THE LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE

Department of International Relations

Confronting the COVID-19 Pandemic

Grief, Loss, and Social Order

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Executive Summary

This research addresses the challenge the 2019-2020 COVID-19 pandemic (COVID-19) presents to social order as a result of mass grieving and loss. It places a particular emphasis on the UK response and lessons that can be learnt for further 'waves'. A tendency for research to look at technocratic policy responses has led to the overlooking of the social impact that pandemics produce. This study, in contrast, employs a qualitative, comparative methodology to examine four key cases – the UK, Italy, South Korea, and Germany – from 1 January to 31 July 2020, as well as the UK during the 1918-19 influenza epidemic – to examine the politics of COVID-9 as a mass death event.

Our research finds that the narrative framing of the pandemic as a particular type of crisis; the ways that deaths have been recorded and managed; and the manner in which loss has been mourned and commemorated vary across cases. This variance, the research suggests, has implications for the ways that societies may respond, particularly in the medium- and long-term. Recommendations are made for governments responding to future 'waves' of the virus in relation to communicating loss to the public, and commemorating deaths in a manner that supports social cohesion and prepares the public for future crises.

Key Recommendations

Based on this research, the report makes the following top-line recommendations. Though largely aimed at government, the general principles may be applied to many local institutions and civil society organisations. For further explication, recommendations, and context, please refer to the Appendices.

- **Provide a clear separation between different types of communication: factual, political, and emotional**
- **Address grief experienced by the public explicitly, empathetically, and consistently in emotive terms**
- **Emphasize that the deaths of elderly people and/or people with underlying conditions are not inevitable**
- **Acknowledge differential patterns of death and grief/loss experienced by different communities in official communications**)
- **Designate a national day of mourning**, marked by a day off work and programming at national and local levels by religious and government officials and community members
- **Commission a nationally funded, locally-embedded four-nations collective history project** to collect remembrances of the deceased and experiences of loss in communities
- **Establish a fund to support commemoration and memorialisation** to which local/regional/national groups and communities may apply to support projects and activities
- **Develop a set of best practices to ensure diversity, inclusivity, accessibility, and representation in commissioning and implementing commemorative practices, events and monuments**
- **Differentiate clearly between commemoration** (recognition of an important event/ social contribution) **and memorialisation** (honouring of the deceased) in public recognition of health, care, and key workers

Introduction

Pandemics present a distinct challenge to social order. The sheer scale of the loss of life, and its differential impact upon particular communities threatens social cohesion, and challenges national and local government agencies. Whilst public health management is naturally the dominant policy response, the *social impact* of the COVID-19 response is potentially overlooked.

This interdisciplinary research project draws upon a cross-country comparison to assess the way that societies have responded to mass death in light of the COVID-19 pandemic. We use a qualitative, comparative methodology to examine four key cases – the UK, Italy, South Korea, and Germany – from 1 January to 31 July 2020, as well as the UK during the 1918-19 influenza epidemic – and their responses to mass pandemic death. An array of literature, including work on post-conflict transitional justice, the politics of military deaths, and memorialisation studies shows that grief, loss, and remembrance – even when conducted in private – are deeply political processes that shape a new normal. Elites have a role to play in this process, in terms of how they narrate the particular crisis; how they relate to the impact of grief, loss, and death; and how they respond to its differential effects. A reluctance to talk about death, particularly in the UK context,[1] makes this research particularly important.

Mass death therefore has social effects. The experience of grief, loss, and death also has a 'long tail'. Memorialisation and collective memory become important not just to address the impact of mass death on social cohesion, but to allow societies to build resilience in the instance of later pandemic 'waves' or different pandemic strains in the future.

1.1 Context: Literature Review

We approach the politics and social impact of COVID-19 fatalities through the lens of international relations, sociology, conflict, and nationalism scholarship. Studies of war, post-conflict reconciliation, and the politics of collective memory offer important insights into the tense relationship between governing narratives of death and crisis and subsequent prospects for social order, cohesion, and the resumption of 'normal' politics.

Our analytical framework (see subsequent section) is drawn from the factors this literature indicates are important to the production of social order following mass death. Given the continually evolving and therefore currently unknown medium- and long-term effects of mass COVID-19 death, this literature also informs our forward-looking analysis and recommendations. Historical literature regarding past pandemics is integrated where relevant – most centrally in the historical analysis of the 1918-19 UK influenza epidemic.

Importantly, we understand 'social order' in the broadest sense. It is not simply an absence dissent, unrest, and/or crime, but the social structures, relations, and community and cultural resources that enable a society to function socially, politically, and economically. Importantly, as social order often refers to notions of stability and consensus, this does not mean order per se is normatively valuable – unjust and violent orders exist – but that it is socially and politically important. Given the quick-moving nature of the pandemic – bluntly, we do not yet know what will happen – and the rapid timeframe for this particular report, we do not precisely disaggregate/measure social order. This is an important avenue for future research. Instead, our

analysis regarding social order is based on the informed interpretation of the relevance of the literature below for both COVID-19 generally and our cases specifically.

Death and Social Order

The sociological and anthropological literature finds that death poses a potential threat to social order.[2] Most societies have developed grieving practices that enable loss to be processed and, eventually, 'normal' life resumed.[3] State institutions and elites play a significant role in managing both the material aspects of death and collective processes of grief and mourning.[4]

How deaths are addressed, or not addressed, by elites can have unintended consequences in enabling or constraining future policy choices by entrenching dominant policies, marginalising alternatives, and making some policy changes difficult by establishing taboos in public discourse.[5] Nationalism and military scholarship demonstrates that 'good deaths' – such as those of volunteer soldiers in a legitimate conflict – are socially interpreted as understandable, tragic but acceptable, and recognised in a precise, meaningful time and place.[6] These deaths follow recognisable social scripts. They can be forged into affirming narratives that produce positive visions of national identity, increase social solidarity, and promote belonging.[7] They also, importantly, normalise the risk of death as a key characteristic of the job of military personnel.

'Bad deaths', in contrast, which are not easily placed into existing narratives[8] – such as sudden deaths, enforced disappearances, or mass catastrophe – reveal the limitations upon state institutions and elites' ability to provide security.[9] They have the potential to undermine public trust in institutions, feelings of political membership, and social cohesion.

Mass Death and Post-Conflict Reconciliation

Studies of mass violence, civil war, and post-conflict justice and reconciliation demonstrate that clashing imperatives between the state and local communities – as well as groups within society – in addressing mass death may exacerbate social cleavages (and produce new ones). Bluntly, the sudden appearance of many dead bodies is not only a logistical problem of material storage and mortuary practices, but also a political problem. [10] In conflict situations, the state's desire to rapidly retrieve bodies to preserve evidence and/or prevent a public health emergency can clash with the desire of victims to conduct funeral rites and respect the dignity of those who died.[11] The disruption of burial and religious rites can project trauma and social division and friction long after the cessation of the initial conflict/crisis.[12]

Societal understandings of mass death are multidirectional, as narratives of loss, cause and effect, and blame are produced by national, regional, and local governments – as well as communities – simultaneously. This suggests that seemingly technocratic responses to mass death, such as hygiene regulations or the means of communicating fatalities, have important affective, social, and political consequences.[13]

Existing research on security and conflict policymaking has demonstrated how a crisis is *narrated*—as an identifiable story outlining what the challenge is and who the players are —can play a critical role in constructing political behaviour. Crisis narratives can mobilise political action, promote certain collective values, and encourage solidarity among the public.[14] Conversely, too

much distance between the lived reality of much of the public, who are grieving the loss of their loved ones, and the government's account of the crisis (or normalisation efforts), which makes such loss less visible or even an acceptable form of sacrifice, can lead to increased public discontent.[15]

The question of responsibility for mass death – in terms of direct harm, neglect, mismanagement, and failures of recognition – can exacerbate racism and other societal divisions.[16] Elite messaging regarding victims and their identities – as well as a failure to discuss or acknowledge all victims and their identities – can produce implicit hierarchies in grief (and social valuations of particular lives).[17] Similar contestations can occur when groups and communities produce claims to visibility, victimhood, and/or blame. These operate as political claims to recognition, power, and a stake in community identity, which may be positive,[18] but can also exacerbate societal divisions and racism.[19] Research suggests exclusive narratives of victimhood are associated with negative attitudes towards members of other groups, whereas inclusive narratives of conflict/atrocity experience and victimhood are associated with positive relationships between groups and increased prospects for social solidarity.[20]

Commemoration and Collective Memory

The experience of mass death, and seemingly short-term social and political choices regarding grief and commemoration have long-term effects.[21] The state has an important – though not singular – role in the formation of collective memory through commemoration, memorialisation, and other public memory-making practices.[22] Commemoration and collective memory carry the social, political, and affective experience of mass death into the future.[23]

Decisions about what and who are commemorated — Including the decision to not commemorate at all[24] — strongly inform popular memory of crises. As a result, commemoration is a foundation for future policy making and societal recovery.[25]

Commemoration, importantly, is not straightforwardly positive or negative.[26] Memory 'is a struggle over power and who gets to decide the future'.[27] Top-down commemorative practices that further a singular, elite-driven narrative of the crisis often prioritise a quick return to a narrow, physical security-based understanding of 'normality' – and the preservation of a particular government's political power – over inclusive and locally-sensitive memorialisation.[28] Narrow and unresponsive commemorative practices can, again, further social cleavages and divisions by providing an account of the crisis that does not align with popular experience. It also, again, indicates, which deaths – and thus people and communities – were seen as important losses to the society (and those that were not).[29] The Black Lives Matter movement, for instance, has revealed the way past commemoration choices (e.g. colonial statues) contribute to a limited understanding of history and the persistence of racism and inequality in the present.

Commemoration is not a guarantee of 'lessons learned' or the prevention of future crises and atrocities.[30] Neither, however, does an absence of explicit commemoration necessarily support recovery and resilience. Historians observe that the so-called 'Spanish flu' epidemic of 1918-19 went largely un-commemorated, partially due to the fact that many of the victims were young, working class and/or marginalised people lacking in political power and social visibility.[31] They argue that the failure to commemorate the 1918-19

pandemic resulted in a collective 'forgetting' that undermined future preparedness and public health measures.[32]

Research indicates that reflective, consultative, and locally embedded commemoration can strengthen social cohesion, through the production of inclusive collective memory. The involvement of victims and survivors' organisations,[33] bottom-up community campaigns,[34] and the pairing of ad hoc and local commemoration with more official state practice has supported these efforts. Commemoration that enables people to engage with loss, and offer many perspectives on the crisis, rather than enforcing a single narrative, has been observed to promote social solidarity.[35]

Key Takeaway

The scale and abruptness of COVID-19 deaths, unprecedented nature of the pandemic, and well-documented disruptions to both private and public mourning rituals give COVID-19 fatalities an ambiguous social meaning. The literature suggests that, unrecognised and mismanaged, COVID-19 fatalities may pose a threat to social order and cohesion, while inclusive, locally embedded reckoning with loss and grief contributes to solidarity and recovery.

1.2 Methodology

The research consists of a cross-national survey of the impact of COVID-19 in four contemporary cases: the UK, Italy, Germany, and South Korea, from 1 January to 31 July 2020. Primary source materials included government communications at the local, national and ministry level as well as press reporting at the national level. In addition, one historical case study of the impact of the 1918-1920 Spanish flu pandemic on the UK, provides historical context. At the time this project began, the scale of death in the UK was unknown. The contemporary cases were therefore selected to capture variance in death rate (with South Korea having a low death rate, Italy high, and Germany in the middle), with the aim of drawing lessons both broadly and for the UK. Since then, a wide disparity has opened up with Italy and the UK exhibiting higher death rates than Germany and South Korea. As the analysis will demonstrate, however, while this variance certainly informs the management and narratives around death in each case, the scale of death is not deterministic in its social interpretation or effects.

Whilst there may be good reasons to infer that institutional differences between governments shape pandemic responses, this study is not concerned with this, nor indeed with explaining the relative success or failure of different policy responses. Instead, the study focusses on the *discourses* surrounding the way that the pandemic has been narrated, how loses have been reported, how grief has been discussed, and how memorialisation has been carried out. We use an interpretive methodology, seeking to understand what conditions of possibility might be created by different ways of dealing with death and memorialisation.

Three core research thematics shaped the interpretation of the primary source material with sub-themes emerging within them (see *figure 1.*).

'Crisis narrative' concerns the way that the pandemic is narrated by elites. A prominent subtheme here was the discourse of the pandemic as a 'war', and the question of blame/responsibility which singles out certain sectors of society for privileged treatment and/or culpability. This theme is also concerned with the ways in which certain

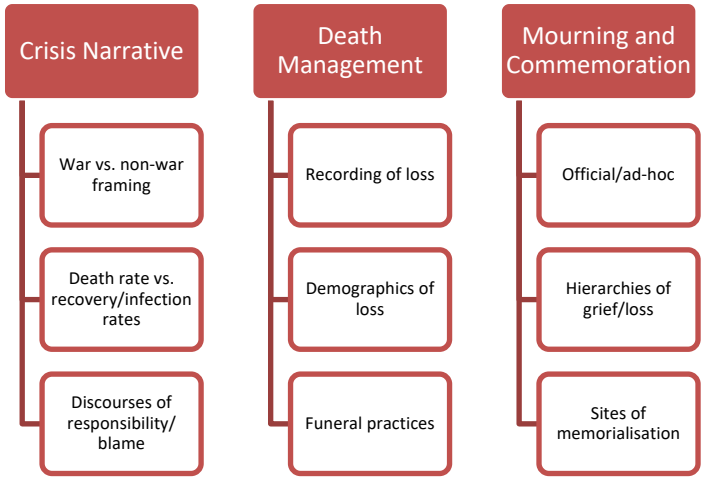
levels or patterns of death are produced as socially 'normal' (or inevitable/acceptable).

'Death management' relates to the way that bodies of the deceased were recorded and processed, and how funeral practices were regulated. It maps the ways in which deaths were recorded and communicated. It also examines the social and political implications of disrupted practices of grief and mourning, such as hospital visitation and funerals. A key sub-theme is the ways in which death management regulations and administration had differential effects upon particular communities.

'Mourning and commemoration' concerns the way that a society remembers. Literature on memorialisation and post-conflict transitions shows society has a stake in the way in which it 'remembers'. Commemoration has long-term social effects. Particularly important here are the 'hierarchies of grief' that opened up between certain groups.

In practice, these thematic pillars are related and intertwined. The crisis narrative (for instance) is both informed by and informs death management; mourning and commemoration are informed by demographics of loss and the hierarchies of grief they foster, and so forth. These relationalities are explored in the case studies outlined below.

Figure 1: Core research thematics and sub-themes



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UK: 1918-1919 Influenza Pandemic

Martin Bayly

In a period of 46 weeks between 1918-1919 the 'Spanish Flu'[36] pandemic killed an estimated 228,000 in the UK, making 1918 the first year on record in which deaths exceeded births.[37] In the US, an estimated death toll of 675,000 reduced the national life expectancy by 12 years. Elsewhere, the mortality rate was staggering. In South Africa, the relatively small population suffered a toll of 140,000 dead - mostly non-Europeans. Cape Town, it was said, was a 'city of the dead', with the Press Association reporting that some 'native' communities had been entirely wiped out.[38] India suffered the worst toll, compounded by an ongoing famine, with estimates reaching as high as 18.5 million deaths.[39] Globally more than one quarter of the world's population contracted the virus.[40]

The origins of the 1918 pandemic are contested, but one important vector was undoubtedly the movement of troops towards the latter stages of the First World War. Military bases in the USA that supplied troops for the American Expeditionary Force (AEF) as well as troop contingents in Northern France have been identified as one breakout site. More recent epidemiology suggests that the virus was in circulation in the two years immediately preceding the pandemic.[41] The pandemic struck the UK in at least three discernible waves. The first, in the spring of 1918; the second, and most deadly, in the winter of 1918; and the third wave in the early spring of 1919. However, newspapers continued to report smaller outbreaks of influenza for at least another two years.[42]

A key contextual factor shaping the public and political response to the pandemic was the sheer uncertainty over what the disease was. Some senior medical practitioners and public health officials had experienced the earlier 'Russian flu' of 1889-1892.[43] However few lessons seemed to have been learned in the interim, indeed repeated influenza visitations arguably induced a degree of complacency.[44] Virology remained in its infancy with medical science tending to the belief that influenza was a bacterium.[45] This was significant since the smallpox epidemic of 1901-1904 had institutionalized a series of counter-measures for notifiable infectious diseases – including vaccination programmes.[46] Influenza, however, was not a notifiable disease and vaccinations were not considered a worthwhile preventive measure, despite their use on military units.[47] Added to this, nineteenth century ideas continued to shape thinking, with notions of the 'miasma', 'bad air', or 'ill wind' still prevalent in both received wisdom and official advice.

Crisis Narrative

The First World War provides the central contextual factor shaping the official response. In material terms, there simply were not the resources for a comprehensive response. The war in Europe diverted medical practitioners away from the UK. Furthermore, the horrifying scale of fatalities as a result of the war had normalized death in such a way as to induce a degree of fatalism in the crisis narrative. Added to this, in the absence of comparative or time-series data, the public were given few tools to anticipate the future course of the outbreak, nor were policy elites willing to regularly narrate the chronology of deaths. Honigsbaum argues that war weariness encouraged an attitude of simply dealing with the crisis with a grim determination.[48] Certain newspapers and public figures, including those within the medical profession, encouraged the idea

that worrying about the disease would increase one's susceptibility to illness and even weaken the nation's resolve in the war effort.[49] In the words of Sir Arthur Newsholme, the Chief Medical Officer of the Local Government Board (LGB), the national circumstances compelled an individual duty to 'carry on'.[50] The prevailing discourse behind the onset of the disease was therefore not one of a 'war' or 'battle', even though the apparent viciousness of the influenza, and the speed at which it developed encouraged the language of an 'attack'.

Despite the vectors appearing to come from troop movements, there was only occasional blame or responsibility accorded to soldiers.[51] Unawareness of how the virus was spread meant attribution of blame tended to fall on a failure to observe proper sanitary habits.[52] One frequent target of blame was the Local Government Board as the only organization capable of oversight of the public health response by local authorities. In 1918 the Ministry of Health did not exist; it came into existence partly as a response to the pandemic in 1919. Public health was the responsibility of locally appointed Medical Officers of Health (MOHs), the Board of Education, and a number of ad-hoc bodies. This decentralization of public health generated disaggregated and uneven countermeasures to address the outbreak. Whilst the proactive MOH at Manchester, James Niven, issued a public advisory as early as June 1918 and closed schools,[53] this was far from standard practice. The LGB did not issue blanket advice till the advent of the second wave in February 1919, advising 'healthy living', well-ventilated rooms, warm clothing, and gargling with a solution of salt, warm water, and potassium permanganate.[54] But few councils reproduced this systematically. Brandy and whiskey remained a popular remedy. The Liverpool Medical Officer of Health, for instance, approved the release of larger rations by the excise authorities.[55] Elsewhere, inspired by methods of eliminating vermin, a sanitary and chemistry expert at Hull came up with a novel solution, offering to gas 'any street in Hull at my own expense as a demonstration. If you can gas vermin, why not influenza germs[?]'.[56]

Death Management

Structural factors also shaped the recording of influenza deaths. In the absence of a Health Ministry, death figures were collated and reported at the local and regional level – often through regional newspapers – and exhibited uneven practices. National figures, time series graphs, and international comparisons were available post-hoc in official publications,[57] but were generally absent in real time, except anecdotally. As a result, the temporality of the crisis differed.[58] Influenza's status as a non-notifiable disease further complicated recording of deaths. Uncertainty over the nature of the disease led to recordings of 'pyrexia [fever] of unknown origin (POU)'. The co-morbidities of pneumonia, bronchitis, heart disease, and phthisis (tuberculosis), were often reported in the death numbers alongside 'influenza', obscuring the deadliness of the virus.[59] The absence of viral testing meant infection rates were not possible, whilst recovery rates were not reported. The wartime context also meant that 'civilian' deaths were separated from military deaths. The latter were reported but not numerated. This further obscured the deadliness of the virus whilst adding to an overall 'absenting of bodies'.[60]

The virus proved disproportionately deadly to adults between the ages of 25-34, and women in particular.[61] Whilst the gender ratios were overlooked, contemporary discourse privileged the

deaths of the young, with the death of children understandably marked out as particularly tragic.[62] Heroization was apparent in the disproportionate coverage afforded to the illness and deaths of serving police officers, health workers, and soldiers.[63] Although the indiscriminate nature of fatalities, in terms of social class, was on occasion acknowledged,[64] this somewhat sensationalist narrative obscured those statistics which suggest that the urban poor were disproportionately at risk.[65] This was occasionally acknowledged in the press.[66]

Funerals were not banned during the influenza pandemic, but body disposal was severely impacted by overworked undertakers, gravediggers, and coffin builders. Conscription led to a shortage in grave diggers and funeral workers. Even a shortage of horses and the low-quality feed available impacted on the provision of ambulances to remove the deceased.[67] In Sunderland, for example, over 200 bodies were left unburied for over a week.[68]

Mourning and Commemoration

This research has been unable to find any public memorial in the UK to the 1918-1919 influenza pandemic. This reflects international practice, with New Zealand providing one exception. Youde points to the social function of memorialisation, and the manner in which this can be dominated by a state effect of selective commemoration. The ambivalence of the state to influenza deaths despite the scale of loss *added to* the wartime context provides an explanation for the absence of public grief. The difference that public commemoration may have made to preparedness in later pandemics is a key counter-factual and arguably provides one of the most compelling 'lessons' from the 1918 pandemic.

Conclusion

Caution must be taken when comparing the present pandemic with the 1918 influenza outbreak in the UK. The wider context of the First World War and its aftermath was key in downplaying the crisis narrative. Rhetoric of a 'war' against the virus was absurd in this case. Scholarship has pointed to 'war-weariness' that seemed to shape the fatalism with which the outbreak was faced, but wider institutional, material, and social effects are apparent. The governing apparatus was radically different, and the paucity of virology expertise was decisive.

The absence of an overarching health ministry created a disaggregated and uneven public health response. Rarely was the crisis grasped by governing elites, either rhetorically, or in practice. The material privations of the war added to the overwhelming demands on body management. Even though funerals were permitted, the sheer pace of death fostered a silencing of grief. Less acknowledged in the literature is the fact that the devastation visited on troops was also silenced.[69] Fighting men were permitted a hero's death on the battlefield, but wartime restrictions meant reporting on the numbers killed by influenza was scarce.

Crucially, the second wave of the pandemic, which was more deadly than the first, appeared to generate more outspoken opinion against the response of the local and national government. In the medium term, newspapers remained alive to the possibility of later 'waves' of influenza for a number of years, demonstrating the long-tail impact of the pandemic on public awareness.

36 'Spanish Flu' was a misnomer. Spain was a neutral in the First World War. Accordingly Spanish newspapers were amongst the first to report the outbreak. Newspaper proprietors in belligerent nations were more wary of causing panic.

37 Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, loc 127, 144, 75.

38 'Spread of 'Flu'. Sheffield Calls for Volunteer Nurses. Home Help Needed.'

39 Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 147.

40 Youde, 'Covering the Cough?,' 358.

41 Phillips, 'The Recent Wave of 'Spanish' Flu Historiography.'

42 'Flu Reappears'; 'Influenza Wave Coming'; "Flu Wave Breaks in Dundee. Worst Is over, Think the Doctors'; "Flu' Perils. Large Factory Has to Be Closed'; 'Influenza'; 'Return of the Flu.'

43 The Medical Officer of Health at Manchester, James Niven, who was praised for taking early action had been the Medical Health Officer for Oldham during the 1889 pandemic. Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 51; Tanner, 'The Spanish Lady Comes to London'; 'Spread of 'Flu'. Sheffield Calls for Volunteer Nurses. Home Help Needed'; Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 51.

44 Honigsbaum records particularly deadly flu seasons in 1895, 1905, 1908, and 1915. Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 39.

45 Honigsbaum, 9; Tanner, 'The Spanish Lady Comes to London,' 63.

46 Tanner, 'The Spanish Lady Comes to London,' 61–62.

47 Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 118; 'Influenza Epidemic. Lord Mayor and Burial of the Dead. Authorities Taking Action.'

48 Honigsbaum, 106.

49 Tanner, 'The Spanish Lady Comes to London,' 59.

50 Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 59. Honigsbaum describes the celebratory atmosphere in London towards the end of the war despite the beginning week of November bringing the highest weekly death rate in London (at nearly 2,500) since the cholera epidemic of 1849, p.89.

51 The MOH in Manchester connected high death rates in the area with the treatment of large numbers of infected American servicemen at the Old Trafford cricket ground, for instance. "Spanish Flu' in Hull,' The Daily Mail, June 28, 1918; Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 50.

52 'Influenza. A Heavy Death-Roll.' The 'filthy' conditions of the Newcastle streets 'which would disgrace the backwoods of America', were one such target.

53 "Spanish Flu' in Hull'; Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 50.

54 'How to Escape 'Flu.''

55 'Influenza. A Heavy Death-Roll.'

56 'Influenza. A Heavy Death-Roll,' 7.

57 Supplement to the Eighty-First Annual Report of the Registrar-General of Births, Deaths, and Marriages in England and Wales: Report on the Mortality from Influenza in England and Wales During the Epidemic of 1918-19.

58 Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 106.

59 "Flu' Death-Roll. Last Week's Increase in Nottingham'; Supplement to the Eighty-First Annual Report of the Registrar-General of Births, Deaths, and Marriages in England and Wales: Report on the Mortality from Influenza in England and Wales During the Epidemic of 1918-19.

60 Youde, 'Covering the Cough?'

61 Honigsbaum, Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918, 106; Tanner, 'The Spanish Lady Comes to London,' 56.

62 'Northfield Notes. Victims of Influenza Epidemic,' 7.

63 "Flu's Lingering Effects,' 3; "Flu' Attacks Police,' 3; 'Stirling Soldier's Death from Influenza'; "Flu Still Serious. To-Day's Conditions in London'; 'Influenza Epidemic. Lord Mayor and Burial of the Dead. Authorities Taking Action.'

64 'The Influenza Epidemic.'

65 Tanner, 'The Spanish Lady Comes to London'; Phillips, 'The Recent Wave of 'Spanish' Flu Historiography,' 799.

66 'Labour in Local Government. Busy Death.'

67 'Spread of 'Flu'. Sheffield Calls for Volunteer Nurses. Home Help Needed.'

68 'Influenza Epidemic Ravages: Hundreds of Unburied Dead at Sunderland'; 'Spread of 'Flu'. Sheffield Calls for Volunteer Nurses. Home Help Needed'; "Flu Spreading. More Schools Ordered to Be Closed'; 'Flu Finishing: Speedy Decrease of Its Virulence Expected'; "Flue' and Funerals.'

69 Phillips, 'The Recent Wave of 'Spanish' Flu Historiography.'

United Kingdom

Katharine M Millar

'I've got to be clear, we've all got to be clear, that this is the worst public health crisis for a generation…And it's going to spread further and I must level with you, level with the British public, many more families are going to lose loved ones before their time' – Boris Johnson, Prime Minister of the UK, 12 March 2020

Background:[i]

As of 31 July 2020, the UK had approx. 303,181 cases of COVID-19 and 41,189 COVID-19 deaths.[70] Excess mortality calculations suggest total fatalities could be closer to 60,000.[71] The first patients in the UK were diagnosed with COVID-19 on 29 January; the first person in the UK died on 5 March. The UK daily fatality total peaked on 21 April, with 1,224 deaths; the record daily case total was 22 April at 5,505.[72]

On March 16, Prime Minister Boris Johnson gave the first daily press briefing on COVID-19, asking the public to work from home and avoid public spaces.[73] On 23 March 2020, Johnson issued a three-week stay-at-home order ('lockdown') requiring people to stay at home absent 'essential' activities.[74] On 27 March, Johnson tested positive for COVID-19, and was eventually hospitalised before recovering.[75] COVID-19 daily briefings were conducted from 16 March to 23 June by members of Cabinet – particularly Health Secretary Matthew Hancock – alongside scientific advisors.[76] The UK government was criticised for inconsistent messaging and guidance regarding permissible and impermissible actions during the stay-at-home order.[77] This was compounded by the use of a four nations (Northern Ireland, Scotland, Wales, and England) approach to pandemic management and communication. 'Lockdown' (for England) was considered to end on 4 July, 'Super Saturday', when service businesses were permitted to re-open and two households were able to spend time together indoors.[78] Thirty COVID-19 deaths, on average, were reported each day that week.[79] On 30 June, the UK government announced the first 'local lockdown' of Leicester, as the pandemic response shifted, in public presentation, from crisis reaction to management[80].

Crisis Narrative

The official UK narrative of the COVID-19 crisis, very broadly, framed COVID-19 deaths as inevitable, while also producing an implicit hierarchy of grief and social value as to regarding lives lost.

On 12 March, Johnson referred to COVID-19 as the 'worst public health crisis for a generation', warning the UK public that 'many more families are going to lose loved ones before their time'.[81] On that day, 38 people in the UK had died of COVID-19, social distancing was not in place,[82] and Johnson announced that track and trace measures would be halted, instead recording only COVID-19 cases in hospital.[83] Following the 12 March statement, death and case numbers were reported daily by the

i This case study is predominantly concerned with the UK government (Westminster). It should be noted, however, that the UK took a four nations approach to public health regulations, leading to differences in rules, expectations, and public experiences of the pandemic in Northern Ireland, Wales, Scotland, and England - an important avenue for future comparative work.

Department of Health and Social Care, and often noted by the UK Cabinet members conducting the daily COVID-19 briefings. The UK did not track, and therefore did not publicize, COVID-19 recovery rates, centring death and risk of death within the UK COVID-19 crisis narrative.

With a few exceptions – Health Secretary Hancock typically engaged with loss more than other Cabinet officials;[84] Johnson published a letter in the *Mail* referencing the many victims of COVID-19[85] – official UK government communications seldom addressed the scale and social and emotional impact of COVID-19 deaths directly. The briefings – and Department of Health and Social Care twitter updates – typically made short acknowledgments of loss, noting that people have 'sadly died'.[86] The death figures were often presented, however, in the context of overall pandemic recovery, worst case scenarios, and future planning, rather than as notable in their own right. This may be partially attributable to the briefings being conducted by an alternating array of Conservative politicians and public health officials, framing the pandemic as: a) a scientific, rather than political problem; and b) improving and manageable. By May, messaging included thanks to key workers and the public for their sacrifices, and more explicit references to grief,[87] but with a continued emphasis upon the inevitability of death.

The UK government did not pursue a zero-fatality COVID-19 strategy and primed the public to expect significant deaths. The implicit level of socially normalised death may be considered to be between 52 and 26 fatalities/day.[88] These are the averages of daily reported fatalities for the week of 23 June, when the government ceased daily briefings, and 6 July, when the Department of Health and Social care stopped tweeting daily death figures (though they remain available daily on the UK COVID-19 website).[89] The normalisation of COVID-19 deaths has been publicly contested by opposition parties (particularly with respect to racialised disparity in death tolls),[90] unions,[91] and COVID-19 Bereaved Families for Justice, a group of 450 families who lost loved ones.[92] They argue that the scale of COVID-19 fatalities reflect government mismanagement and error, calling for a formal inquiry.[93]

The treatment of death figures instrumentally, as evidence of a need to adhere to regulations and eventual progress, facilitated an avoidance of the mass social experience of loss. The UK lacked a 'mourner in chief' to consistently convey empathy and officially acknowledge the mass loss of life. Two addresses made by the Queen in early April, which directly commented upon the loss of life, grief, vulnerability, and sacrifices, are exceptions to this overall trend.[94]

The Queen's initial statement on the pandemic invoked World War Two and the Blitz as a means of calling for solidarity and conveying British resilience. The 'war frame' was a common trope in early UK public COVID-19 narratives, though explicit analogies declined as the pandemic progressed. In early March, for instance, Johnson referred to the measures required to combat COVID-19 as unlike any seen since WWII, and framed the Conservatives as a 'wartime government'.[95] References to war were also common in popular discourse and the press – particularly the tabloids.[96] Martial metaphors referring to fighting the virus, and to COVID-19 as an 'enemy' were common. The use of war analogies invoked nationalism to convey a sense of urgency, but also sense of order, hope, and rules compliance: collective sacrifice was a common

theme during lockdown. War frames were also, however, critiqued as: a) misrepresenting the nature of the crisis; b) suggesting that aggression and fear, rather than caring and protection were the appropriate response; and c) militarising a public health problem.[97] The Blitz analogy was also turned against the government as death tolls rose, and it became likely that the approximately 44,000 UK civilians killed in the Blitz would be exceeded by COVID-19 fatalities.[98] The use of war frames declined through May and June as the peak of initial cases/fatalities passed.

The war frame also played into a broader normalisation of death and hierarchicalisation of grief within the UK. Inspired by similar practices in continental Europe, the UK quickly recognised the contributions of health workers. The most famous example is the Clap for Carers campaign,[99] but also included the proliferation of rainbow imagery associated with the National Health Service (NHS),[100] adverts and public posters thanking the NHS,[101] and frequent references to NHS workers by public officials. The government's first official pandemic slogan 'Stay Home, Save Lives, Protect the NHS' reinforced this message,[102] as the health system (and over-worked doctors, nurses, and hospital staff) were framed as in need of assistance from the public. Health workers were constructed as national heroes, not unlike soldiers in wartime.

The 'hero' frame was shortly extended to other 'key workers',[103] including transport,[104] delivery, and retail workers.[105] This heroization recognises their important public service, but also normalises death as a risk associated with health, caring, and other key occupations. Unions have observed and resisted the dangers of this frame.[106] It posits key workers as potentially disposable in the pursuit of social and economic recovery.[107] This created a hierarchy of grief that implied that those who are not considered to be economically essential, such as elderly and disabled people, were less deserving. Compounding this hierarchicalisation were the references to age and 'underlying health conditions' as risk factors related to fatalities, suggesting that some deaths were less preventable (and, implicitly, less sad and more acceptable) than others.[108]

Death Management

COVID-19 death tolls were reported on a daily and weekly basis and reported widely in the press. Comparisons with international death figures were included in daily briefings until 12 May, when the UK had the highest global excess death rate.[109] The initial reporting of the death figures was confused and understated. This was due to the fact that the four nations within the UK used slightly different definitions and practices of reporting COVID-19 deaths,[110] leading to some discrepancies in COVID-19 fatality numbers.[111] Until 29 April, moreover, Public Health England recorded only deaths in hospital due to COVID-19 in its reporting, meaning that care home fatalities were excluded from daily briefings by Department of Health and Social Care briefings.[112] This obscured deaths of the elderly and misstated the severity of the pandemic to the public for the first six weeks.

COVID-19 fatalities reflected both global trends and existing patterns of socio-economic disparity, health inequality, and racial and ethnic marginalisation within the UK. 91 per cent of people who died of COVID-19 had pre-existing conditions; older people were substantially more at risk of COVID-19 death than younger; and men were 50 per cent more likely to die of COVID-19 than women.[113] Socio-economically deprived areas

also experienced higher COVID-19 death rates.[114] People belonging to Black, Asian, and minority ethnic (BAME) communities were also found to be at substantially higher risk of dying from COVID-19,[115] due to the continuation of socio-economic and health inequalities, as well as racism and discrimination.[116]

Funeral and mortuary practices were subject to regulation. As regulatory specifics relating to hospital visitation, body transport/storage, and funerals were delegated to local authorities,[117] there was substantial variation in death management – and the experience of loss – across the UK. Many hospitals severely restricted or stopped hospital visits. Many people died without loved ones present and survivors experienced distress at their inability to say goodbye or offer comfort in person.[118] Unlike many countries, the UK did not mandate cremation of the bodies of COVID-19 fatalities, but did relax the regulation of cremation to expedite the process.[119] The UK sought to expand its mortuary capacity by 30,000 places through the construction of temporary mortuaries.[120] Some temporary mortuaries were criticised for their failures to adhere to appropriate PPE protocols, train new staff, and treat the deceased with dignity.[121] Several local authorities dug new graves in anticipation of COVID-19 fatalities.[122]

Funerals were officially permitted, but socially distant and severely restricted in numbers.[123] Some crematoriums did not permit attendants at all.[124] Many people chose to forego a funeral entirely, instead choosing 'direct cremation' of the deceased, which is less expensive but also a less formal marking of death.[125] Many people dealt with grief in isolation, often compounded by guilt at an inability to conduct appropriate funerals and/or religious services.[126] Minoritised religious and cultural groups were particularly affected by funeral and mortuary regulations that prohibited family members from attending the bodies of loved ones, as is common within Jewish and Muslim religious and cultural practices.[127] Religious leaders and funeral directors reported being overwhelmed with the volume of the deceased, and the difficulty in consoling the bereaved absent social contact and conventional services.[128]

Interestingly, absent a few isolated instances of abuse of funeral workers, there appears to have been little public contestation of these restrictions.[129] The most notable was a small group of Conservative MPs calling for the Church of England to resume services prior to the Church deeming it safe.[130] Charities, religious leaders, and the bereaved noted that the disruption of traditional mourning intensified the pain and experience of grief, with some recommending that remembrances or services be held at a later date.[131]

Mourning and Commemoration

Ad hoc commemorative practices – and calls for memorialisation of COVID-19 fatalities – are taking place across the UK.

Mass and/or national-level commemoration has, thus far, tended to again emphasize the sacrifices of key workers – particularly health workers. These practices include the Thursday evening 'Clap for Carers';[132] a minute's silence for deceased health workers on International Workers' Day (28 April);[133] and the celebration of the NHS's 75th birthday on 5 July.[134] Initial coverage of individual COVID-19 deaths – rather than total fatalities – in the press also emphasized the deaths of healthcare workers.[135] There have been calls to add a figure of

a health worker to a planned '999' monument in Central London;[136] a monument to NHS workers at the National Arboretum, a space for recognising self-sacrifice and public (usually military) service, has also been discussed.[137]

These practices demonstrate a blurring of commemoration – of an important event and social contribution – and memorialisation of the deceased in remembering COVID-19. This is compounded by a tendency to recognise the dead through their occupations. A memorial to deceased transport workers, for instance, has been proposed for Victoria Station, London.[138] This further normalises the deaths of key and health workers as sad, but potentially necessary or understandable, in the service of not only the health of others, but the economy overall.[139]

Thus far, no official national government plans have been announced for the commemoration of COVID-19 or memorialisation of victims. The most prominent effort to recognise all of the deceased, rather than solely key workers, was a moment of silence declared for the evening of 4 July, prior to the NHS's birthday the following day, that asked the public to light a candle for the dead.[140] Layla Moran of the Liberal Democrats called for a national memorial to all COVID-19 fatalities on 19 July.[141] Given the scale of death, individuated memorialisation, such as obituaries, that recognise dignity and loss of each person, has been challenging. Many media organisations have made efforts to collect and publicise tributes to the dead.[142] To date, the St. Paul's (virtual) Book of Remembrance – announced on 22 May and supported by Prince Charles[143] – is the only place of national symbolic significance where the names of all deceased may be recorded and memorialised.

There is also a proliferation of local and regional commemorations and memorialisations. As these are continually emerging and not recorded in a central manner, it is difficult to generalise about their form and content. They seem, however, unlike more official or national efforts, to distinguish less between key workers and other COVID-19 fatalities, providing a space for mourning all deceased within communities. These memorialisation and commemoration sites range from walking trails;[144] memorial gardens at care homes, crematoriums, and on private land;[145] to conventional statuary monuments.[146] Memorial gardens are common (particularly in the UK) in instances where the scale of death challenges individuated memorialisation.[147]

The scale of COVID-19 death and loss has yet to be explicitly prioritised at the national level. Local commemoration efforts address this challenge but are less able to provide symbolic recognition of loss, and communicate the diversity of the overall UK experience of grief than national efforts. The Black Lives Matter movement brought commemorative culture to public consciousness in the UK in June, effectively connecting racial disparities in COVID-19 death to broader processes of discrimination.[148] It is therefore likely that moves towards COVID-19 commemoration will involve negotiations and contestations of its appropriate form, content, and representation of community experiences and differences within/between groups.

Conclusion

The United Kingdom suffered the greatest COVID-19 fatalities from January-July 2020 (and to date) of the countries considered here. It is therefore significant that official UK COVID-19 discourses

place a great deal of emphasis upon death as a) inevitable and b) an important indicator of pandemic recovery/success rather than a mass experience of loss and grief. There are benefits to this approach, in attempting to cultivate hope, solidarity, and individual sacrifice/inconvenience for the protection of others. It has also, however, resulted in an official and publicly-circulating narrative of the COVID-19 pandemic as first a crisis, and now a challenge, to the NHS – and, perhaps most centrally – the economy. The resumption of 'normal' life, rather than recognising the loss of 40,000 to 60,000 people (and potentially more, in a 'second wave'), has become the focal point of the UK crisis narrative.

There is a risk, in either avoiding discussions of loss or treating it indirectly in the context of recovery, that official narratives and policy become disconnected from popular experiences of COVID-19 death, grief, and the emotional processing of the potentiality of death and loss. The failure to centre death in COVID-19 narratives may facilitate a social and political forgetting that undermines public health planning (including for future 'waves' of COVID-19). The recent shift from excluding care home deaths from Public Health England fatality reporting, which served to socially normalise the risks of COVID-19 to the elderly, to recent campaigns warning young people not to 'kill [their] Granny' exemplifies this problem.[149]

Moreover, UK citizens' experiences of COVID-19 grief, loss, and risk varies substantially. Failing to recognise the differential vulnerability to, and experience of, death by particular communities and groups within the UK may therefore inadvertently produce the opposite effect to that intended by 'recovery' oriented narratives. For example, Islamophobic rhetoric has accompanied local lockdowns in the North of England, as Muslim communities and families are wrongly blamed for rising cases,[150] and the differential toll of COVID-19 on minoritised racial, ethnic, and religious groups, as well as poorer people, is under-acknowledged.

There is therefore also a risk that working 'around' death in official narratives and policies results in the formation of a simplistic collective memory of the pandemic that excludes marginalised and minoritised communities and perpetuates social divisions (of race, class, region, citizenship status, etc). The UK's management and narrativization of the pandemic thus far strongly risks undermining social solidarity and the production of an inclusive social order. Dissatisfaction with the existing order can already be seen in the rise of protests concurrent with the pandemic. Some, such as the Black Lives Matter Movement and Extinction Rebellion, highlighting existing social cleavages, failings, and power dynamics that exacerbate the crisis, while others, such as anti-lockdown protests in August and September, [151] contest the severity of the crisis.

Overall, the UK experience indicates that the empirical fact of death, and its technocratic management, does not mark the end of the social and political relevance and experience of loss, but rather its beginning, as the inability to meaningfully address death as it occurs extends it in time. The effects of COVID-19 deaths on UK, in addition to short-term challenges to social cohesion, are likely to extend into the medium and long term, as issues of public recognition of different experiences/losses by different groups and communities within UK, and the formation of collective memory are negotiated.

'It has become tragically clear that fatal mistakes have been made by the government […]. As the staggering statistics continue to roll in, so too do the stories of personal tragedy […] [E]very one of those statistics was a living breathing person, taken before their time […]. For many, the wounds caused by their loss will never truly heal. For those left behind there is pain, confusion and a sense of having been failed by the system that should be protecting them.' - Matt Fowler, co-founder of COVID-19 Bereaved Families for Justice, 12 June statement

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https://www.nytimes.com/2020/05/11/world/europe/coronavirus-uk-boris-johnson.html

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79 Gov.uk, 'Coronavirus Dashboard: Deaths' (2020) https://coronavirus.data.gov.uk/deaths

80 At time of writing, the number of local lockdowns in the UK has increased substantially, and the country is preparing for a potential worsening of the pandemic during the winter (anticipating further regulations).

81 Prime Minister's Office. 'Prime Minister's statement on coronavirus (COVID-19): 12 March 2020' (12 March 2020)

https://www.gov.uk/government/speeches/pm-statement-on-coronavirus-12-march-2020

82 Heather Stewar, Kate Proctor and Haroon Siddique, 'Johnson: many more people will lose loved ones to coronavirus', *The Guardian* (12 March 2020) https://www.theguardian.com/world/2020/mar/12/uk-moves-to-delay-phase-of-coronavirus-plan

83 Sarak Boseley, 'UK to start coronavirus contact tracing again', *The Guardian* (17 April 2020)

https://www.theguardian.com/world/2020/apr/17/uk-to-start-coronavirus-contact-tracing-again

84See, for instance, Department of Health and Social Care, 'Health and Social Care Secretary's statement on coronavirus (COVID-19): 27 May 2020' (27 May 2020) https://www.gov.uk/government/speeches/health-and-social-care-secretarys-statement-on-coronavirus-covid-19-27-may-2020; 'We mourn them and will remember them'.

85 Prime Minister's Office, 'Prime Minister's article in the Mail on Sunday: 17 May 2020', (17 May 2020) https://www.gov.uk/government/speeches/prime-ministers-article-in-the-mail-on-sunday-17-may-2020

86 See, for instance, Foreign and Commonwealth Office, 'Foreign Secretary's statement on coronavirus (COVID-19): 6 April 2020' (6 April 2020) https://www.gov.uk/government/speeches/foreign-secretarys-statement-on-coronavirus-covid-19-6-april-2020

87 See for instance: Boris Johnson, *Hansard* Volume 676 (13 May 2020) https://hansard.parliament.uk/Commons/2020-05-13/debates/7F8336E1-EDA2-4AF8-9923-A65B8A9B3F7E/Engagements?highlight=death#contribution-99BA3877-9722-41EB-B7A0-EA873001D19B

88 Please note, however, that these figures reflect the UK government's adjustment to the counting of COIVD-19 deaths, from all deaths of people ever diagnosed with COVID-19 to only those who died within 28 days of diagnosis. The social perception of this number at the time would therefore be higher – July 7, for instance, was initially reported at 128 fatalities.

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Italy

Irene Morlino

'These are terrible days for our community, for the national community. Every day we are forced to register new deaths: it is a pain for our community that is continuously renewed, we lose the most fragile, the most vulnerable. We would never have thought, in our country, to look at images picturing rows of army trucks parading full with coffins of our fellow citizens. Mine, our heartful thought, and emotional proximity goes to their families.'' –Giuseppe Conte, President of the Council, 26 March 2020

Background

Italy was the first country in Europe to be reached by COVID-19. Two tourists from China were confirmed to have COVID-19 on 31 January 2020; the first instance of community transmission was diagnosed on 18 February, in Codogno, Lombardy.[152] During the last week of February, the village and region quickly became the epicentre of the pandemic. Initially, the government and local authorities of Lombardy were hesitant to take rapid action to tackle the spreading of COVID-19. The last week of February is now recognised as a lost opportunity to contain the outbreak.[153] National authorities imposed a progressive lockdown of the North of Italy on 23 February. On 9 March, the whole country was declared to be under lockdown. The peak of fatalities was reached on 27 March, with 86 000 cases of infections and 969 deaths.

When the infections began decreasing in April, lockdown measures were loosened. On 4 May, the so-called 'second phase' of the Italian COVID-19 response began with the re-opening of bars and restaurants and the resumption of travel within the same region.[154] This was followed by the 'third phase', beginning on 3 June, when travel within Italy resumed and borders were re-opened. By 31 July, Italy had experienced 247,537 cases of COVID-19, including infected (12,422), deaths (35,141), and recovered (199,974). [155]

Crisis Narrative

There were two main trends in the Italian crisis narratives: first, the framing of the pandemic as a war; second, a narrative mourning 'an entire generation passing away', with particular emphasis on elders.

The key actors shaping the crisis narratives in Italy were the government and the press. The Civil Protection Department, responsible for risk prevention and intervention following an emergency, held a daily press conference and briefing communicating the number of infections, deaths, recoveries, referencing scientific and statistical data. The briefings took place every day at 6pm during the lockdown and were transmitted on the main national channel (Rai Uno). The President of the Council (PoC) Giuseppe Conte periodically delivered public speeches to the nation, Senate and Parliament. In general, the PoC, together with the Head of State (HoS), Sergio Mattarella, were always present in the public discourse. This gave a sharp sense that health was prioritised over economic interests. Conte declared that health was a top priority for the government[156] and set up a Scientific and Technical Committee on February 2020 tasked with providing guidelines for managing the pandemic.[157] This was reinforced

by Conte's insistence that: 'The State is here. Nobody will be left alone'.[158]

In public speeches, the PoC urged the public to follow lockdown rules, adopt social distancing and follow hygiene practices. He also advocated for taking appropriate, scientifically-based measures to curb the spread of the pandemic. These speeches also discussed the social and economic provisions required to address the disruption of COVID-19.[159] Together with the HoS, Conte also conveyed messages of solidarity, grief, 'official sadness' and hope.[160] Importantly, his statements frequently featured expressions such as 'fighting an invisible enemy' and 'our battle', thus framing the pandemic as a war. Again, alongside the HoS, he consistently referred to the pandemic as 'a challenge', 'a crisis', 'an emergency'.

The press also contributed to this form of crisis narrative. The media directly defined the pandemic 'as a war', and used expressions such as 'darkest hour', 'doctors in trenches', 'silent enemy'.[161] Thus, during lockdown, official and media narratives were dominated by references to death and infection rates, as well as war framing, rather than either individual or economic/social recovery. This generated a general sense of fear and, for a large part of the population, appeared to be translated into a sense of duty and responsibility to respect the rules. High fines (ranging from € 400 to € 3000) also contributed to general adherence to fairly strict rules (e.g. mandatory masks and gloves, social distancing, funeral restrictions, movement restrictions).[162] Though Italy is often understood to be a fairly fragmented society traditionally distrustful of state institutions,[163] the period of lockdown saw a high degree of rule abiding behaviour and solidaristic social action.

The popular sense of fear was also the consequence of the second type of crisis narrative adopted primarily by the press, expressing concern over 'an entire generation [of elderly Italians] passing away'.[164] Within a societal context of an aging population and highly important family bonds,[165] the loss of elderly people was particularly striking. The average age of Italian COVID-19 fatalities was 81 years old.[166] This narrative, which was also reflected in government statements, implied that the primary aim of the pandemic response was to avoid the deaths of elderly people. This suggested that citizens' health was the government's top priority, and required a mass, shared effort. In the words of PoC Conte, 'Everyone's effort is needed [...] the government's top priority is to protect citizen's fundamental right to health […] we protect the freedom of each citizen from the disease and death'.[167] The attention to older people was magnified by a mid-April *Corriere della Sera* investigation focussing on Lombardy. It revealed that the decision to close care homes to external visits came late into the pandemic (4 March). Even more importantly, on 8 March the regional government moved patients considered 'less infected' into care homes to create more space for intensive care in the hospitals. Many people living in care homes died as a result. The event, known as the 'Trivulzio scandal' (after the name of the care home), was defined as a 'massacre' by the press.[168] A judicial inquiry investigating the government (in particular, the PoC, the Minister of the Interior and the Minister of Health) for 'multiple manslaughters' and 'wrongful exposure' soon followed.[169] Thus, widespread press attention was not on people who recovered from COVID-19 but on the dead.

In this context, health workers, as well as individuals and those belonging to civil society, such as charitable organisations, who showed

solidarity at the local level, were framed as 'heroes'. On 2 June, as part of ceremonies marking the anniversary of the Republic, HoS Sergio Mattarella awarded the Order of Merit to 57 people. This included doctors, nurses, teachers and volunteers who gave their support to the community by hand-fabricating thousands of masks, cooking food for nurses and doctors, helping victims of violence domestic violence, crowdfunding to buy computers and tablets for poorer students, etc.[170] Although the media emphasised the deaths of nurses and doctors, defined by the press, again, as 'a never-ending massacre',[171] the deaths of elderly people were considered particularly tragic. This created an implicit hierarchy of grief, with elderly people at the 'top', followed very closely by the deaths of doctors and nurses. This hierarchy facilitated a reading of adhering to lockdown and public health rules as expressing respect and concern for elderly people, health workers, and other key workers 'who put their lives at risk to guarantee cures and services'.[172] This, at least temporarily, fostered a sense of duty and solidarity.

It is important to note that the effect of COVID-19 on minoritised and marginalised groups within Italy did not feature highly in the broader public pandemic narratives. This may be partially attributed to the fact that Italy is less racially and ethnically diverse than, for instance, Germany and the UK.[173] Italian party leaders do not centre the issue in their agendas; most of the press does the same. This likely reflects the marginalisation and non-integration of some minoritised communities (and refugees) within broader Italian society.[174] In July and August, following the resumption of migrant and refugees arrivals, the popular debate that between February and June only focused on the pandemic started again to revolve around migration.[175] The extreme right, in particular, criticized the government about the way it handled the arrivals, accusing it of adopting 'too soft' measures.[176] Tensions between migrants and local populations were particularly pronounced in Southern Italy (e.g. Sicily and Calabria) as regions refused to host those who tested positive to COVID-19.[177] In August, the government decided to isolate new migrants and refugees on a cruise ferry off the Sicilian coast.[178] In contrast to the UK, the government and press did not meaningfully discuss issues of differential vulnerabilities to COVID-19 or its social impact.

Finally, based on scientific research, the government began to loosen lockdown measures first on 4 May, then further on 3 June. This period may therefore be taken as a proxy for the implicit social normalisation of a particular rate of death. A study by the Statistics National Institute (ISTAT) and by the Ministry of Health, conducted between 15 May and 15 July, shows that the ratio between deaths and the total infections in Italy was reasonably low, around 2.14%.[179] In addition, starting from the end of March, there was a slow but progressive decrease of deaths and infections. In March deaths were 15,133 and those positive to COVID-19 amounted to 113,351; by June, when the third phase of loosening restrictions began, there were 1,292 deaths and 6,967 infections.[180]

Death Management

The number of deaths, infections and recoveries, was daily communicated by the Civil Protection Department based on scientific collection of data. According to this data, elderly people have been the primary victims of the pandemic. Since the start of the emergency, the average death age was 81 years old.[181] According to the Italian National Institute of Health (Istituto Superiore della Sanità, ISS), there has not been a significant difference

between Italians and ethnic minorities with respect to COVID-19. In the words of the ISS director: 'It is possible to refute the hypothesis of a difference between Italians and foreigners'.[182] Data from April, indicates that foreign communities with the highest number of infected were Romanian, Peruvian, Albanian, Ecuadorian, Moroccan, and Ukrainian.[183] Regionally, Lombardy was most affected by the pandemic, and, as a result, struggled with death management – notably in Bergamo.[184] On 18 March, the day later chosen as a national day of remembrance, 70 military trucks transported bodies that could not be buried in the city's cemetery to other regions.[185]

The Ministry of Health, supplemented by local guidelines, regulated death management and body storage. Access by relatives in care homes and hospitals was severely restricted. Public discourse around these restrictions again focussed on the impact on the elderly. The press expressed a sense of broad distress at 'the tragedy of dying alone' and the 'tragedy' of those relatives that could not 'bid farewell' to their dears.[186] The suspension to funerals stayed in place until 4 May as well as the restriction on visits to cemeteries.[187] Nationally, funerals were suspended but cremation, although more practiced, was not mandated. Only religious officials were allowed to be at the burial/cremation.[188] During the second phase of the pandemic response, a maximum of 15 people could attend funerals, which, under new rules, were required to be held outdoors. The measures taken for Catholic communities were the same for Jewish and Muslim communities. All religious services started again on 18 May.[189] After 3 June, more people were allowed to participate in funerals, and religious services may also be held indoors, if the place of worship is big enough to guarantee social distancing.

Despite a general understanding of the public health rationale behind the restrictions, the suspension on funerals caused a widespread *malaise*. As Italy is a largely Catholic country, funerals and related services are considered a fundamental ritual for grieving and a time of pain processing in a context of sorrow.[190] Catholic associations and right-wing parties picked up the issue and presented the restrictions to funerals and masses as a limit on freedom of religion.[191] This resulted in a heated debate with the PoC, who advocated for caution in re-opening Italian society. On 4 May, a compromise was reached between the government and all Jewish, Catholic, Muslim communities on when and how to hold funerals and ceremonies. The compromise consisted in opening the places of worship on 18 May and in the optional measurement of the temperature before attending liturgical ceremonies and funerals.[192]

'[…] The victims of the invisible war die like during the times of the plague, and many people die alone. Elderlies, especially. One dies in the hospital or at home. The Coronavirus does not allow for a last good-bye.' --La Repubblica, 17 March 2020

Mourning and Commemoration

Following the high number of deaths, particularly of the elderly, and the suspension of funerals, mourning and commemoration became extremely important both during and after lockdown. Mourning and commemoration occurred at many levels: the central state, local authorities, single citizens and in the press. At the state level, the

Head of State is the main conveyor of grief. For instance, in his speech, during a commemoration ceremony in Bergamo on 28 June, Sergio Mattarella highlighted the importance of remembering those who passed away: 'to remember means to reflect seriously, with rigorous precision, on what did not work, on system shortcomings, on errors to avoid to be repeated'.[193] He also participated in numerous initiatives at the local level. He paid tribute, for instance, attending the cemetery of Codogno to honour the victims of COVID-19.[194]

Another official initiative came from the Parliament, which recently approved a law establishing 18 March as a symbolic national day in memory of the COVID-19 victims.[195] State initiatives were dedicated to memorialising all the victims, without, interestingly, a noticeable emphasis upon the deaths of health or key workers. As per local authorities, each region had mourning and commemoration initiatives that ranged from concerts to religious services to sports events. There have, for instance, been several concerts dedicated to thanking health workers.[196] In addition, 31 March, all mayors observed a minute of silence for the dead and all major institutions flew their flags at half-mast.[197] Local monuments in honour of COVID-19 victims are in the process of being constructed.[198] Citizens also participated in clapping outdoors at a designated time, home concerts, and rainbow drawings. The latter, in particular, were intended to thank health workers. Taken together, these initiatives were both a way to give strength and courage and, again, perhaps, in contrast to other cases, to remember those who passed away.[199] Facebook groups, similarly, have been created as a place to share the life and memories of those who passed away.[200] Finally, at the beginning of June, *Corriere della Sera* dedicated an entire supplement to the COVID-19 victims, reporting their names, their stories and their pictures and underlining 'those are not just numbers, they are people, they are lives'.[201]

'Our life will not be as it used to because we will miss loved ones, friends, colleagues. It will not be as it used to, because the collective suffering that we all suddenly experienced has certainly affected everyone's life and the way we look at reality. It affected the priorities, the order of value attributed to things, the importance of feeling responsible for each other. […] Remembering, therefore, means, first of all, remember our dead and also means becoming fully aware of what happened. Without the illusory temptation to put aside these dramatic months so to start again as before.'—Sergio Mattarella, President of the Republic of Italy, 28 June 2020

Conclusion

The narratives adopted by Italian institutions and the press emphasised death rather than recovery. This generated a sense of fear as well as a sense of respect for those who passed away, especially elders, and for the service and sacrifice of health workers. This sense of generalised apprehension,

together with legal penalties, facilitated solidarity and respect for the rules, somewhat surprisingly solidifying social order during the months of lockdown. Contrary to the UK, where death was considered inevitable and herd immunity was initially advocated,[202] the Italian approach to death was explicitly characterised by loss and grief. Death was framed as something to be avoided at all costs, underscored by the state's obligation to protect the health of its citizens. In this context, the impossibility to hold funerals was particularly disruptive in the Italian case, fuelling disputes between the government and religious (especially Catholic) communities. Similarly, contrary to the UK, where there have not yet been national efforts for public commemoration yet, Italy has seen many official commemoration ceremonies. The state (especially the HoS), as well as parliament and local authorities, consistently conveyed messages of mourning and was present at official commemoration ceremonies. Parliament and local authorities were also officially involved.

Furthermore, the general fear of death and the sense of duty had, at least initially, a positive, solidaristic effect on social order – not unusual, in a crisis - and might be considered as 'a lesson learnt'. Anti-lockdown protests and those organised by extreme-right parties (e.g. Lega per Salvini premier, and Fratelli d'Italia), pro-socially (and somewhat ironically), did not take place until the third phase of decreased restrictions on 3 June. During the months of lockdown, though Matteo Salvini attempted to organise protests and gather people, the initiative was overlooked and did not take place.[203] That said, though religious, racial, and ethnic minorities do not appear to have experience COVID-19 in a differential manner, it is reasonable to believe that already marginalised groups will be particularly adversely affected by the economic crisis – and social consequences – that appears imminent. On 9 July, the Ministry of Interior, suggested it is likely that social tensions will rise in the upcoming months.[204] The longevity of the gains in inclusivity and solidarity seen during the height of the COVID-19 crisis therefore remains to be seen; it is possible this period only briefly obscured the continuing relevance of underlying structures of inequality.

Overall, three aspects of COVID-19 fatalities, and their public management/narration, differentiate Italy from the UK: a) the strong emphasis on avoiding death and on elders; b) lesser to little emphasis on minoritised groups (partially due differences in underlying social fabric); and c) the proliferation of official commemorations. That said, for Italy, as for the UK (and likely all states), the effects of COVID-19 deaths on social order will most probably be not only short term but also medium and long term. The social, emotional, and economic impact of these months could foster existing trends of fragmentation, at both the national and local level. Indeed,[205] the country is characterised by 'localism and social particularism', meaning that Italians are especially attached to 'local, familial and individual interests'.[206] Thus, the crisis is expected to accentuate these dynamics, leading to the further erosion of national social cohesion, especially if the current policies associated with the Recovery Fund do not succeed. As noted above, the likely economic crisis can also be expected to exacerbate existing differences. The economic, social and educational gap between North and South is likely to widen and deepen. The already existing aversion towards migrants is at risk of increasing, as local communities fear of a resurgence of the virus brought 'from overseas'.[207] On a positive final note, however, greater political attention and allocation of resources towards health, and care for the elderly, is also quite likely –

and may foster increased social and emotional investment in state institutions.

152 See Portal of the Ministry of Health informing on Coronavirus pandemic: http://www.salute.gov.it/portale/nuovocoronavirus/dettaglioContenutiNuovoCoronavirus.jsp?area=nuovoCoronavirus&id=5351&lingua=italiano&menu=vuoto

153 The reasons why this has happened surfaced during a judicial inquiry started in June involving national and regional authorities. Being one of the most industrialised regions of Europe, all authorities were put under many pressures by the Lombard industrial lobbies. Despite knowing the urgency of closing the Bergamo area, the Lombardy governor Attilio Fontana waited for the President of the Council (PoC)'s decree of 7-8 March. The COVID-19 crisis highlighted an important issue: there was a relevant unpopular decision to make, and no one (nor the central neither the local authorities) was open to taking responsibility for it. (M. Gabbanelli & S. Ravizza, Troppa sanità privata, medici di base pochi e abbandonati, nessuna sorveglianza sui contagi, la strage nelle Rsa, la mancata chiusura di Nembro e Alzano: tutti gli errori della Regione Lombardia, Corriere della Sera, April 15th 2020 https://www.corriere.it/la-bussola-di-oggi/2020/04/14/tutti-errori-regione-lombardia-come-colao-vuole-riaprire-l-italia-governo-spaccato-mes-305cb154-7e5d-11ea-9d1e-3b71f043fc58.shtml.

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160 Conte and Mattarella Speeches to the nation, the Parliament, the Senate from 4/03 to 28/06.

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205 E.g. De Rita (2002), *Il regno inerme. Società e crisi delle istituzioni*, Einaudi: Torino; Magatti, M. De Benedittis M. (2006). *I nuovi ceti popolari. Chi ha preso il posto della classe operaia?* Feltrinelli: Milano; Diamanti, I. (2009). *La società italiana*. Enciclopedia Treccani. https://www.treccani.it/enciclopedia/la-societa-italiana_(XXI-Secolo)/

206 Diamanti, I. (2009). *La società italiana*. Enciclopedia Treccani. https://www.treccani.it/enciclopedia/la-societa-italiana_(XXI-Secolo)/

207 P. A. Valenti, *La paura del contagio da coronavirus accende la fobia dei migranti*. Euronews, August 8th, 2020 https://it.euronews.com/2020/08/08/la-paura-del-contagio-da-coronavirus-accende-la-fobia-dei-migranti

South Korea

Yuna Han

'We have already become a leading nation in pandemic response. K-Prevention [Korea's epidemic response system] has become a global standard'—Moon Jae-In, President of the Republic of Korea, 10th May 2020

Background

The first confirmed COVID-19 case in South Korea was on the 20th of January 2020.[208] The office of the presidency released its first press briefing focused on the virus on 2nd January, stating that President Moon Jae-in was briefed on the transmission of the virus and response by the Korean Centers for Disease Control and Prevention (KCDC). It quoted the President expressing concern during a Cabinet meeting, regarding containment of the virus during the upcoming Lunar New Year holidays and its potential impact on the economy.[209] On 1 February, the KCDC held its first regular daily briefing, which have continued throughout the course of the pandemic.[210] The government raised the infectious disease crisis alert to red (highest level) on 23 February, convening the Central Disaster and Safety Countermeasures Headquarters (hereafter CDH) to coordinate and direct responses by different ministries and local authorities.[211] On 22 March, high intensity social distancing policy was put in place, mandating that all non-essential businesses and social activities, including school, be cancelled. Workplaces, including public services, were strongly encouraged to transition to home office and flexible working arrangements. Individuals were also encouraged to reduce travel outside of the house and to adopt basic hygiene measures.[212] On 6 June, the government officially transitioned to an 'in-life distancing' model, in which most everyday economic and social activities were allowed, but with additional requirements such as physical distancing and mask-wearing.[213] Overall, the government has tended to use localised restrictions and shorter-term lockdown measures to control transmission, and prioritised the implementation of a comprehensive testing and tracing system.

As of 31st July 2020, there have been a total of 11,909 confirmed cases of COVID-19 and 301 deaths reported. Daegu—the fourth largest city in South Korea with approximately 2.465 million residents—was the epicentre of the pandemic during its first peak with 6,942 confirmed COVID-19 patients (48.2% of all confirmed patients) to date and 191 deaths (63.5% of all COVID-19 related deaths).[ii]

Crisis Narrative

There are three distinct trends in the South Korean crisis narrative shaped by the government: first, the narrative of 'civic consciousness'; second, the narrative of 'global standard-setting' 'success' in the country's response to the pandemic; and third, the narrative of long-term struggle. Narrative frames about the crisis also highlight dimensions of international cooperation and recognition. Narrative trends do not focus on the experience of

[ii] This project does not take into account events that occurred after the 31st of July, and thus does not reflect the on-going 'second wave.'

death and death rates; more emphasis is placed on transmission rates and recovery numbers. This is clearly made possible by the comparably low death rates. This does not, however, mean that government discourse did not reference COVID-19 deaths, as discussed more in detail in the subsequent section.

The key actor shaping the crisis narrative is the CDH, formally led by the Prime Minister. Operationally, the CDH is led by the KCDC; it is also comprised of the Ministries of Health and Interior. Daily press briefings are led by the KCDC, by either the director (Jung Eun-Kyeong) or her deputy (Kwon Joon-Wook), and the CDH releases regular public updates. The division of labour between affective messaging (communicating sentiments of grief and solidarity) and more technocratic aspects of messaging (such as guidelines for social distancing) is not always clear. While the KCDC is leading the technocratic messaging, the daily press briefings led by KCDC leadership also directly convey messages of grief, suffering, and loneliness. For example, a description of a fatality case is always followed by a message of condolence to the family and loved ones of the decedent. Messaging in the South Korean model is thus marked by different technocratic intervention objectives. The KCDC communicates the lion's share of the public health related policies and manages sentiments around them, with the rest of the political leadership (e.g. President) also communicating economic policies related to COVID-19 and their affective impact on society. As discussed below, these narratives are not always aligned.

The CDH frames pandemic response as a form of 'civic consciousness' and emphasises collective participation in local and national actions.[214] This includes, for instance, encouraging people to avoid hoarding supplies, particularly masks, in order to support the medical community. [215] References to 'local community,' both in the context of local transmission as well as pandemic responses such as social distancing, are frequent.[216] War framing is not commonly used by the CDH,[217] but can be seen in public narratives in the mainstream media. Rather than invoking public support and solidarity, as seen in some of the other cases, war framing in South Korea was used to convey the difficulty, chaos, and horror of the pandemic, particularly from the perspective of medical professionals.[218] War framing was used sporadically by both the government and opposition parties in the leadup to the April 2020 parliamentary elections.[219]

Despite efforts to show a unified front by the political elites and the more technocratic leadership of the KCDC and Ministry of Health, fractures in the narrative framings are becoming increasingly visible the longer the pandemic persists, particularly with regard to the narrative of 'success'. Top politicians, particularly President Moon Jae-In, frequently portray South Korea's response to the pandemic (at times branded as 'K-Prevention') as a 'global standard.'[220] Media narratives are also sensitive to the framing of the pandemic response as a 'success case' internationally.[221] Conversely, the KCDC and other operational members of the CDH frame the pandemic as a 'long term' struggle, highlighting uncertainty and the need for continued patience.[222] In February, for example, the President declared the crisis to have 'come close to the end'[223]—a message that was quickly refuted by the CDH, which reiterated its framing of the pandemic response as a long-term challenge.[224] As discussed below, the eagerness of the political leadership to declare the pandemic response as a 'success'—largely based on lowering community

transmission rates—is considered by some members of the public to be insensitive to grief and loss as experienced by some, and may provide future flashpoints of social tension.

Public discourse implicitly frames COVID-19 as part of a broader phenomenon, both in terms of international cooperation and as one instance of a series of epidemic experiences (albeit an extreme one). There are frequent reports on South Korean cooperation with the WHO and health aid provided to other countries.[225] For example, the Ministry of Foreign Affairs publicized how testing kits used by KCDC were provided to developing countries, particularly those like Ethiopia that were part of the UN force that fought in the Korean Civil War.[226] President Moon, in a virtual speech at the WHO World Health Assembly, stated that a successful pandemic response 'does not think of neighbours as dangerous subjects that can spread the virus and blockade them' and that the definition of a neighbour 'crosses national borders.'[227] Previous instances of viral epidemics, such as MERs or SARS, are also noted by officials and media reports and, interestingly, framed as less successful pandemic response efforts (i.e. 'lessons learned').[228]

There is no clear recognition of differentiated risks of death experienced by different members of society, including minoritised groups (such as ethnic or sexual minorities). This is against a broader social context in which South Korean society is frequently represented as internally homogenous. However, the additional risks minoritised groups face when identified as a COVID-19 patient or transmitter became apparent in May during a localised outbreak in the club district of Itaewon, popular amongst the LGBTQ+ community. People avoided contact tracing efforts because of fears of being 'outed' and becoming the target of public abuse.[229] This experience did not change the overall crisis narrative of the government. The clear exception to the homogenising tenor of government narrative is recognition of economic class differences in the pandemic experience. As the government shifted towards economic recovery between mid-April and August, particular emphasis was placed on the disproportionate suffering experienced by 'low-income' citizens. There is also explicit awareness that economically vulnerable populations will have more difficulty keeping safe from virus transmission (e.g. due to lack of access to masks). A citizen campaign to facilitate mask access to vulnerable and low-income people, for instance, was supported by the government.[230] The KCDC and Ministry of Health also explicitly recognise the psychological distress caused by the pandemic, highlighting mental health ('corona depression') in public messaging.[231]

Media reports emphasise the infection and deaths of medical professionals.[232] As in other contexts, health workers are implicitly and explicitly framed as 'heroes' of the pandemic response. The government-led #thankstochallenge campaign explicitly frames medical professionals —both those working in Korea and all other medical professionals across the world in the global response— as heroes. It is also an attempt to open up the discourse on heroization to other 'ordinary' individuals.

Death Management

The Ministry of Health maintains up-to-date information regarding number of deaths on the centralised website on COVID-19 response (ncov.mohw.go.kr).[233] Fatality numbers on the COVID-19 response website are presented

alongside more comprehensive information regarding the total number of confirmed patients, number of tests carried out, and total number of 'recovered' patients (people who have been released from quarantine and/or treatment following a negative test). On days COVID-19 related deaths occur, the numbers are also reported during daily briefings by the KCDC. They are mentioned at the beginning of the press conference, contextualised by other statistics such as number of confirmed patients, their regional breakdown, and patterns of contact that explain community transmission.[234] The briefings are usually led by the KCDC Director, but also by other experts within the organisation.

Deaths are reported in a highly individualised manner during the briefing. Each report includes demographic information about the person, such as age, nationality, and gender. This information is released in the context of providing further details regarding the transmission route, characteristics of the virus, and adequacy of the medical response (e.g. whether the individual had an underlying condition or emergency treatment was efficiently deployed). The contextual information also, however, has the interesting effect of revealing the individual person behind the aggregate statistic, potentially humanising the narrative. It also implies that there is no set threshold of 'normalised' death, as each death is treated as a singular event. The briefings include explicit recognition of the grief experienced by the families and loved ones. At the same time, such individualised representation may raise privacy concerns, particularly for minoritised groups. It could also imply individuals are responsible (or even culpable) for contracting the virus, thus negatively effecting social cohesion.

The pandemic has resulted in substantial disruption to funeral practices. The Ministry of Health made cremation mandatory for COVID-19-related deaths. This is a significant intervention, as socially and culturally, cremation is not the preferred option for many families. Funerals would typically involve three-day wakes with many guests in attendance, all of which were strongly discouraged by the government which pushed for a 'cremation first, funeral later' policy without wakes or visitors.[235] Public rhetoric by key members of the CDH have recognised the dramatic nature of such interventions by emphasising that the policy will still prioritise the dignity of the deceased and be carried out with the consent of the families.[236] They have advertised the financial support available for cremation and funerals in COVID-19 cases, an intervention lacking in many other countries.[237] Despite such public assurances of consent-based policies, media reports suggest that many families felt they were unable to say a 'proper farewell' to their loved ones.[238] This was aggravated by the fact that hospital and care home visitations were, in principle, barred for COVID-19 patients, although exceptions were granted in some cases of imminent death.[239] This sense of disruption was most pronounced during the peak of the pandemic in Daegu.[240] There is concern in public discourse that this may result in legal challenges against the government in the coming months, as was the case during the MERs outbreak of 2015.[241]

'I am greatly saddened by the fact that families are not able to stay by the sides of their elders at their death. I understand that from the families wish to be by their loved ones, and from their perspectives [not being with them] will

be a lasting emotional wound.'—Jung Eun-Kyeong, KCDC Director 1st May 2020

Mourning and Commemoration

There are no explicit central government-led commemorative or memorial efforts for those who died of COVID-19. Some media reports suggest that this lack of commemoration is noted by the families, who draw comparisons between public commemorative events held for other mass deaths events (e.g. the 2014 Sewol Ferry Disaster).[242] This suggests an absence of commemoration may become a point of future social conflict between the centralised government narrative of 'success' in COVID-19 response and the experience of grief and suffering by individual citizens. Ad hoc commemoration of medical professionals is carried out by professional organisations.[243] Media reports include condolences for victims and recognise the grief of families.[244]

The key government commemorative effort is the #thankstochallenge campaign, promoted by the CDH on social media. This social media campaign enlisted participation of celebrities as well as the general public. The core message was appreciation for 'heroes' of the pandemic, generally understood as medical professionals and other key workers, but also individual citizens who practiced social distancing and other public health measures.[245]

Conclusion

South Korea experienced the lowest death rate thus far amongst the cases examined in this project. This, however, did not mean death was an insignificant part of COVID-19 narratives. Rather, the low death toll contributed to two major differences in the South Korean government's approach to talking about death and grief in comparison to the UK. Firstly, the South Korean discussion of death is significantly more individualised and specific in contrast to that of the UK, preventing the discussion of death from becoming a report of 'mere statistics.' It also provides additional information about the virus itself, including the effects of underlying conditions, range of symptoms, and common routes of transmission, that can help the broader public health effort. Such details provide further opportunities for state accountability; it is not uncommon to see journalists asking for further elaboration on whether all possible public health and medical interventions were adequately deployed to prevent each individuated death during regular press briefings. Relatedly, the South Korean messaging does not imply a particular number of deaths are an acceptable ('normalised') outcome, treating each case (or cases in a particular day) as a significant event that should be understood, grieved, and learned from. This is in stark contrast to the UK government messaging, wherein changes to death rates are noted, but each death is not explicitly marked as a singular event. This specified treatment of death is further enabled by the fact that, unlike the UK, the state has a division of labour between public health messaging and communication on other policy interventions. Discussions of death and grief are thus managed by a consistent entity (the KCDC) and are not presented as a trade-off with other forms of loss due to COVID-19, such as economic hardships.

Secondly, the low death rate, alongside relative success in quickly 'flattening' the first wave, allowed the South Korean government to advance a narrative of success in its COVID-19 response. This narrative is augmented by the fact that the

CDH publishes virus recovery rates alongside confirmed infection and death rates. Two comparative lessons can be drawn from this. First is a cautionary tale—even with significantly lower death rates than the UK, the overarching narrative of success sits uneasily alongside the individual grief and challenges felt by ordinary citizens, potentially negatively impacting social order. With the recent increase in transmission rates (officially denoted as the 'second wave', accompanied by an increase in partial lockdowns and social distancing measures), it remains to be seen whether the narrative of success will contribute to greater social solidarity in longer-term interventions or produce social fatigue and disillusionment with the government. Second, South Korea's narrative of success exists in the context of public experiences of past, recent regional epidemics, and a corresponding embrace of the necessity of multilateral public health cooperation. This is undoubtedly a strategic move by the government, attempting to leverage its COVID-19 response as a form of 'soft power' internationally. That said, South Korea's emphasis on cooperation with the WHO and aid to other countries as part of its 'success' narrative is notable in an era marked by nationalistic competition, including COVID-19 responses. This type of messaging may be reasonably speculated to result in a different, more transnationally-oriented form of social order in comparison to the more implicitly exclusive, nationalist visions of community promoted in other cases (most notably the UK).

'Thanks to our citizens who, demonstrating mature civic consciousness and embodying the spirit of 'freedom for all', acted as the main agents in our efforts to curb the virus, we were able to preserve the principles of 'openness, transparency, and democracy' in our pandemic response. […] If the international community strengthens its shared commitment to the principle 'freedom for all,' we can overcome this crisis faster and foster greater hope for the 'post-corona' world.'—Moon Jae-In, President of the Republic of Korea 18 May 2020

208 'First confirmed case of novel Chinese pneumonia domestically […] Chinese woman who visited Wuhan'*Joongang Ilbo.* (20th January 2020) https://news.naver.com/main/ranking/read.nhn?rankingType=popular_day&oid=025&aid=0002969069&date=20200120&type=1&rankingSectionId=102&rankingSeq=12 Last accessed: 1st September 2020

209 Deputy Press Secretary of the Presidency, 'Written Press Briefing on the 3rd Cabinet Meeting' http://www.korea.kr/news/blueHouseView.do?newsId=148868507 (21st January 2020) Last Accessed: 15th September 2020

210 Briefings are available online here: https://www.youtube.com/watch?v=Z-NqgEubCvE

211 The Central Disaster Management Headquarters are headed by the Minister of Health and Welfare, while the Pan-Government Counter-measures Support Headquarters is headed by the Minister of Interior and Safety.

212 Government of Republic of Korea, 'Intensive 'Social Distancing' Guideline for Citizens' http://ncov.mohw.go.kr/duBoardList.do Last accessed: 15th September 2020

213 Jun Joon-Young, Seo Jiwon, '45 days of 'social distancing' to end […] from the 6th transition to 'in-life distancing' [45 일간의 '사회적 거리두기' 종료 […] 6 일부터 '생활 속 거리두기'로 전환' *Donga-Ilbo* (3rd May 2020) https://www.donga.com/news/Society/article/all/20200503/100895408/1 Last accessed: 15th September 2020

214 For example, in a virtual Open Government Partnership meeting, a high-level civil servant in the Ministry of Interior and Safety stated that in the government's self-assessment,

success of the COVID-19 response was due to 'mature civic consciousness [높은 시민의식]' of citizens who voluntarily followed the government's guidelines. Ministry of Interior and Safety *Press Release* (3rd February 2020)

https://www.mois.go.kr/frt/bbs/type010/commonSelectBoardArticle.do?bbsId=BBSMSTR_000000000008&nttId=77039 Last accessed: 1st September 2020.

215 Ministry of Health *Press Release* (5th March 2020) http://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0403&page=39&CONT_SEQ=353384 Last accessed: 1st September 2020.

216 Apart from reference to local community in the context of community transmission, economic recovery efforts are also referenced in terms of 'local community.' For example, Ministry of Interior and Safety *Press Release*(31st March 2020) https://www.mois.go.kr/frt/bbs/type010/commonSelectBoardArticle.do?bbsId=BBSMSTR_000000000008&nttId=76458 Last accessed: 1st September 2020.

217 A rare example is seen during a press briefing by a regional public health official, as part of the CDH's regional operations, in which medical facilities and care homes are referred to as 'key battlegrounds [핵심 전장]' in the fight [싸움] against COVID-19. Kwon Sang-Eun. 'Where did 78% of the corona deaths come from? […] Kyunggi province notes 'key battlegrounds are medical facilities, care homes.'' *Chosun Ilbo.* (24th June 2020) https://www.chosun.com/site/data/html_dir/2020/06/24/2020062402861.html?utm_source=bigkinds&utm_medium=original&utm_campaign=news Last Accessed: 1st September 2020

218 For example, see: Ahn Kyu-Young. 'How do you fight without guns (masks)? […] Medical field pleads, lack of masks' *Kookmin Ilbo* (25th February 2020) http://news.kmib.co.kr/article/view.asp?arcid=0014281776&code=61121111&cp=kd Last accessed: 1st September 2020

219 For example, a candidate from the Conservative United Future Party (미래 통합당) said on Facebook that the 'Corona crisis' reminds him of the 1592 *Imjin* wars, during which the Japanese invasions of Korea was thwarted by the resolve of ordinary citizens. Joo Hee-Yeon, 'United Future Party Kim Ung 'Corona crisis, reminiscent of *Imjin* wars.' *Chosun Ilbo.* https://www.chosun.com/site/data/html_dir/2020/04/05/2020040500093.html?utm_source=bigkinds&utm_medium=original&utm_campaign=news Last accessed 31st August 2020.

220 For example, in a speech at the 3rd anniversary of his inauguration, President Moon stated that 'We have already become a leading nation in pandemic response. K-Prevention has become a global standard. [이미 우리는 방역에서 세계를 선도하는 나라가 되었습니다. K 방역은 세계의 표준이 되었습니다.' Full transcript available here: http://overseas.mofa.go.kr/uz-ko/brd/m_8555/view.do?seq=1346890 Last accessed: 1st September 2020.

221 Ahn Jun-Yong. 'Already 20th call […] President Moon discussed corona response with foreign Heads of State.'*Chosun Ilbo.* (8th April 2020) https://www.chosun.com/site/data/html_dir/2020/04/08/2020040804697.html?utm_source=naver&utm_medium=original&utm_campaign=news Last accessed: 1st September 2020.

222 For example, the KCDC Deputy Director Kwon stated during the regular press briefing on 30th June that the 'Our quarantine authorities will also respond without haste and think about the long term struggle, focusing on controlling the scale and speed of COVID-19 outbreaks and minimizing its damage. [저희 방역당국에서도 조급하지 않게 대응하고 '장기전'을 생각하면서 코로나 19 의 발생 규모, 속도를 억제하고 통제하고 동시에 피해를 최소화하는 데 집중하겠습니다.]" For summary transcript see: http://news.kbs.co.kr/news/view.do?ncd=4483061&ref=A Last accessed: 1st September 2020

223 President Moon declared during a meeting with Korean Chambers of Commerce that the pandemic is 'close to ending' MBC News (recording) 'Corona19 close to ending […] have trust and invest [코로나 19 머지않아 종식…믿고 투자해 달라]' (Feb 14th 2020) https://imnews.imbc.com/replay/2020/nwtoday/article/5660903_32531.html Last accessed: 31st August 2020.

224 KCDC Director Jung responded to questions about President' Moon statements during her regular press briefing, stating that 'from the perspective of KCDC it is difficult to say that the current situation is stable or in abeyance [지금 상태가 소강상태 혹은 안정적인 국면인지 질문을 많이 하지만 방역당국은 그렇게 전망하기 어렵다]' and emphasised broader developments across the globe, not just in South Korea, will have long term repercussions. KCDC Regular Briefing (14th February 2020), recording available here: https://www.youtube.com/watch?v=rdmAKiLGhZw Last accessed: 31st August 2020

225 Ministry of Health. 'Korea-WHO held expert meeting for international cooperation on COVID-19 clinical trials' *Press Release* (18th March 2020) http://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0403&page=1&CONT_SEQ=353612 Last accessed: 1st September 2020

226 Ministry of Foreign Affairs stated that the South Korean government has provided humanitarian aid and public health support for Ethiopia's struggle against COVID-19, including shipment of test kits. It emphaised the close ties the two countries have, particularly as Ethiopia supported South Korea during the 6.25 War (i.e. Korean War) Ministry of Foreign Affairs, 'Minister, commemorating 6.25 War, we will further strengthen ties with Ethiopia, an allied country' *Press Release.* http://www.mofa.go.kr/www/brd/m_4080/view.do?seq=370273 Last accessed: 1st September 2020.

227 Summary transcript here: http://www.segye.com/newsView/20200519504671 Last accessed: 1st September 2020.

228 For example, in a speech at the 3rd anniversary of his inauguration, President Moon stated that the success of COVID-19 response was based on experiences of previous MERs and SARs outbreaks. Full transcript available here: http://overseas.mofa.go.kr/uz-ko/brd/m_8555/view.do?seq=1346890 Last accessed: 1st September 2020.

229 http://biz.heraldcorp.com/view.php?ud=20200513000003

230 For example, the 'Challenge Korea' campaign was a contest based on 'voices of citizens

(e-People, Gwanghwamun District 1, various civil complaints) that seeks an effective supply system for those who cannot receive and purchase emergency equipment and masks during a pandemic such as COVID-19 [이번 공모는 코로나 19 와 같은 감염병 발생 상황에서 마스크 등 긴급

물자를 직접 수령·구매하기 어려운 취약계층에 대해 효과적인 공급방안이 필요하다는 국민의 목소리(국민신문고, 광화문 1 번가 등 민원 다수 제기)가 있어]' https://www.gov.kr/portal/ntnadmNews/2130892 Last accessed: 1st September 2020

231 Ministry of Health *Press Release.* (27th March 2020) http://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0403&page=32&CONT_SEQ=353770

232 Wee Sung-Wook and Lee Eunji. 'Sad commemoration of corona victim doctor, 'someone who accepted all patients'' *Joongang Ilbo.*(3rd April 2020) https://news.joins.com/article/23746654 Last accessed: 1st September 2020

233 http://ncov.mohw.go.kr; Key contents are also available in English http://ncov.mohw.go.kr/en/ and Chinese http://ncov.mohw.go.kr/cn/ Last accessed: 1st September 2020

234 All regular press briefings are available here: https://www.youtube.com/playlist?list=PLu8fcI7I5zqsTqJT8OSg8TL1QDn2fCB4u Last accessed: 1st September 2020

235 CDH *Press Release* (3rd March 2020) http://ncov.mohw.go.kr/tcmBoardView.do?contSeq=353307 Last accessed: 1st September 2020

236 Ibid.

237 KCDC Directive 2020-2 *Corona19 Death Related Guidelines.* Available here: http://www.mohw.go.kr/react/jb/sjb0406vw.jsp?PAR_MENU_ID=03&MENU_ID=030406&page=1&CONT_SEQ=353446 Last accessed: 1st September 2020

238 For example, see: Kim Min-Ok and Baek Hee-Yeon. 'When wife of 55 years was sent to be cremated 79 year old husband cried at home' *Joongang Ilbo.* (9th March 2020) https://news.joins.com/article/23725201 Last accessed: 1st September 2020

239 CDH 'Coronavirus-19 Guidelines for Medical Facilities to Prevent Transmission: Care Facilities'; CDH 'Examples of Coronvirus-19 Adjustments by Medical Facilities' http://ncov.mohw.go.kr/upload/ncov/file/202006/1592282640139_20200616134400.pdf Last Accessed 15th September 2020

240 'No mourners allowed […] sad funerals in Daegu for 'corona deaths'' *Donga Ilbo.* https://www.donga.com/news/article/all/20200304/99995871/1 Last accessed: 1st September 2020

241 Yoo Sul-Hee. ' 'Cremation first, funeral later' policy for virus deaths 'possibility of legal challenge.'' *Kyunghyang Sinmun.* (3rd March 2020) http://news.khan.co.kr/kh_news/khan_art_view.html?artid=202003032247025&code=940301 Last accessed: 1st September 2020

242 See, for example, a blogpost on a popular news blog notes that 'Families of loved ones burst out in tears as President Moon self-congratulated 'success' in corona response' https://m.post.naver.com/viewer/postView.nhn?volumeNo=27725730&memberNo=29949587&vType=VERTICAL Last accessed: 1st September 2020

243 Korean Medical Association held their own commemoration of medical professionals who died during the pandemic. https://www.doctorsnews.co.kr/news/galleryView.html?idxno=134146 Last accessed: 1st September 2020

244 See, for example: Jung Dae-Ha. 'Lonely deaths in the 'corona era' that prevents even final farewell' *Hankyoreh.* (30th August 2020) http://www.hani.co.kr/arti/area/honam/959916.html Last accessed: 1st September 2020

245 The #thanksto challenge is a social media campaign in which an individual states their gratitude for the medical staff (#thankstomedicalprofessionals [#의료진덕분에]) and in addition nominates three other people or entities that they are grateful for in the COVID-19 response. The nominated individuals continue the challenge. See, for example, speech by President Moon participating in the challenge (nominating the 'babyshark' music for accompanying children during a difficult period; a volleyball player on the national team for demonstrating team spirit; and a sign language translator for help conveying vital COVID-19 response messages to hearing impaired people). Office of the Presidency, *President Moon Jae-In's Speech Compilation* vol. 3: Pg 393-394

Germany

Katharina Kuhn

'No, this pandemic is not a war. Nations are not standing against nations, soldiers not against soldiers. But it is a test of our humanity. It elicits the worst and the best in humans. Let's show each other the best in us!' —Frank Walter Steinmeier, President of the Federal Republic of Germany, 11 April 2020

Background

As of 31 July 2020, Germany has seen a total of 208,698 cases and 9,141 deaths.[246] The first case of COVID-19 was reported on 28 January 2020.[247] Until the end of February, new cases were isolated and not met with community-wide measures. COVID-19 was not considered a health risk until 17 March, when the Robert Koch Institute (RKI), a federal government agency responsible for public health, disease control and prevention, changed the risk assessment to 'high'.[248] The daily number of new cases peaked between the end of March and the first week of April and began to decline.[249] The highest number of new infections per day was reached on 28 March, with a total of 6,294 new cases; the highest number of deaths reported in one day was 315 on 16 April.[250]

The RKI held its first press briefing on 27 February and continued doing so on a daily basis until 07 May.[251] The first politician-led COVID-19 specific press conference occurred on 11 March, led by Chancellor Angela Merkel, health minister Jens Spahn, and the head of the RKI Lothar Wieler.[252] A comprehensive lockdown was first issued in Bavaria on 20 March 2020[253] with other states following from 22 March.[254] The lockdown restrictions were gradually eased from 20 April 2020 onwards, according to the severity of the respective local situation in each state.[255] On 6 May, Merkel and state leaders agreed to a threshold of 50 new infections per 100,000 inhabitants within seven days on a district level, at which time district authorities impose lockdown measures and regulations.[256] This regulation was first implemented on 23 June, in Gütersloh and Warendorf.[257]

Crisis Narrative

During the pandemic, a special relationship evolved between political actors and scientists. The communication of relevant facts about the pandemic, including death figures, was the responsibility of the RKI. Starting on 4 March, the RKI published daily status reports on its websites and held daily press briefings that were broadcasted on TV and radio. Political actors at the federal and state level, in contrast, held press conferences only in order to communicate political measures (such as contact restrictions or the closure of schools), but not to inform the public about the pandemic as such. Press conferences at the federal level were held by Chancellor Merkel together with the minister presidents of Bavaria and Hamburg, as well as the Vice Chancellor, initially once and twice a week and every fortnight after 6 May. During some of the press conferences politicians conveyed their sympathy with the deceased.[258]

Death played a minor role in the overall German COVID-19 discourse (though it was more prominent in mainstream media than government communication). This relative absence of death in

the German context created the perception that death 'happens somewhere else'. Mainstream media closely followed the situation in the most affected countries (such as Italy, Brazil, and the US). Politicians regularly conveyed their sympathies with Italy and France. President Steinmeier stated in a TV address: 'Many thousands have died. Here in our own country. And in Bergamo, in the Elsass, in Madrid, New York and in many other places in the world.'[259] Linking COVID-19 deaths in Germany to the suffering elsewhere underlined the severity and tragedy of the pandemic.

This outward focus of pandemic discourse reflects a general perception that, compared to elsewhere, Germany and the German health system 'did well'. Newspapers appreciated Chancellor Merkel's unagitated and matter-of-factly communication style and proudly reported about positive comments on her crisis management from abroad.[260] The perception that Germany 'did well' was integrated into a broader narrative that has shaped German national identity since 2016, framing Germany (and Merkel in particular) as the last 'leader of the free world'.[261]

Instead of death tolls or numbers of new cases, the most important reference point to describe the pandemic was the so-called R-value, which refers to the approximate number one COVID-19 positive patient infects on average.[262] The R-value was part of media debates and well known by the public. Merkel and other politicians stressed that a normalisation of everyday life was not possible until the R-value was below one for several days.[263] The COVID-19 pandemic was considered under control on May, when the R-value had been below one for three subsequent weeks.[264] The daily number of deaths at this time was around 100.[265]

Though this might be taken as an indicator of implicitly 'acceptable' death rates, it is important to note that this phase was not framed to the public as 'back to normal'. Lockdown and social distancing restrictions remained in place until the beginning of June (in some states even longer).[266] Daily deaths at this time, likely a better indicator of normalisation, oscillated between 10 and 30, similar to the Italian and UK cases.[267]

The term most frequently used to refer to the pandemic in media and political discourses was 'crisis' or 'COVID-19 crisis' (*Krise*), followed by 'fight' (*Kampf*). The terms highlight different strands of the pandemic crisis narrative: By talking of the COVID-19 pandemic as a 'crisis', the media linked the COVID-19 pandemic to the 2008 Financial Crisis.[268] This comparison centred on: a) Merkel's reputation as 'Crisis Chancellor'; and b) the economic relief package adopted by the *Bundestag* on 25 March. The comparison to the Financial Crisis framed the pandemic as a long-lasting, systemic problem (Merkel referred to the COVID-19 pandemic as a 'marathon')[269] that needs to be *managed* and simultaneously drew attention to the expected economic ramifications and their overcoming.[270] This framing contributed to de-centring death as a theme in the public discourse.

At the same time, the term 'fight' (*Kampf*) was used to undermine the importance of 'closing ranks' as a society and using combined efforts to counter the threat of the virus. The term 'fight' (*Kampf*) was used less with the connotation of a 'battle' than in the sense of 'strong efforts' and appeared together with terms such as 'test' (*Prüfung*)[271] or 'challenge' (*Herausforderung*).[272] This overall framing of the pandemic as a 'stress test' (*Bewährungsprobe*)[273] that society as a whole has to 'pass' (*bestehen*)[274] emphasized solidarity

and mutual support as appropriate remedies and appealed to the collective efforts of each individual.[275]

Since the beginning of the pandemic, one of the defining features of official discourse was an insistence that every death is tragic and should be avoided by all means. Merkel, for instance, stated on 18 March that deaths are 'not only abstract numbers in a statistic, but it is a father or a grandfather, a mother or a grandmother, a partner – it is humans'.[276] Politicians at all levels of government opposed any form of normalisation of death by stressing that 'we are a community in which every life and every human counts'[277]. They did not distinguish between different groups in their condolences. Similarly, official statements made it clear that pandemic management was not a question of health *or* the economy, but *both* had to be protected and supported simultaneously.[278] The Minister President of Bavaria, for instance, stressed that '[w]e want to sustain as much economic activity as possible. But everything that could endanger humans, everything that could harm the individual or our community, is what we now need to reduce'.[279]

That said, the protection of the elderly, who made up more than 85% of deaths, was a special concern.[280] The media referred to the elderly as 'the weakest'[281] and called for society to 'protect the grandparents'[282]. Politicians stressed that it was intolerable to accept high risks for the elderly and people with underlying health conditions, even if this meant damage to the economy.[283] In the same vein, the mainstream media highlighted extraordinarily tragic deaths, such as those of 34 elderly people died in two residential care homes in Würzburg or a pregnant woman.[284] In addition, both politicians and media emphasized the responsibility of younger and healthier members of society for the elderly and risk groups. Even though politicians otherwise tried to prevent a hierarchization of grief by stressing the momentousness of each individual death, the portrayal of vulnerable persons as in special need of protection nevertheless created an implicit hierarchy of tragedy. This subtle hierarchicalisation interestingly reverses that seen in the UK, as vulnerability informed the tragedy of a case. Based on the framing of the pandemic as a 'stress test' (*Bewährungsprobe*)[285] for societal solidarity, the death of a vulnerable person is framed as a failure of society's responsibility to protect them.[286]

Attention to the differential needs and vulnerabilities of religious and minoritised ethnic communities was relatively low. Religious communities actively supported the lockdown measures during the first weeks of the pandemic, but called for an easing of restrictions from May onwards.[287] While political actors sought dialogue with religious communities, non-mainstream religious groups, such as Pentecostal, Baptist, and Muslim communities, were occasionally blamed in the media for new outbreaks.[288] Though the full social and political effects of these discourses – and failure to explicitly incorporate different communities into official COVID-19 narratives – remains to be seen, it appears that, as in other cases, the pandemic reflects and reinforces existing social divisions, with potentially negative consequences for social order and solidarity.

Death Management

COVID-19 related statistics are compiled by the RKI and published in daily briefs (*Situationsberichte*) on its webpage. The statistics are based on data that is reported to, and collected by, local health authorities and transmitted to the RKI by the

respective responsible state-level health authority.[289] The RKI as well as other virologists enjoyed great levels of trust during the pandemic; the data collected and presented by the RKI was received as trustworthy and reliable by media, politicians, and the public alike.

Demographically, more than 85% of deaths were of people over 70 years old; the median age of COVID-19 related deaths is 82.[290] 55% of all deaths were men. [291] About a third of all deaths occurred among residents of care homes, underlining the heightened vulnerability of elderly patients. [292] There are no statistics on the ethnic background of COVID-19 related deaths.

To protect vulnerable groups, access restrictions to care homes were implemented on 16 March; hospitals and care home visits were completely forbidden between 16 March and 9 May.[293] The German Foundation for Patients' Rights (GFR; *Deutsche Stiftung Patientenschutz*) criticized this step. They argued that many patients and care home residents suffered isolation and loneliness due to these restrictions, which they called 'organised deprivation of liberty' (*organisierte Freiheitsberaubung*).[294] Some families and media commentary argued that the access restrictions had 'killed' (*getötet*) care home residents[295] and, together with the GFR, called for a more 'human' (*menschlich*) approach.[296] Since 9 May, each patient or care home resident is allowed to receive one visitor for up to one hour per day.[297]

There were no (new) specific regulations concerning the disposal and management of deceased bodies. On 16 March, funeral attendance was limited to close family members only.[298] Singing was not allowed, which led to very short funerals that family members perceived as unsatisfactory in assisting them to process grief.[299] Funeral restrictions interrupted important traditions of grief such as having dinner with friends and family after the funeral ('funeral feast'). Muslim and Jewish communities were affected particularly strongly due to the disruption of appropriate/typical mourning and care for bodies. The lack of collective mourning and grief distressed many bereaved people across religious communities; relatives of the deceased questioned the proportionality of the measures.[300] By March different stakeholders, including a politician and members of the Protestant church, recommended to plan additional memorial services after the pandemic to support the mourning process.[301]

That said, funeral restrictions were generally followed.[302] From May onwards, religious communities' calls for an easing of these restrictions, as well as restrictions on religious services in general, grew louder.[303] In parallel to their growing contestation, breaches of the restrictions increased.[304] Funeral restrictions were eased when social distancing regulations in each state were lifted (starting from 3 May 2020).[305]

Mourning and Commemoration

Since the beginning of the pandemic, health workers and workers in jobs of 'systemic relevance' – such as cleaners, delivery workers, and shop assistants – received heightened attention in mainstream media. Political stakeholders to thanked 'system-relevant' workers and health and care workers for their efforts.[306] Discussions emphasized their working conditions and low income. The term 'systemic relevance' was initially coined during the 2008 Financial Crisis to describe banks so large their bailout was essential to the economic and financial system. The transfer of the term 'system relevant' to

COVID-19 not only linked the pandemic to the Financial Crisis, but also implicitly questioned societal priorities and hierarchies. According to the emerging narrative, it is no longer banks and businesses ('at the top') that should be bailed out, but those whose work is often financially and socially de-valorised. While the narrative of 'system relevant workers' has the potential to reforge a more inclusive capitalism post-COVID, there is a risk that symbolic compensatory activities such as clapping or giving small gifts will conceal the systemic origins and potential solutions to socio-economic inequalities. This criticism was expressed by some 'system relevant' workers, who argued that 'more sustainable measures' than clapping or chocolates were really required.[307]

Interestingly, the *deaths* of members of health and 'system-relevant' workers received comparatively little attention. The deaths of 'system relevant' workers did not feature in mainstream media at all and were also not addressed by political stakeholders. The deaths and infection of health and medical professionals received slightly more attention. The media criticised the lack of data about infections and deaths among health and care workers[308] and reported their heightened risk of infection due to a lack of adequate PPE. These reports, however, were framed as warnings and stressed that a lack of political action on this issue could lead to deaths *in the future,* rather than commemorating deaths that had already occurred.[309]

There was very little heroization of health or system relevant workers in mainstream media or by politicians. News articles in national media reported on deaths of health and care workers matter-of-factly and did not feature pictures of deceased workers or their biographies. [310] There was no official, nation-wide commemoration of the death of medical and care staff, and political stakeholders did not convey condolences to their families specifically.

This lack of commemoration may be partly due to the structure of the German health system, which is perceived as a less coherent, unitary entity and much less entangled with the state than the NHS in the UK. The German health system is less strongly associated with national identity than in other cases (such as the UK and South Korea). Another reason may be the comparatively low number of overall deaths of health and care workers related to COVID-19. As of 28 July, 62 health workers had died, of which 22 worked directly in health institutions such as hospitals or surgeries and 40 in 'care institutions', ranging from care homes to doss houses and prisons.[311] There is no data on deaths of workers in non-health related system-relevant jobs. [iii]

Despite the interruption of private funeral, commemorative, and mourning practices, very little commemoration has taken place. Some commemorative practices are apparent in local (secular or religious) contexts. For instance, a woman put up grave candles for every victim of COVID-19 in her garden;[312] a local shooting club fired gun salutes during a celebration of the Catholic festival of Corpus Christi.[313] The only nation-wide form of commemoration so far took place in the context of various football leagues, where, similar to other tragedies, players held minute's silences before starting their matches and appeared in crepe.[314] There was no list of all victims of the pandemic or other forms of

iii Data on the professional occupation of COVID-19 patients is not reported in about 25% of all cases.

commemoration in the mainstream media, as newspapers elsewhere produced.[315]

The lack (so far) of government-led commemoration is exceptional insofar as recent terrorist attacks were commemorated with a memorial service attended by high-ranking politicians[316] and memorial established by the city council.[317] This approach to memorial culture has been criticized as too 'pragmatic' and reflecting a premature insistence on a 'return to normal' narrative by Merkel.[318] A (very) recent 5 September proposal for national commemoration has to be seen in this context. President Steinmeier suggested a state memorial in commemoration of the victims of the pandemic, which was well received by politicians, the media and the public, but has not been followed by state-level proposals.

'These are not only abstract numbers in a statistic, but a father or a grandfather, a mother or a grandmother, a partner, these are humans. And we are a community in which every life and every human counts.'—Angela Merkel, Chancellor of Germany,18 March 2020

Conclusion

The framing of the pandemic as both a crisis and a fight placed the responsibility for overcoming the virus on the individual, community-oriented behaviour of each person. In line with this framing, there was a strong sense of cohesion during the first weeks of the pandemic. The mainstream media supported lockdown measures and citizens largely adhered to the regulations.[319] The emphasis on health workers and other 'system relevant' jobs created a narrative that valorise the commitment and work of each individual 'man in the street' and praised everyday acts of solidarity.[320]

This sense of social cohesion showed signs of fracture when what had been growing discursive contestations of lockdown regulations since May became demonstrations.[321][iv] Protesters called the lockdown measures 'unreasonable' and 'undemocratic' and trivialized the virus and its lethality.[322] The continuing protests also disseminate conspiracy theories, anti-Semitism, racism, and other exclusionary ideologies currently proliferating within German society. [323] This suggests that, similar to COVID-19's perpetuation of existing vulnerabilities and inequalities, the anti-lockdown protests are also informed and animated by pre-existing political grievances and cleavages. German social order is therefore in the process of being shaped by COVID-19, but in a somewhat ambiguous manner, as it intensifies existing cleavages while also promoting some forms of solidarity.

Three central factors distinguish the Germany case from the UK. First, death was framed as 'tragic' and 'avoidable' by political stakeholders but was at the same time strikingly absent from the official and media discourse. Whereas death was routinely mentioned in UK press briefings as (one of several) inevitable consequences of the COVID-19 pandemic, political actors in Germany only rarely mentioned deaths, and if so, did this only in order to convey their condolences and to communicate the tragedy and social and emotional

iv The two largest protests took place in Berlin on 01 August 2020 and 29 August 2020, with more than 20,000 participants on 01 August and almost 40,000 protesters on 29 August.

momentousness of deaths. The infrequency with which death was mentioned by political stakeholders, interestingly, prevented its normalisation, further supporting the narrative that 'every life and every human counts'.[324] The separation of communicative responsibility between the RKI and political actors also underlined the extraordinariness of death, as it separated technical details related to death (such as death tolls and infection rates) from the communication of sympathy and condolences by political actors.

The second and perhaps most striking difference relates to German politicians' eschewing of 'war' frames. Instead, the crisis was framed much more as a challenge for society as well as 'technical' issue that needs to be managed, similar to other crises in the past – particularly the Financial Crisis of 2008. This framing de-centred death as a theme in the public discourse, while emphasizing both economic aspects of the pandemic and its manageability. While there is a risk that such a framing contributes to downplaying the momentousness of death that occurred due to the pandemic, the simultaneous emphasis on the tragedy of death prevented such a dynamic.

Third, in contrast to the UK, commemoration plays only a minor role in the public discourse. While health and other 'system relevant' workers were praised by politicians and mainstream media in both countries, this did not lead to official commemorations of their efforts or deaths in Germany. In contrast to the UK, commemoration was limited to very few local instances, and there were no calls for commemoration by the wider public. The sole exception to this is President's Steinmeier's recent call for an 'act of state' to commemorate COVID-19 loss. While this proposal was well received by politicians, the media and the public, its top-down nature differentiates it from the UK, where commemoration emerged within affected communities. Although official state commemoration may serve an important role in recognising the grief and experiences of those who lost friends and family, there is a risk that a lack of community ownership will deplete its meaning for some parts of society.

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Conclusions and Recommendations

The COVID-19 virus does not respect borders. Governments confront the same virus as it moves around the world. Despite this, the research presented here shows that governments adopt different narrative approaches in how they present the pandemic as a crisis, how they represent and narrate the deaths that the virus continues to cause, and how they memorialise ongoing loss. Despite all countries in our study facing at least the prospect of significant loss of life, individual countries adopted different approaches to narrating the crisis. Crucially, the sheer scale of death was not, as some might expect, deterministic of the narrative approach, nor indeed of the commemorative or governance choices taken.

This research therefore suggests that governments and elites are faced with distinct choices over the narrative frames they adopt in addressing the nature of the crisis; how they address death, loss, and grief as an individual and collective experience; and how they discuss or prepare for memorialisation. We argue that these choices hold important implications for social cohesion.

Crisis Narrative

The war framing was not consistent across cases. In the case of the UK and Italy, this framing served as a rallying cry, whilst in South Korea, war-framing served to communicate the tragedy of the pandemic. The exception was Germany, where war-rhetoric was largely absent in favour of the discourse of 'challenge' or 'test'. War framing could be understood as an effort to relate the pandemic to a crisis that is more familiar in the public imagination. However, the use of the war frame depends on the meaning of war in differing national contexts. This demonstrates that the politics of martial framings are not as straightforward as they may appear. More specifically, the differences between war and pandemics suggest that this framing is limited in both the short and long term. War-framing suggests a greater role for human agency, a discrete temporality, and a less contested designation of culpability. As the historical and contemporary case studies suggests, elites struggle to narrate a crisis that appears to violate the division between reasoned rational human action on the one hand, and the natural world on the other. Pandemics raise questions over how societies relate to occurrences in the natural world, the governance of which is tenuous.

Countries also varied in how they chose to organize the communication of information to the public. Here we might distinguish between *technocratic* (i.e. relating to policy responses) and *affective* (i.e. relating to emotional expressions of sorrow, sympathy, and solidarity) forms of communication. In the case of Germany and (to some extent) South Korea, more technocratic data was outsourced to the Robert Koch Institute and the Korean Centers for Disease Control and Prevention respectively. In the case of Germany, this division of labour was clearest, relieving politicians of the duty of communicating information on the pandemic as such – including death rates – and allowing them to concentrate on political responses, and more *affective* communication strategies. This is in contrast to the UK where government ministers frequently blurred the boundaries between the communication of pandemic data, public health messaging, and the political and/or *affective* response. At times this ambiguity seems to have clouded the government's messaging strategy and

enabled accusations of the 'politicization' of the pandemic response. In extreme cases, the numerical representation of loss alongside affective responses potentially trivialized death, and allowed stale expressions of remorse to emerge as almost scripted.

Death Management

Countries also differed on how they chose to communicate death figures and, as a result, the relative emphasis placed on death per se, in the overall pandemic crisis narrative. South Korea's Ministry of Health provided the most comprehensive figures, including tests and recovery rates. Germany's emphasis on the 'R-value' rate of infection appears to have laid greater emphasis on individual responsibility. In Italy and the UK death figures were reported daily during the height of the crisis, with Italy highlighting the tragedy of the fact of loss, and the UK framing deaths as indications of the overall trajectory (and eventual recovery) of the pandemic. As lockdowns ended and daily briefings were discontinued, death figures were de-emphasized (though the figures remained available, if one searched). Accordingly, the UK and Italy may be understood as setting de facto rates of 'normal' or 'acceptable' death. This normalisation of death, particularly in the UK, may be seen as silencing, or minimizing, the grief and loss experienced by many.

It is important to note too that the scale of loss was not commensurate with the time spent by elites on communicating the significance of individual losses. Here we might speak of the individualization versus the collectivization of death. Perhaps facilitated by relatively low death rate, South Korean officials humanised individual instances of loss by providing greater detail on the deceased, offering a more micro-level discourse of blame and culpability, falling on both individual behaviours as well as management of the state health system. This played into a wider definition of success that implicitly aspired to a 'zero deaths' policy, rather than setting an implicit threshold of deaths that would be considered a 'success', or at least socially acceptable, as in the UK context. The South Korea example suggests that narrating and humanising individual deaths offers an alternative narrative of death that may provide a more relatable message on the importance of following public health guidance, as well as a didactic function in providing information or lessons learnt on how to respond to the virus. In Germany, despite also experiencing relatively low death rates, a macro-statistical collectivizing approach was in evidence. Though it was expressed in abstract terms that each death was a tragedy, actual deaths were not discussed individually in public discussions. Italy, in contrast to all three, framed mass deaths, particularly of the elderly, as extremely tragic, insisting both that each death was sad, but also directly engaging with the scale of death as itself a form of tragedy.

Commemoration and Memorialisation

Across all cases, memorialisation practices were uneven. Italy, thus far, is alone in having explicitly outlined state-backed memorialisation plans in addition to more local and regional initiatives – though a recent proposal for federal commemorative action in Germany has just been tabled. Elsewhere, ad-hoc, private, and community-led initiatives lead the way. The relative dearth of state-led memorialisation perhaps reflects the fact that the pandemic is ongoing, but this should not obscure the ongoing practices – what might be termed 'implicit' memorialisation – through which elites singled out collective moments of grief amongst certain communities. These implicit

memorialisations served to mobilize wider collective efforts. In the case of the UK, singling out carers and health workers underscored the 'protect the NHS' message. In Italy, stress on the differential generational impact identified the elderly as requiring particular protection. Germany is distinct in the relative absence, thus far, of local commemorative efforts – though public discourse reiterated the tragedy of the loss of vulnerable people as a failure of society.

As the historical case study suggests, this hierarchalisation of grief carries with it the implicit silencing of loss amongst particular communities, often members of marginalised and minoritised groups. As a result, hierarchies of grief risk perpetuating existing patterns of inequality and exclusion, and creating new ones – particularly amongst groups most affected by the pandemic in terms of both health and/or economic impacts. The *misrecognition* of loss – as well as the total *non-recognition* of loss – is an important aspect of trauma. Failing to recognize loss may exacerbate collective and individual grief and trauma, particularly when, as each case demonstrates, funeral practices and ritualised grieving processes are disrupted. This is an example of how seemingly technocratic decisions to restrict funerals intersect with memorialisation and commemoration practices, with attendant social and political effects.

The corollary of this is that the decision *not to* memorialise is a choice in itself with longer-term implications for social cohesion and preparedness for future crises. Here, the temporal dimensions of memorialisation are clearer. Commemoration serves to demarcate the start and end of mass death events, providing a site around which communities may grieve, seek catharsis, recollect, prepare, and place into context future mass death events. As the historical case study demonstrates, pandemics do not sit prominently in public memory, with implications for future preparation. The Avian flu pandemic of 1957 killed 14,000 in the UK alone, with the impact on industry dipping the country into recession. Commentators at the time remarked on the failure to heed the lessons of 1918.[325] Signalling an intention to commemorate may also offer a temporal horizon to the present pandemic, providing a future point in time at which society may begin the process of remembering. Commemoration may also be re-framed as an on-going process, serving to recognise the many forms of uncertainty, grief, and loss produced by the pandemic. Not commemorating, or commemorating in a non-inclusive manner, also represent choices that will entail longer-term effects on social order.

Contestation over the appropriate response to the pandemic has so far not obviously manifested in large-scale social order challenges. Indeed, the immediate crisis, as perhaps might be expected, prompted expressions of solidarity and belonging in most places. There is, however, evidence of fracture in that consensus. Concurrent expressions of dissent – whether the Black Lives Matter movement, Extinction Rebellion demonstrations, or the libertarian/populist counter-movements in Germany and Italy – also show that parallel (though certainly not equivalent, in terms of politics and ethical claims) movements may respond to perceived failings in pandemic governance. The pandemic response also, further, highlights existing inequalities and inequities, such as racism, classism, ableism, ageism, and health inequalities, that typified the pre-COVID 'normal' social order. The historical case study similarly highlights how the British public and newspaper commentators were less forgiving of the response

to the second wave of the influenza pandemic. It impacted with more deadly effect, prompting far closer scrutiny of the efficacy of the government's response at a local and national level.

This research then highlights the choices that elites (and publics) face in their response to further iterations of the pandemic. The policy implications of these with regard to government communication and commemoration are discussed in the appendices. In brief, these choices may be framed by a series of questions:

- ***How central should death be in public communications and narratives of the pandemic? How can public communications address ostensibly more 'positive' subjects such as recovery and social/economic normalisation without trivialising or normalising death in pursuit of social and economic goals?***

- ***What metaphors and analogies, if any, are most appropriate when narrating and framing future iterations of the COVID-19 pandemic?***

- ***Which agency, or individual, should hold responsibility for communicating the data surrounding the progress of the pandemic?***

- ***Which agency(ies), or individual(s), should hold responsibility for communicating grief and loss?***

- ***What form should memorialisation and commemoration take, and at what scale? How can different communities be supported in practices of memorialisation and commemoration?***

- ***How can the state and local authorities support communities and individuals in managing experiences of grief and disrupted mourning?***

COVID-19 itself, as a mass death event, presents a major challenge to social order – and will likely remake that order in ways that may not yet be visible or imaginable. The choices made today, technocratic, narrative, and commemorative, including those that are stop-gap or ad-hoc, will be part of this process of remaking. This is true for all aspects of the pandemic, but particularly so in relation to death, wherein the fact of change, absence, and loss is impossible to deny and is therefore socially and politically central. How each society chooses to narrate, manage, and commemorate death in the COVID-19 pandemic will thus play a key role in shaping the post-COVID-19 world.

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Appendix: Policy Briefs

Communicating the Pandemic

Bolstering Social Cohesion in the Context of a Second Wave

- The COVID-19 pandemic presents specific challenges to government communication: the cause of the crisis is invisible, policy responses are multifaceted and based on specialist technical expertise, and the effects are diffuse and highly complex.

- New LSE research comparing government communication and commemoration, and national media coverage of the pandemic across four countries (Germany, Italy, South Korea, and the UK) highlights differing national approaches in communicating the pandemic, and their potential societal impact.

- **In the UK, differing experiences of pandemic vulnerability and loss risks undermining government messaging and damaging social cohesion. Government communication needs to engage with grief, explicitly recognising sadness and loss, to counteract this.**

- The crisis being framed in the UK using 'war' metaphors risks analogizing certain key worker professions as soldiers, and their deaths as inevitable or expected. It also suggests a clear end point to the crisis, which may not be helpful for managing longer term policy interventions.

Recognising grief and loss in official communication

- Government narratives about a crisis—messaging about what has occurred, who is responsible, and what are likely and/or acceptable costs— can play a critical role in galvanizing public support for policies. They can also have the unintended consequence of limiting future policy choices in longer-term interventions.

- Our research suggests that government messaging that neglects the emotional experience of the pandemic, particularly grief and fear of loss, by everyday citizens may reduce public trust and exacerbate social tensions.

- The South Korean government's messaging of the pandemic includes explicit recognition of depression and loneliness one may feel due to longer-term policy interventions to control the pandemic. This accurately reflects the emotional experience of citizens, given continued social distancing and localised lockdowns.

Differing experiences of grief and loss in the UK

- Current UK patterns of death – marginalised communities are more at risk, and fatalities tend to be concentrated locally – produce an unequal distribution of grief and loss across different groups and cities/regions in the country.

- At the same time, citizens' media consumption – frequency, medium, and outlet – may produce different perceptions of the pandemic and fatality patterns. For example: *The Guardian* reported on BAME vulnerability to COVID-19 at approximately 10x the rate of *The Sun* or *The Daily Mail*. For care home deaths, this reduces to about 5x more often.

- Overly simplistic government messaging has the danger of obscuring such different experiences of grief, loss, and risk of COVID-19 within the UK. This may result in reduced support for public health measures during a second wave of COVID-19.

- Government messages that exclude the experience of marginalised and minoritised communities may also perpetuate and intensify social divisions.

Differing communication of deaths in the UK

- In the UK, the prominence given to age and 'underlying health conditions' in reporting fatalities is understandable in terms of managing public anxiety, but suggests these deaths are inevitable and less sad than the deaths of younger and healthier people. This perpetuates ageism, ableism, and health inequalities.

- In contrast, our research found that in Italy, government narratives explicitly and frequently grieved the loss of elderly people who died as a result of the pandemic, and highlighted their vulnerability to COVID-19 as part of a narrative about the importance of social distancing as protection.

- Framing deceased key workers as 'heroes' recognises public service, but also normalises death as a risk associated with health, caring, and other key occupations, and creates an implicit standard of visible and conventional public sacrifice as criteria for deserving grief – often excluding people outside work, such as elderly, disabled and homeless people.

- This risks undermining the efficacy of public health messaging by normalising the deaths of elderly people, people with 'underlying health conditions', and key workers as acceptable or inevitable. If these deaths are framed as acceptable or inevitable, calls for future social distancing and other public health measures may be less compelling or effective.

Recommendations

- Instead of a war narrative, **government should use a narrative frame that evokes manageable difficulty and captures the multifaceted effects of the pandemic** - communicating the nature of the crisis, including what kind of suffering it entails, what the appropriate policy responses are, and what the desired outcomes are, and as a 'challenge' that explicitly evokes solidarity and community.

- **Communication around deaths of the elderly or those with underlying conditions should emphasise that they are not inevitable.** All deaths should be addressed directly and without metaphors or euphemisms

- **Openly recognise the differential patterns of death and grief/loss in official communications** (e.g. BAME communities, difficulties for religious groups to hold services).

- **Provide a clear separation between different types of communication: factual, political, and emotional**. **Explicitly, empathetically and consistently address the grief experienced by the public in emotive terms.** This should be independent from the briefings on public health or economic policies, and led by a designated 'mourner in chief' – such as the Prime Minister – for consistency.

The Challenge and Necessity of Commemorating COVID-19

- New LSE research compares government commemoration and communication, and national media coverage of COVID-19 in four countries (Germany, Italy, South Korea, and the UK) as well as a study of the UK response to the 1918-1919 Spanish Flu pandemic, to examine the key factors in successful pandemic commemoration.

- The research finds that commemoration and collective memory are crucial, though often overlooked, components of pandemic management and recovery. Inaccurate collective memory impedes future policy making and creates and exacerbates social cleavages, undermining social cohesion and public trust in government.

- **Commemoration that excludes specific types of victims or does not adequately recognise the different types of suffering experienced by the public can result in social tensions and perceptions of marginalisation. Government should try to ensure commemoration and memorialisation reflects different UK experiences.**

- **Key recommendations from the research are for a national day of mourning, a four-nations collective history project, and a commemoration and memorialisation support fund.**

- Currently, UK citizens' experiences of COVID-19 grief, loss, and risk vary substantially, differentiated along geographic, occupational, class and ethnicity lines, and by differing media consumption. This risks the formation of a simplistic collective memory of the pandemic that excludes marginalised and minoritised communities and perpetuates social divisions.

- At the moment, Government and media messaging about COVID-19 vulnerability inadvertently perpetuates ageism, ableism, and health inequalities. It also risks undermining the efficacy of public health messaging by normalising the deaths of elderly people and those with 'underlying health conditions' as acceptable or inevitable.

- Past research on narratives of victimization and suffering following incidences of mass death indicate that exclusive or overly homogenized national narratives of the event can exacerbate social cleavages, by creating a sense of marginalisation of certain social groups and contributing to hostility between groups. This can result in greater propensity towards social unrest and conflict.

- Conversely, inclusive national narratives that recognise a wide array of suffering and victimization can contribute to greater understanding between social groups and overall increase in societal openness and tolerance.

The current commemoration situation

- The scale of COVID-19 death and loss to families and communities in the UK has yet to be directly and officially acknowledged in its own right.
- Ad hoc commemoration of COVID-19 is already taking place across UK. However national-level commemoration has emphasised the sacrifices of health and key workers, not COVID-19 deaths overall (e.g. 28 April minute's silence).
- Individuated memorialisation, such as obituaries, recognise dignity and loss of each person, and humanize suffering beyond statistics, however the scale of death makes collecting and

communicating individuated remembrances challenging, though media organisations are making efforts to collect tributes.

- St Paul's Cathedral's Book of Remembrance is (to date) the only place of national symbolic significance where the names of all deceased may be memorialised – there are no plans yet announced for official national commemoration of COVID-19 or memorialisation of victims.

- The most prominent commemoration efforts were brief and/or attached to another event. The moment of silence for the dead on 4 July preceded the 'main event' celebration of the NHS's birthday on 5 July. A 'frontline hospital worker' is being added to the already-proposed national emergency services '999' memorial in London.

- Local commemoration efforts help fill this void, but are less able to provide symbolic recognition of loss, and communicate the diversity of the overall UK experience of grief.

- Reflective and inclusive commemorative practices that recognise different experiences of grief are crucial to maintaining social cohesion and reducing tensions between different social groups. This is particularly critical as the UK moves towards more localised forms of lockdowns.

Recommendations

- **Government should designate a national day of mourning**, for one year only, marked by a day off work and official programming at national and local levels by religious and government officials.

- **A four-nations collective history project should be commissioned** to collect remembrances of the deceased and experiences of loss in communities. This should lead to locally-embedded online social histories to help communities remember local experiences and loved ones, while also mapping COVID-19 experiences.

- **A fund should be established to support commemoration and memorialisation** to which local/regional/national groups and communities may apply to support projects and activities. **A steering committee should consider proposals,** with membership including religious authorities, unions, families and loved ones of the deceased, health and care workers, grief counsellors, funeral workers, artists and others.

- **Government should develop a set of best practices to be applied to commemorative practices, events, and monuments**. This could include:
  - Processes for consultation with local communities and guidelines for ensuring project leaders and consultations are diverse, inclusive, and representative
  - Requirements for considering diversity, inclusivity, and accessibility in the commissioning and design of monuments, statues, and events

- **A clear differentiation should be drawn between commemoration** (recognition of an important event/social contribution) **and memorialisation** (of deceased) in public recognition of health, care, and key workers.

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