer in International Development at the University of Bath. She has worked on the politics of humanitarianism, violence and global health from an anthropological perspective. She participated as a social scientist in the 2015 Ebola vaccine trials in Sierra Leone and on subsequent efforts to integrate social science in emergency outbreak responses.

Serena Masino is a Lecturer in economics and international development at the University of Westminster in London. She had worked on social policy and the political economy of development and more specifically also on the political economy of health-care reform in sub-Saharan Africa

References

Abramowitz, Sharon. 2017. "Epidemics (Especially Ebola)." *Annual Review of Anthropology* 46: 421–45.

Bardosh, Kevin, Daniel de Vries, Darryl Stellmach, Sharon Alane Abramowitz, Adama Thorlie, Lianne Cremers, and John Kinsman. 2019. "Towards People-Centered Epidemic Preparedness and Response: From Knowledge to Action." http://www.glopid-r.org/our-work/social-science-research/.

Benton, Adia. 2017. "Whose Security? Militarization and Securitization During West Africa's Ebola Outbreak." In *The Politics of Fear: Medecins sans Frontieres and the West African Ebola Epidemic*, edited by Michiel Hofman and Sokhieng Au. Oxford: Oxford University Press.

Benton, Adia, and Kim Yi Dionne. 2015. "International Political Economy and the 2014 West African Ebola Outbreak." *African Studies Review* 58 (1): 223–36. https://doi.org/10.1017/asr.2015.11.

Bortel, Tine Van, Anoma Basnayake, Fatou Wurie, Musu Jambai, Alimamy Sultan Koroma, Andrew T Muana, Katrina Hann, Julian Eaton, Steven Martin, and Laura B Nellums. 2016. "Psychosocial Effects of an Ebola Outbreak at Individual, Community and International Levels." *Bulletin of the World Health Organization* 94 (3): 210.

Enria, Luisa. 2015. "'You Think This Is an Ebola Office?' Rebuilding Trust in the Aftermath of Sierra Leone's Outbreak." Mats Utas Blog. 2015. https://matsutas.wordpress.com/2015/10/13/you-think-this-is-an-ebola-office-rebuilding-trust-in-the-aftermath-of-sierra-leones-outbreak-by-luisa-enria/.

———. 2019. “The Ebola Crisis in Sierra Leone: Mediating Containment and Engagement in Humanitarian Emergencies.” *Development and Change*.

Enria, Luisa, Shelley Lees, Elizabeth Smout, Thomas Mooney, Angus F Tengbeh, Bailah Leigh, Brian Greenwood, Deborah Watson-Jones, and Heidi Larson. 2016. “Power, Fairness and Trust: Understanding and Engaging with Vaccine Trial Participants and Communities in the Setting up the EBOVAC-Salone Vaccine Trial in Sierra Leone.” *BMC Public Health* 16 (1): 1140. https://doi.org/10.1186/s12889-016-3799-x.

Kingori, B P, and Catherine McGowan. 2016. “After the End of Ebola.” *Somatosphere*.

Mazzola, Paolo, Stefania Maria Lorenza Rimoldi, Paolo Rossi, Marianna Noale, Federico Rea, Carla Facchini, Stefania Maggi, Giovanni Corrao, and Giorgio Annoni. 2016. “Aging in Italy: The Need for New Welfare Strategies in an Old Country.” *The Gerontologist* 56 (3): 383–90.

Robertson, Emma, Karen Hershenfield, Sherry Lynn Grace, and Donna Eileen Stewart. 2004. “The Psychosocial Effects of Being Quarantined Following Exposure to SARS: A Qualitative Study of Toronto Health Care Workers.” *The Canadian Journal of Psychiatry* 49 (6): 403–7.

Sams, Kelley;, and Alice Desclaux. 2017. “From Ebola to Plague and Beyond: How Can Anthropologists Best Engage Past Experience to Prepare for New Epidemics?” Cultural Anthropology. 2017.

Shepler, Susan. 2017. “‘We Know Who Is Eating the Ebola Money’ : Political Effects of Perceived Corruption in the Ebola Response.” *Anthropological Quarterly* 90 (2): 457–80. https://aaa.confex.com/aaa/2015/webprogram/Paper44380.html.

Wilkinson, A., and M. Leach. 2015. “Briefing: Ebola-Myths, Realities, and Structural Violence.” *African Affairs* 114 (454): 136–48. https://doi.org/10.1093/afraf/adu080.