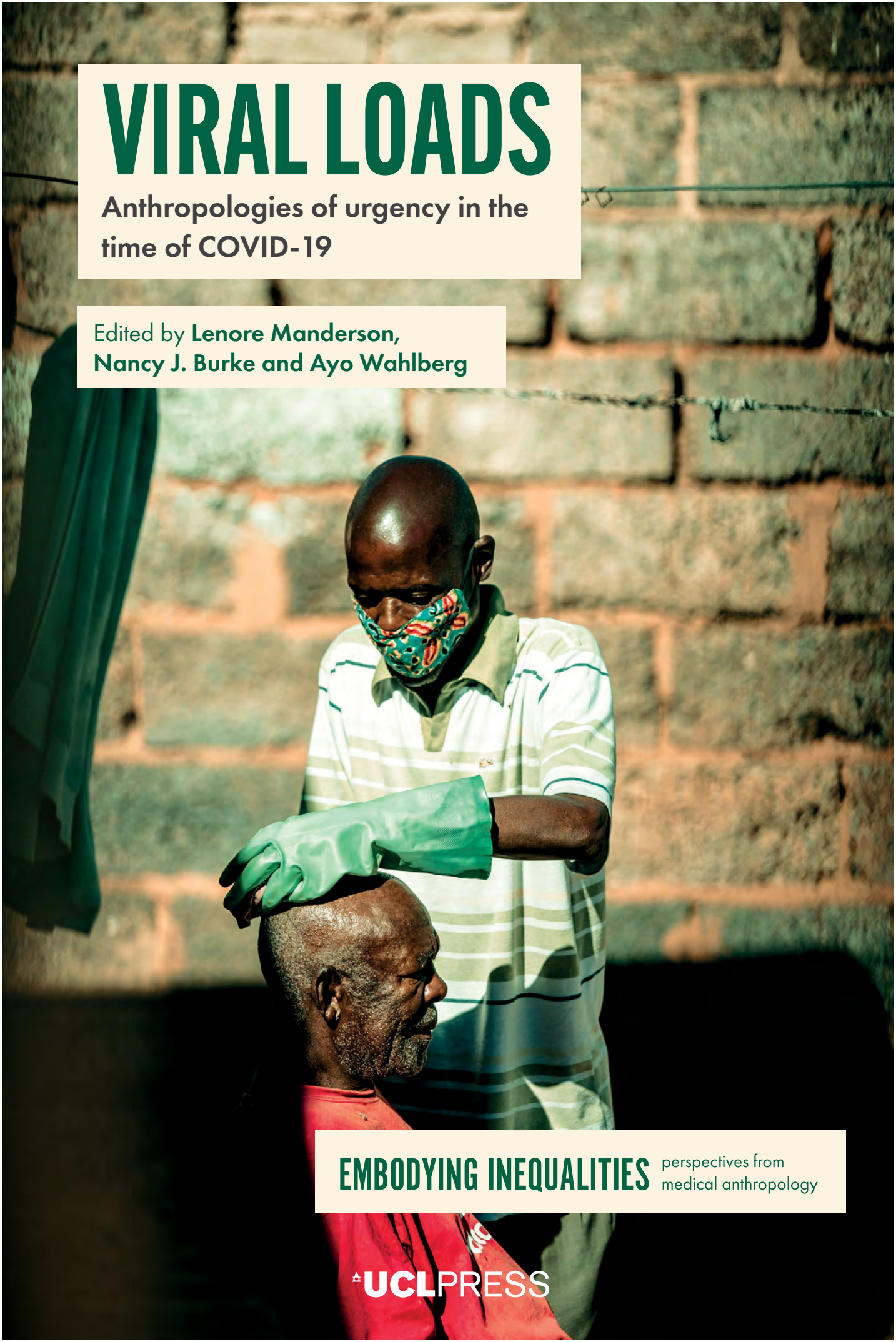

VIRAL LOADS

Anthropologies of urgency in the time of COVID-19

Edited by **Lenore Manderson, Nancy J. Burke and Ayo Wahlberg**

EMBODYING INEQUALITIES perspectives from medical anthropology

UCLPRESS

Viral Loads

EMBODYING INEQUALITIES: PERSPECTIVES FROM MEDICAL ANTHROPOLOGY

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This series charts diverse anthropological engagements with the changing dynamics of health and wellbeing in local and global contexts. It includes ethnographic and theoretical works that explore the different ways in which inequalities pervade our bodies. The series offers novel contributions often neglected by classical and contemporary publications that draw on public, applied, activist, cross-disciplinary and engaged anthropological methods, as well as in-depth writings from the field. It specifically seeks to showcase new and emerging health issues that are the products of unequal global development.

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COVID-19 in Italy

A new culture of healthcare for future preparedness

Chiara Bodini and Ivo Quaranta

When the first autochthonous cases of COVID-19 were diagnosed in Lombardy in late February 2020, the whole country went into a shock (Raffaetà 2020). Both the virus and the effect it elicited quickly spread to the rest of Europe. Suddenly, what had been described as a 'Chinese virus', a threat confined to far away countries perceived as 'less developed', was inside our borders, in the very heart of a rich and productive region in Northern Italy. The severe underestimation of the pandemic in Italy, that was already rapidly spreading worldwide, resulted in the slow and chaotic reaction of Italian authorities facing the diffusion of the virus. The lack of preparedness, and fragmentations in governance between central government and the regions, led to contradictory messages being communicated to the public and incoherent and inconsistent measures being adopted. This led to the exposure of large numbers of people, including many 'essential services' workers. Huge numbers of critically ill patients required hospital care in a healthcare system that had suffered from budget cuts and privatisation over the past decades, particularly in its primary care and public health components. It was a very long time since hospitals in Europe had been overwhelmed in the way that they were in Lombardy, and this was seen as a wake-up call for other European countries and a portent of how COVID-19 might impact other settings. Measures to contain the epidemic, including a two-month national lockdown, were introduced.

However – as we argue in this chapter – the response to COVID-19, consistent with the culture and the organisation of health and medicine

in Italy, was largely biomedical, and so failed to incorporate the social dimensions of the disease. This response was inadequate to build future preparedness.

COVID-19 in Italy

In late January 2020, two Chinese tourists visiting Rome were diagnosed with COVID-19. The news was alarming as it showed that the virus had entered the country, but not too disturbing as it fitted the stereotype of a foreign-borne virus that could be controlled by closing the borders. In what appeared to be strategic timing, the day before these cases were diagnosed, the government had blocked all flights to and from China; this measure was later labelled as detrimental as it made it impossible to test and trace people coming from China who chose other indirect routes to reach Italy. For two more weeks, no other measures were taken, until – on 21 February – the first Italian case of COVID-19 was diagnosed in Lombardy. To the shock of many, the 38-year-old man, labelled as 'patient 1', had not travelled to China, and all efforts to find 'patient 0' and trace the origin of the virus failed. From then on, the situation rapidly escalated, with new diagnoses concentrated in the same geographical area. Lombardy became the first 'red zone' under lockdown. Still, the belief was that the virus came from abroad and, if contained where it had first been found, the rest of the country would be spared (Horton 2020a). Unfortunately, the data later showed that the virus had been circulating in Lombardy since at least a month before, with hundreds of cases of infection – including severe ones – that had not been tested and therefore not diagnosed.

The period that followed was intense and confusing. The central government and regional authorities took decisions in an uncoordinated way, and messages to the population were openly contradictory. While the people in Codogno were locked in their homes, neighbouring cities such as Milan and Bergamo launched a media campaign to emphasise that life there was going on as usual – 'Milan does not stop' (#milanononsiferma) – and that there was no reason to panic. Similar messages appeared on social media, posted by key political figures from different parties.

Less than a week later, on 4 March, schools and universities were closed across the country and, on 8 March, a national lockdown was imposed. It was an unprecedented measure for Italy and for the world. People could not go out of their homes unless they carried a

self-declaration that stated the reason to do so – for health, work or to assist relatives in need – and few were so permitted. The (rather arbitrary) application of this norm resulted in thousands of fines ranging from 400 to 3,000 euros , many of which have been contested.

Many praised the Italian government for acting decisively. However, the delay in implementing lockdown measures are, at time of writing, under investigation: this applies especially in the province of Bergamo, the hardest hit by the epidemic. Government documents, made public over the northern summer 2020, showed that on 3 March the National Scientific Committee had called for a 'red zone' in the area, and an investigation is ongoing to find out why this had not been applied, although allegedly motivated by the desire to avoid the economic consequences of a lockdown. At the same time, for several weeks, even under the lockdown, so-called 'essential services' continued to function, exposing health providers, transport workers and cleaners, among others, to a higher risk of infection.

The daily report issued by the Civil Protection from early March was dominated by the escalating number of new cases, hospital admissions, patients in intensive care units (ICU) and deaths. The National Health System (NHS), although still considered as one of the best in Europe, soon became insufficient to admit and adequately treat all patients, especially in Lombardy. Despite a referral system which included all public and some private facilities throughout the country, there were increasing reports by physicians in Lombardy that patients were being told to stay at home because hospital facilities were overloaded, and that patients could not be ventilated – despite meeting the clinical criteria for such action – because there were not enough ventilators available. These reports were so shocking that they were silenced or openly contested by public authorities, but they circulated widely, particularly among health professionals. A few weeks later, the army trucks moving coffins of coronavirus victims from Bergamo because there were no spaces available in local cemeteries could not so easily be concealed.

The lack of preparedness and insufficient human and material resources, combined with an elderly population and a high level of air pollution in the areas most affected, likely contributed to a particularly high mortality rate in the first wave of the pandemic. Delays in admitting patients to the hospitals and inappropriate approaches to both antimicrobial and intensive care treatment were particularly called into question by public health officials and health activist networks; so too was the approach to test and trace in Italy in ways that did not follow the recommendations of the World Health Organization (WHO).

As of 22 December 2020, Italy had recorded 1,977,370 cases and 69,842 COVID-19 deaths. One quarter of the cases and almost one third of the deaths were recorded in Lombardy (Ministry of Health 2020).

A healthcare response to a public health emergency

Interviewed in early April, the president of the Medical Board of Bergamo, the city in Lombardy that became the symbol of the COVID-19 crisis in the country, declared:

> The National Healthcare Service (NHS) has been dramatically dismantled, hospitals and community services … A public health emergency has been mistakenly considered as an emergency of intensive care units. At the beginning, COVID cases were not isolated, epidemiological investigations were not done, patients were not tested, doctors did not have personal protective equipment (Marinoni 2020).

In a few words, Dr Marinoni summarised the failure of the initial response to the crisis and identified its root causes.

It is now clear that Italy was not prepared for the epidemic, and its preparedness plan, drawn up in 2006 and unknown to most health professionals, has been judged 'old and inadequate' (Giuffrida and Boseley 2020). In addition to this, since the early 1990s the NHS has been subject to reforms and budget cuts that severely altered its capacity to react to a sudden increase in health needs (Geddes da Filicaia 2020). As in many countries across the globe, privatisation affects the capacity of public state-funded and government-run health systems to coordinate large-scale preventive campaigns, and limits their capacity to expand curative services in crisis situations, while eroding the broad public's confidence in the health system as a whole (De Ceukelaire and Bodini 2020). Moreover, the regionalisation of healthcare – very much part of a broader design to progressively dismantle and privatise the NHS – significantly delayed the adoption of coherent measures to contain the disease and strengthen the health system. While the Italian public health authorities at regional and national levels tried to cope with the growing epidemic, the highly fragmented health system resulted in a complex situation that became difficult to manage (Villa et al. 2020).

The area that suffered the most from these processes, now considered the weakest link of the NHS, is primary healthcare (PHC), particularly at

the intersection of public health, primary care departments and family doctors. Structural weaknesses date back to the healthcare reform of 1978, when, under pressure from the physicians themselves, legislators decided that family doctors would not be employed by the NHS, but would be contracted as private professionals under a national agreement. A decade after, what were initially called 'local social and healthcare units' (Unità Sanitarie Locali, USL) became 'local healthcare enterprises' (Aziende Sanitarie Locali, ASL), with a double shift: the removal of the word 'social' and the shift from 'unit' to 'enterprise'. This change marked the inauguration of the managerialisation of the NHS, which coincided with the progressive reduction of the national public healthcare budget. The participation of citizens at different levels of the system's governance, included in the original reform, was never developed.

The region that most aggressively pursued privatisation, and that developed secondary and tertiary-level hospitals to the detriment of primary care, is Lombardy. This has been repeatedly used as (part of) the explanation of why the region was hit harder by coronavirus and why the region failed to implement a coherent and effective strategy in an effort to contain it. To date, the problems of primary care and public health organisation have not been addressed, and professionals in the field are still left alone to face a new wave of infections.

As a critical situation, the pandemic revealed the impact of austerity and market-oriented reforms in undermining the capacity of the NHS to perform its biopolitical duties of health promotion, prevention and care (Basu et al. 2017). It also made explicit the cultural values informing national health policy: the pandemic was mainly dealt with at the hospital level, with a reactive approach that focused on acute care, infection control and virology, rather than a proactive public health approach grounded on epidemiological surveillance and health promotion. Moreover, although the spread of the virus began to be contained mainly through lockdown and people's willingness to modify their social behaviour, the NHS did not act through its community-based local articulations such as primary care health facilities and professionals. These were, in fact, rather inaccessible to the public, as either closed down (as in the case of many primary care facilities) or overwhelmed (as in the case of GPs). It was not until late April that special 'home care units' were established, in order to assist and monitor patients who did not meet the criteria for hospitalisation. However, their implementation has been uneven across the country in terms of both capacity and timeliness.

The inadequate management of the COVID-19 epidemic, particularly evident in the region that invested the most in a privatised,

market-oriented and hospital-centric healthcare system, draws attention to the failures of such an approach in dealing with a complex public health emergency. More intensive care beds and ventilators, although necessary at the beginning of the crisis, soon became a technical fix that was ineffective at the source of the problem. In the community, the virus was circulating, undetected by an inadequate public health effort.

Cultural values informing national health policy

These preliminary considerations help us understand how human agency contributes to shaping the local configuration of COVID-19 in a specific context. In order to further develop the analysis, we now examine the implicit cultural assumptions that guided the Italian response to the pandemic.

The initial underestimation of the pandemic was clearly rooted in the fallacious idea that highly contagious infectious diseases are a medical reality confined to low-income countries in the Global South (Kleinman and Watson 2006). Consistent with this, the initial tracing operations focused on 'Chinese contacts' of the first cases. Rather than engaging in collaborative and cooperative actions with Chinese (and other national) authorities, the government decided to stop flights arriving in Italy from the risk regions, ignoring the most basic global health assumptions on the collective nature of any local phenomenon (Biehl and Petryna 2013; Farmer et al. 2013). Looking at the patterns of its distribution and at the different national responses to it, we can certainly consider COVID-19 as an indicator of our *glocal* (Kearney 1995) (dis-)order: an assemblage by which the viral pathogen mingles with specific social configurations within which people's actions unfold at the local and global level. Infectious viruses are about social networks and cultural norms, as much as about microbes. As virological research makes clear, viruses are inert, sometimes for thousands of years, unable to attack us. We transmit viral data though our social networks and cultural pathways. We give viral information to each other by how we live and what we do. Understanding cultural contexts is therefore just as important as sequencing genomes in tackling viral outbreaks (Napier and Fischer 2020).

The very absence of an adequate pandemic plan testifies the lack of a global health perspective in the Italian institutional response, that might have been able to explicitly address the social nature of the virus agency. The Italian response reduced COVID-19 to its aetiology: SARS-CoV-2. Even the National Scientific Committee, appointed on 5 February

2020 by the government to manage the emergency, has been mainly informed by a reductionist medical perspective with little acknowledgement of socially-oriented approaches including public health, epidemiology and the social sciences. In so doing, the complex reality of COVID-19 was stripped of its social dimensions, limiting the possibility for action (Rajan et al. 2020).

A behavioural approach to prevention

Such reductionism was also present in the preventive strategy adopted by the state, rooted in a well-known behavioural approach geared around the spread of information for the adoption of individual practices such as avoiding contact, frequently washing hands, wearing masks and gloves and so on. Such campaigns, as they unfolded in Italy, have a number of limitations and side effects which were not adequately considered.

In the first place, in general behavioural campaigns fail to address possible structural constraints impacting on individual behaviour. This was particularly evident when trying to halt the transmission of coronavirus in the cases of homeless people, asylum seekers and refugees living in overcrowded centres, seasonal migrant workers living in informal settlements, Roma people living in camps (see also Pop, Chapter 8) and detainees in prisons. Despite vibrant protests by people who were imprisoned, and different advocacy actions by groups, associations and networks working with vulnerable populations, very little was done to improve the structural conditions contributing to their risks for contagion. On the contrary, rather than highlighting such constraints, people's culture and values tended to be presented as obstacles in health promotion, leading to forms of blaming of different groups of people. Depending on the phase of the emergency and the lockdown, these included migrants who were alleged to bring the virus from abroad (as Onoma, Chapter 10, also describes), even if at the time – given the situation in Italy – the risk was rather that they would become infected upon arrival. Blame was also directed at people walking or jogging in parks, who were accused of placing individual interest above everything else; and youth, who were charged with returning too quickly to socialising after the lockdown was eased. Both public authorities and the social media accused these groups of people of deliberately ignoring public health norms and so of being responsible for the spread of infection.

Framing the issue of responsibility in individual terms undermined the very possibility for a representation of the crisis as a collective

condition to be dealt with in cooperative terms. Even now, rather than imagining new forms of sociality as a collective response to the perduring emergency, we are facing increasing sanitisation of sociality, with the risk of its very criminalisation. To strip COVID-19 of its social dimensions inevitably precludes the possibility of acknowledging the importance of looking at people's perspectives, and of considering how to promote their wellbeing. Paraphrasing Napier and colleagues (2014, 1611), if we ignore what brings value and meaning to another's life, it becomes difficult to make it better when it is necessary to do so.

Yet little room was left for an approach capable of taking into consideration people's understandings of their needs and how to meet them. Unless we look at health as a cultural construct and equip our healthcare services with the proper competence to foster the participation of people in the very definition of their best interests, we are always at risk of producing ineffective interventions. Again, we have a cultural issue here, related to the biomedical devaluation of the cultural dimensions of health and wellbeing.

People as a resource

If there is one lesson from social science analysis of past epidemics, it is that people's behaviours make a difference and, therefore, the ability to actively involve them in the processes that concern them can be decisive (Packard 2016; Richards 2016). Yet, to address people's behaviours implies the need to consider their capabilities, for example, to negotiate the terms of their social engagement and circumstances in a given local reality. Despite the fact that it was only through a lockdown that the emergency was kept under control, people's behaviours were never assumed as a possible resource in managing the crisis. Yet these behaviours made a difference also by attending to the needs of those who were most affected by the economic and relational consequences of lockdown.

At the grassroots level, many initiatives took shape. In the Municipality of Bologna, for example, formal and informal civil society groups organised themselves to support those in need, delivering to them food supplies, medical equipment and pharmaceuticals. This effort largely came from below, as in many other places throughout the country, while public services were shut down and public officials were discussing what should be done in endless online meetings. Well-established charity organisations linked to churches, political parties, trade unions and private foundations were joined (or, at times, were preceded) by many

new and often informal networks, largely composed of students and people who, due to the lockdown, suddenly had a lot of spare time and felt the urge to help others. New needs also appeared and were rapidly addressed by grassroots solidarity networks, such as the need for laptops and tablets for families with children who – with all schools closed – had to follow distance learning programmes.

Even in the City of Bologna, with a centuries-old tradition of good governance and progressive welfare policies, it took several weeks, even months, for the public system to acknowledge, support and finally regulate such efforts. Meanwhile, this activity remained fully voluntary and largely autonomous of public institutions, and was hyperlocal in nature, involving people at the level of buildings, blocks and streets. These forms of mutual support from below were the only ones capable of making a difference for those already trapped by socio-economic inequalities, who were, and still are, the most vulnerable to and affected by the pandemic (see also Burke, Chapter 2).

These initiatives were crucial in complementing the institutional actions prescribed by the national government and by local authorities, which invested a substantial part of the public budget to support those most in need. In this regard, Italy might be seen as a good example in addressing both the medical and the socio-economic consequences of the COVID-19 pandemic (Horton 2020a). Yet a critical dimension is in the incapacity of government, at all levels, to develop the operative integration of social and medical actions grounded in community participation as a form of care and the promotion of equity.

In the summer of 2020, as transmission of COVID-19 slowed down, local and national institutions developed emergency plans in order to be adequately prepared for a possible second wave of the pandemic (as occurred a few months later). Such plans were mainly designed to enhance the capacity of medical services to treat patients, to store equipment for testing and treatment, and to ensure a proper supply of personal protective equipment. In other words, preparedness was again tailored on pathology rather than on the wider reality of which pathology is part. By stripping COVID-19 of its social dimensions, again, institutional preparedness ended up limiting its effective responsiveness. No attention was given to those dynamics that made resilient specific local contexts, i.e. community participation. The crucial role of social relations is the main issue that was exposed by the COVID-19 pandemic. Yet Italian institutions have not been able so far to consider them as part of any form of preparedness.

In anthropological terms, preparedness should be seen as a means by which a specific social order is produced, especially in a critical time in

which habitual forms of relatedness are compromised and need to be rethought. The post COVID-19 scenario cannot be imagined as a return to a previous normality, as if the impact of the pandemic might leave no trace in our conscience and social arrangements. Clearly, we have to talk of new forms of normalisation, by which a new social order becomes embodied and can promote our unproblematic being-in-the-world. In order to avoid that such a process of re-normalisation ends up in naturalising the medicalisation and criminalisation of sociality, we must engage in forms of creative social relatedness to produce new forms of sociality capable of sustaining a meaningful collective existence. For this reason, we need to include the promotion of those forms of social relatedness that have proved protective in our institutional responses to the pandemic. If we reduce preparedness merely to the adoption of protective individual behaviours, we are stripping the person of its constitutive social dimension. As anthropology has long taught us, by focusing on the body, cultural practice articulates broader social and political issues. This is precisely why it is crucial to work beyond the sole adoption of protective individual behaviours and towards the idea of designing forms of protective social relatedness.

Primary healthcare as a space for integrated action

Institutional action on COVID-19 has not valued community participation as a resource in dealing with the emergency, despite its crucial role in giving birth to adaptative forms of sociality. Such a lack stems in part from having relegated institutional action to the hospital level, without drawing on the network of community-based primary care services, the only component of the health system capable of proximate contact with local neighbourhoods and their inhabitants. As already discussed above, primary healthcare (PHC) has been severely undermined over the last decades by processes of underfinancing and cultural devaluation (Geddes da Filicaia 2020). Yet PHC represents the only articulation of the NHS capable of producing forms of participation and mutual trust between institutional actors and people.

This is not intended to diminish the decisive role that hospital settings have played in treating people affected by COVID-19; this would be both ungenerous and inaccurate. Rather, it highlights that the healthcare system is culturally calibrated on values that do not take into account the proximity of services to local neighbourhoods, the only context in which it would be possible to create a proactive synergy between institutions and people's agency.

Again COVID-19 seems to play a pedagogic role in making manifest the limitation and contradictions of our social reality, shedding light on its fault lines, a critical situation that unveils those implicit processes that inform our social reality.

A different approach for future preparedness

By dividing medical action from social support, and by formulating the latter mainly in a top-down manner centred on individuals, Italy ended up limiting its institutional capacity to manage the local configuration of the pandemic. The focus of Italy's response was mainly on the virus, SARS-CoV-2, rather than on the disease, COVID-19. The current challenge is related to the possibility of grounding medical and social services with a view of health as a cultural construct that requires the participation of people to define their needs. This must be socially produced, and this can only occur through the constitutive relations that people have with the social circumstances of their life in a given context. Unless we are capable of taking into account the constitutive social dimensions of medical reality, we are bound to a permanent state of emergency.

Future preparedness, in other words, should not be reduced to the adequate storage of medical supplies. It should rather take advantage of the lessons we are learning in the current global predicament. On the one hand, we need a global perspective capable of looking at health as a common global good, and we need to strengthen an approach that looks at the mutual involvement of the contexts we imagine as local, with awareness that one's own interests coincide with the promotion of those of others. On the other hand, we need to place as central community involvement and participation (Rajan et al. 2020), with the aim of considering people as actors in the process of health promotion, avoiding their reduction to a 'mere population' (in Foucauldian terms) crushed by top-down measures and incapable of generating their active valorisation (Loewenson et al. 2020). To do so, we need a culture of health and healthcare capable of creating conceptual and political room for local participatory action in local services.

As anthropologists, we know well that communities are not entities but forms of relatedness rooted in the ongoing symbolic processes of belonging. Institutions should accommodate and rely on forms of symbolic belonging that emerge at the grassroots level (especially if they proved to be resilient in facing the critical circumstances produced by the pandemic). Otherwise, when community participation is most needed,

we run the risk of having no community to rely on. Social policy should complement medical reasoning in designing emergency plans for future preparedness, bearing in mind the symbolic performance of institutional activity. Our challenge today relates to the ability to create organisational settings capable of overcoming those cultural fragmentations that reduce care to disease treatment, while they strip health of those social relationships on which we might act for its promotion (Wilkinson and Kleinman 2016).

Conclusion

The COVID-19 pandemic has laid bare the many strains that Italy's healthcare system has amassed over past decades. Yet we have shown how analysis cannot be reduced to the mere impact of austerity measures: we also need to address the broader cultural assumptions at the core of medical and public health policy. As we have shown for the Italian context, in order to design an effective preparedness, we need an institutional culture capable of considering health as a cultural construct to be socially generated, where participation is the means to operationalise both: people's involvement in defining their best interest, and their engagement in transformative actions.

Quite timely, on 26 September 2020 *The Lancet* chief editor, Richard Horton (2020b), claimed that we should look at COVID-19 as a syndemic rather than a pandemic. In introducing the concept of syndemic, Merrill Singer (2009) referred to the constitutive social embeddedness of any given biological reality, and their complex articulations at the local as well as global level. Along such a line of reasoning, in this chapter we have showed the local emergence of COVID-19 in Italy, arguing for a finer approach capable of addressing its social articulation at the local level. Likewise, we have tried to show how to translate the outcome of such a theoretical approach in designing institutional responses capable of taking into proper account the constitutive social dimensions of COVID-19.

The concept of syndemic is most welcome if it helps to drive institutional reasoning towards the appreciation of human agency and responsibility in medical reality, and coherently of public health interventions as cultural practices by which a specific social order is produced, and, by focusing on the body, naturalised. The way we approach the present critical situation related to COVID-19 will inevitably have a deep impact on the way we represent ourselves, social relations and the global scenario – in a nutshell, the very meaning of humanity.

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