

Stuck and Exploited

Refugees and Asylum Seekers in Italy Between Exclusion,
Discrimination and Struggles

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Asylum Seekers and Immigrants in Italy during the First Phase of the Pandemic

A Medical Perspective

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Abstract Health conditions of asylum seekers and immigrants during the COVID-19 pandemic have worsened: the analysis in this chapter refers to the first wave of the pandemic (until August 2020). Early evidence from Anglo-Saxon countries, which showed a disproportionate impact for the foreign population and “ethnic minorities”, was confirmed also by the Italian data of resident foreigners. In addition, management problems were found with respect to the infection containment in the reception facilities and phenomena of social stigmatization were highlighted. The impact was generally worst for socially disadvantaged groups, the available data support a non-biological origin but linked to the role of social determinants, highlighting a theme of equity.

Keywords Immigrants. COVID-19. Italy. Public health. Inequalities.

Summary 1 Social Inequalities and Unequal Impact of the Virus. – 2 The Italian Uncertainties: Fake News, Ports Closure and Lack of Indications for the Management of Migrants Receptions. – 3 The National Framework: Between Protection and Instrumentalisations. – 4 Conclusions.



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This chapter aims to provide a key to understanding the impact of the COVID-19 pandemic on asylum seekers, refugees and, more generally, immigrants in Italy, using materials and data available until August 2020.

Starting from surveys carried out in Anglo-Saxon countries, where the scientific community is historically inclined and attentive to a reading of data distinguished by “racial-ethnic groups”,¹ the impact of the pandemic is greater in the population of foreign origin and ethnic minorities, reflecting the underlying economic and social inequalities that can be found with specific national characteristics also in Italy.

The second paragraph presents what happened in Italy, during the first months of the emergency, in terms of political and institutional uncertainties and management criticalities, also linked to delays in guaranteeing precise and shared indications on the prevention and contrast of the pandemic among asylum seekers, refugees, immigrants and other particularly vulnerable groups.

In the following paragraph, we report the national data on the immigrant population already permanently present on the national territory and on asylum seekers and recently arrived immigrants within the reception system. On the one hand, these data make it possible to discredit fake news and the related political exploitation aimed at attacking immigrant populations or populations of immigrant origin; on the other hand, they confirm the role of social inequalities in the differentiated impact of the virus, in line with what has already emerged in Anglo-Saxon countries.

1 Social Inequalities and Unequal Impact of the Virus

By the end of August 2020, the COVID-19 pandemic had caused more than 25 million confirmed cases and almost 800.000 deaths; 209 countries in the world had at least one confirmed case (to date, some islands in Oceania and other particularly isolated territories are uninfected); the continental areas with the highest number of infections were the Americas (almost 13 million cases) and Europe (more than 4 million) (WHO 2020).²

For migrants, refugees and ethnic minorities, who are already more exposed to inequalities, the advent of COVID-19 has worsened

1 The use of the term ‘racial-ethnic groups’ refers to the categories used in the literature reviewed.

2 These figures increased, by August 2021, to a cumulative number of cases reported globally of nearly 216 million and a cumulative number of deaths just under 4.5 million (WHO 2021).

conditions both in terms of health risks and protection of rights. Every situation of serious crisis, including health crises, inexorably affects, in a more or less predictable timeframe, the most vulnerable people in society, causing further inequality and marginality. In Italy, statistics and health data, hardly disaggregate by migrant status, while in the Anglo-Saxon world this variable is also taken into account in official data. It is therefore possible, based on such data, to state that the social and material conditions that characterise different social, racial-ethnic groups lead to a differentiated impact of the virus in terms of viral spread, symptoms and the evolution of the disease. Social inequalities, which existed before and during the spread of the pandemic – such as the cohabitation of several households in the same housing unit, occupational exposure, socio-economic status, access to treatment – constitute a risk factor and are reinforced with the pandemic itself. COVID-19 clusters with pre-existing diseases and conditions (such as diabetes and hypertension), interacts with them, and is driven by broader social, economic, and political factors (Gravlee 2020), to the point where it is not a ‘pandemic’ but rather a ‘syndemic’ (Horton 2020).

The theory of syndemics allows us to focus and highlight how social and political factors (Marmot 2016) determine, reproduce or exacerbate the emergence and clustering of diseases. This trend becomes clear if we look, for example, at the mortality rate by ethnicised and racialised groups in the United States, one of the countries with the highest number of infections in the world. In July 2020, it was 69.7/100,000 for ‘black Americans’, 51.3/100,000 for ‘Native Americans’ and fell to 30.2/100,000 for ‘white Americans’ (APM Research Lab Staff 2020). Analysing the data by age group and in relation to the white population, the differences were even more marked: blacks > 3.8 folds; natives > 3.2 folds; native islanders > 2.6 folds; Latinos > 2.5 fold; Asians > 1.5 folds. Black Americans experienced the highest actual COVID-19 mortality rate nationally, more than double that of white and Asian Americans, who have the lowest actual rates, but the disproportionate impact is also significant for Native Americans (both American and Islanders) and Latinos. The differences were dramatically reinforced during the pandemic.

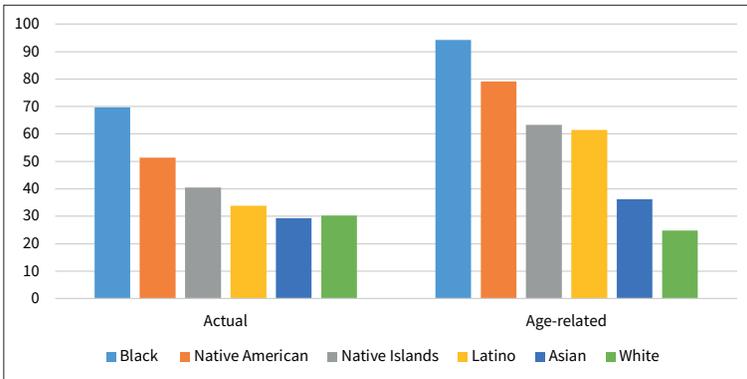


Figure 1 COVID-19 deaths per 100,000 people in the United States: actual mortality and age-adjusted mortality by ethnicised and racialised groups. Data: July 7th 2020 (source: APM Research Lab Staff 2020)

The factors causing such higher mortality vary in different communities and are linked to pre-existing elements of inequality. Some are linked to the world of labour, with greater exposure to infection due to lower protection (poor safety at work, greater difficulties in working from home or accessing other means of protection). In addition, factors such as poorer housing conditions and greater use of public transport, as well as post-infection factors related to health conditions and the outcome of the disease, lower access to testing, higher incidence of pre-existing conditions such as diabetes, hypertension and asthma, and delayed or lower quality of care due to lack of health insurance/coverage may also have contributed to higher exposure.

This evidence was confirmed by a systematic review of the international literature (Pan 2020) which compared data from more than 1,000 articles published, between December 2019 and May 2020, in medical-scientific journals and grey literature and suggested an increased exposure of the so-called 'BAME groups' (Black, Asian and Minority Ethnic)³ to the risk of infection and worse clinical outcomes from COVID-19, mainly in the US and the UK.

In the case of the UK, as reported by the UK government itself (Public Health England 2020a), by June, an excess of mortality was indicated among BAME populations compared to 'White ethnic groups',

3 The literature referring to UK data, as well as data released by Public Health England (2020b), use the 'BAME' definition in reference to the Office for National Statistics classification system based on the self-definition of a presumed 'ethnic' membership by census participants.

and in terms of infection, among people of ‘Bangladeshi ethnicity’,⁴ for example, the infection rates were almost double those of ‘white’ British citizens.

2 The Italian Uncertainties: Fake News, Ports Closure and Lack of Indications for the Management of Migrants Reception

Italy was the first country in the ‘global North’ to be affected by the epidemic and, following the Chinese example, declared a state of emergency and instituted a lockdown. Against this backdrop, news spread that immigrants would be ‘immune’ to the SARS-CoV-2 infection (Gonzato 2020).

The apparent absence of immigrants among those first hospitalised for COVID-19 had led to a cautious interpretation, yet to be verified, of the ‘virus door’ being closed or half-closed in certain ethnicised and racialised groups. In the mainstream communication, during the first phase of the pandemic, and thanks to the instrumental attitudes of social entrepreneurs and the media, this was enough to attribute a supposed immunity to anti-malarial therapies or to anti-tubercular vaccination (more widespread in the African continent). These dynamics, in their amplification, have been fed and strengthened by the myth of black immunity (Carter 2020), which spread in the United States and rebounded in Italy, where it reinforced interpretations – which can be defined, borrowing from the journalistic jargon, “fake news” – denied by the facts, even before than the scientific community did. In Italy, such anti-scientific statements were refuted in April by the data, published by the *Istituto Superiore di Sanità* (National Health Institute), indicating that the under-representation among the in-patients was due to a delay in access – most likely ascribable to the subordinate working, housing and social conditions of the immigrant populations and, often, to the internalisation of this subalternity.

Once again, the issue of immigration entered ideologically into the media discourse and political debate: on 7th April 2020, with an inter-ministerial decree, the Italian Government declared Italian ports to be ‘unsafe places’ because of the pandemic, effectively circumventing the mandatory constitutional and international obligations regarding the right to asylum, protection from the risk of inhuman and degrading treatment and search and rescue at sea, and condemning hundreds of people to be abandoned at sea. Many refugees from African

⁴ The statistical category used by Public Health England is reported, without supporting its perspective.

countries, but also from war zones such as Syria and Afghanistan, therefore found themselves marginalised in Libya, Greece or Turkey because they were stigmatised as alleged carriers of the virus.

In the same weeks, there was a growing concern among civil society associations, due to the risks linked to considerable housing discomfort and poor access to water and sanitation, particularly in informal settlements, where many immigrants are forced to live also as a result of ‘expulsion factors’ triggered sometimes by Italian institutions themselves (see, for example, Legislative Decree 113/2018), in the fear that these factors could determine a marked risk of infection (Geraci et al. 2020). For months, the issue of health safety in reception facilities in Italy was not on the political and organisational agenda, as illustrated by a survey carried out by the National Asylum Table and the Immigration and Health Table (Camilli 2020; Tavolo Nazionale Asilo, Tavolo Immigrazione e Salute 2020).

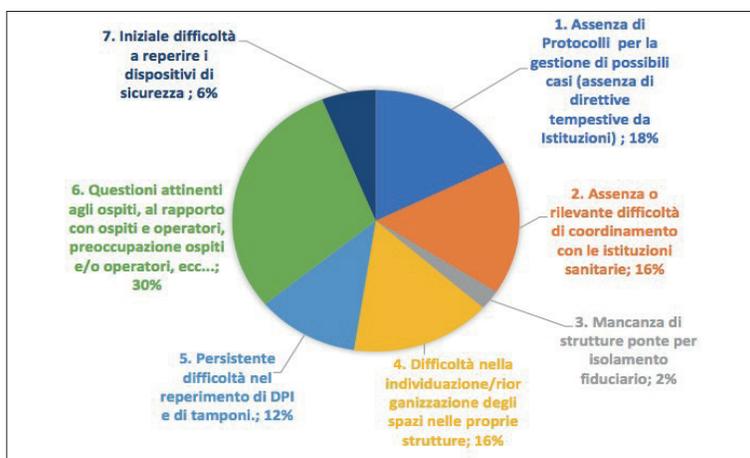


Figure 2 Main issues reported in the management of Italian reception centres, in the COVID-19 emergency (source: Tavolo Nazionale Asilo, Tavolo Immigrazione e Salute 2020⁹)

5 1. Lack of protocols for the management of possible cases (lack of timely directives by institutions) (18%); 2. Lack or considerable difficulty in the coordination with health institutions (16%); 3. Lack of bridging facilities for fiduciary isolation (2%); 4. Difficulty in identifying/organising spaces in their structures (16%); 5. Persistent difficulty in obtaining PPE and diagnostic tests (12%); 6. Issues about guests, guests-operators relationship, concerns by guests and/or operators, etc. (30%); 7. Initial difficulty in obtaining protective equipment (6%).

The survey included almost 200 reception centres throughout Italy and took a snapshot of what had happened since the start of the pandemic until the end of June, i.e., before specific institutional indications were given. In the absence of institutional guidelines concerning “Pathways, Procedures and Processes” for safe reception, in 60% of cases there was an autonomous activation of the subjects involved through the identification of a “do-it-yourself solution”, aimed at the management of infected people, through the use of isolation rooms or, when possible, by transferring them to another structure, provided by the same managing body. Only 28% reported transfer to a dedicated facility provided by the local authority. Similarly, 46% of suspected cases were isolated by the organisation itself, while only 21% received an institutional response.

The report shows how, before the definition of organic and specific indications, the managing bodies worked to protect their staff and the migrants already hosted within the structures. The precautions and measures, determined by a correct willingness to prevent the spread of the virus with the available means and tools, determined, for a long period, a significant slowdown of new admissions in reception: about one third (29%) reported to have interrupted them because of the lack of safety procedures, 15% instead declared not to have interrupted new admissions for reasons other than the lack of procedures and, specifically, for express indications of the Local Authority/Prefecture.

Those who did not discontinue their reception adopted their own procedures, which were necessarily heterogeneous and diversified throughout the country: 24% asked for a negative result to the PCR or serological test; 15% activated 14 days of fiduciary isolation in a ‘bridge’ facility; 13% required asymptomatic persons to carry out a 14-day quarantine with active surveillance within their facility; in 4% of cases, a health screening was carried out for asymptomatic persons who had not been in contact with positive or suspected cases.

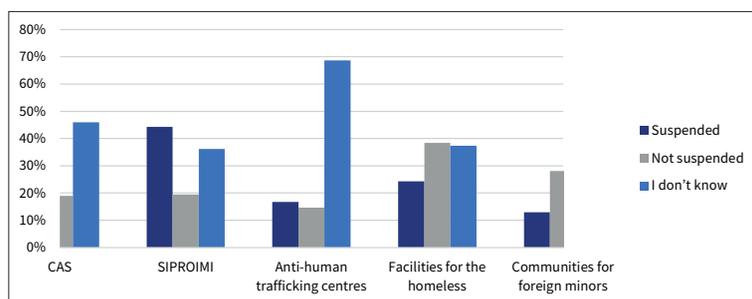


Figure 3 Admissions by type of reception centre
(source: Tavolo Nazionale Asilo, Tavolo Immigrazione e Salute 2020)

Disaggregating the data by type of centre, in the SIPROIMI (Protection System for Persons with International Protection and Unaccompanied Foreign Minors⁶), the managers declared with more certainty than the others that new insertions are suspended. The people in charge of the CAS (Extraordinary Reception Centres) also confirmed the suspension of new entries. On the other hand, facilities for the homeless cannot avoid new admissions: in 38% of cases – the highest percentage – new admissions have not been suspended.

At the end of July, in line with international indications (WHO Regional Office for Europe 2020; ECDC 2020), following the request by the associations belonging to the aforementioned tables and on behalf of the Ministry of Health, the “Interim operational indications for the management of facilities with people with high fragility and socio-health marginalisation in the framework of the COVID-19 epidemic” were published, edited by the National Institute for the Health Promotion of Migrant Populations and for the fight against Poverty-related diseases (INMP Publishing Group 2020). As for the reception, even following institutional indications, significant uncertainty has remained regarding entry procedures, particularly for the homeless – among whom are both foreigners and Italians.

The lack of indications, in terms of “Pathways, Procedures and Processes”, regarding the safe reception of the newly arrived immigrant population and vulnerable Italian groups, including the homeless, is even more striking when compared with the vastness of indications, infographics, technical reports, circulars, decrees on all aspects of prevention, management and control of the SARS-CoV-2 infection that have been produced for the indigenous Italian population.

3 The National Framework: Between Protection and Instrumentalisation

At the end of April 2020, as previously mentioned, the Istituto Superiore di Sanità published the first pandemic data on the foreign population in Italy (ISS 2020; Quotidiano Sanità 2020). By 22nd April, 179,200 cases had been diagnosed, out of which, of those with known nationality (69.3%), 5.1% were attributable to individuals of foreign nationality. This is much lower than the percentage of foreigners in Italy, which is 8.7%. At that time, except for the two Chinese nationals diagnosed at the end of January, there were no cases of COVID-19 among foreigners that could be traced back to infections imported from abroad.

⁶ Now SAI (Reception and Integration System).

The distribution of foreign cases, classified according to the Human Development Index (HDI) of their country of origin, showed that most of them came from countries with a medium HDI (57.5%), represented mainly by Latin American countries and European countries outside the European Union. They were followed by foreigners from high HDI countries (25.1%, mostly from EU countries) and those from low HDI countries (17.4%, mainly from Asia and Central and Southern Africa).

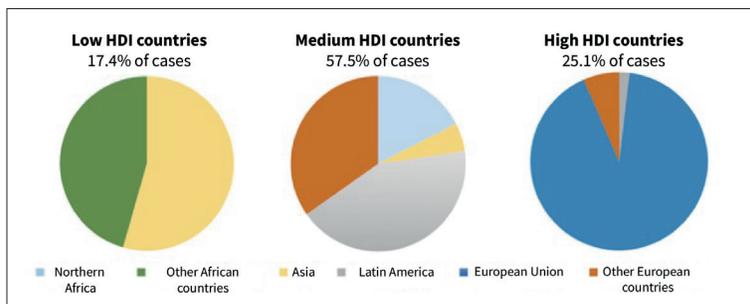


Figure 4 Origin of foreign cases diagnosed in Italy by Human Development Index (source: ISS 2020)

In that period, a significant part in the spread of the infection in the foreign population was likely played by occupational exposure, especially in the care and domestic work professions, occupational sectors characterised by the over-representation of the immigrant population, with a large representation in Northern Italy of South American people. The number of cases per 1,000 residents is in line with the above: there is a markedly higher value in the Peruvian community ($8.1 \times 1,000$) than in the total number of foreigners ($1.2 \times 1,000$) (Mennona 2020). On the other hand, there is a clear absence of the Chinese population among those infected, since, alerted by the events in their country, they took effective preventive and self-isolation measures, anticipating what was later imposed by the government. Finally, asylum seekers, mainly from sub-Saharan Africa, were relatively “protected”, albeit amidst the uncertainties mentioned above, in reception facilities (Geraci, Declich, Marceca 2020).

Again referring to the data published by the Istituto Superiore di Sanità, the demographic structure of the foreign casuistry was different from that of the Italian casuistry, reflecting, in part, the differences observed in the general population, resident in Italy. Foreign cases were more frequently women (56.4% vs. 50.8%) and with a much lower median age (46 years, IQR: 37-55), compared to that of Italian cases (64 years; IQR: 54-80): the most affected age group among foreigners was 30-64. The geographical distribution also dif-

ferred between the two groups, showing a higher concentration of foreign cases in the Northwest (72.8% vs. 57.5%) and in the country's urban areas (52.1% vs. 31.0%). Clinically speaking, they had 1.4 times higher risk of hospitalisation and admission to intensive care than Italians. The epidemic curve of COVID-19 was similar to that of the Italians, albeit with a delay of 8-10 days and with more serious manifestations in relation to age, probably due, as mentioned above, to a delay in diagnosis due to late recourse to health services.

The pandemic in Italy, as in the rest of the world, is constantly evolving, as is its impact on immigrants, accompanied by constant attempts at instrumentalisation: the prejudice of immigrants as spreaders of the plague, invaders and profiteers strongly re-emerges (Ambrosini 2020; Della Puppa, Perocco, 2021; Marceca 2018).

Yet, data paint a different picture: In particular, for immigrants accommodated in reception facilities, significant research – on 5,038 reception facilities out of the 6,837 surveyed by the Ministry of the Interior, with a coverage of 73.7% – carried out by the National Institute for the Health Promotion of Migrant Populations and for the Fight against Poverty-related Diseases (Costanzo et al. 2020), in a period from 11 May 2020 to 12 June 2020, reveals that, out of 59,648 immigrants received, only 239 tested positive for COVID-19 (0.4%), distributed in 68 facilities, 97.1% in the North, particularly in Lombardy (27.9%) and Piedmont (22.1%).

60.7% of confirmed cases were under 30 years of age and 80% between 20 and 34 years of age. They were mainly men (90.8%). Of the positive cases, 25.9% (62 persons) required hospitalisation, including two in intensive care. The disease outcomes were similar to those in the corresponding age groups of the native population. No deaths were reported. The prevalence of positive cases is similar to that of the general population, with a geographical distribution of cases showing a North-South gradient consistent with that observed in the country.

These data confirm how proper attention to the prevention of contagion can prevent the spread of the virus even in potentially critical environments such as reception centres, but, precisely for this reason, adequate institutional interventions are needed in terms of planning and prevention and in support of the managing bodies.

Table 1 Facilities participating in the study, guests, confirmed cases, by region

Regions	% participating facilities (n = 5,038)	Guests	Confirmed cases	Confirmed cases by no. of guests (%)
Piedmont	81.4	5,860	61	1
Valle d'Aosta	93.1	94	0	0
Lombardy	86.2	8,827	61	0.7
Trentino-Alto Adige	86.0	973	40	4.1
Veneto	89.1	4,215	36	0.9
Friuli Venezia Giulia	97.5	1,967	0	0
Liguria	89.1	2,267	8	0.4
Emilia-Romagna	86.0	6,268	30	0.5
Tuscany	84.2	3,604	0	0
Umbria	86.5	693	0	0
Marche	81.5	1,542	0	0
Latium	84.9	5,994	2	0
Abruzzo	80.5	1,303	0	0
Molise	66.4	658	1	0.2
Campania	59.7	3,358	0	0
Apulia	66.5	2,837	0	0
Basilicata	73.7	1,108	0	0
Calabria	66.1	2,704	0	0
Sicily	71.1	4,415	0	0
Sardinia	51.3	961	0	0
Italy	79	59,648	239	0.4

Source: Costanzo et al. 2020 (modified)

Towards the end of the first phase of the pandemic and with the arrival of the summer, the attention, especially in the media, shifted to those entering or returning to Italy as tourists or from travelling abroad, Italians and immigrants, and to immigrants arriving by sea from the central Mediterranean route, or crossing the country's Eastern borders from the so-called 'Balkan route'.

At the end of July, following the discovery of a significant number of infections among immigrants (all asymptomatic) hosted in a reception centre in the Treviso area (129/315, or about 41% of those examined), the political debate against the immigrant component of the population gained new momentum. The situation was essentially repeated a few days later in a reception centre housed in the former Cavarzerani barracks in the province of Udine.

The health alert situation was clearly the inevitable product of the inadequate management of reception (linked in that area to the abandonment of widespread reception in small centres) which, by

producing ghettos, risked presenting the victims (i.e., immigrants crammed into centres without effective protection) as responsible for the spread of the epidemic (Giovana 2020).

The potential issues of places such as reception centres, in the absence of adequate measures, can, therefore, explode and, sometimes, they did. The close correlation between overcrowding and the risk of infection was confirmed in the above-mentioned research by the National Institute for Health Promotion of Migrant Populations and for the Fight against Poverty-related Diseases, in which the so-called “saturation index” of the facility’s capacity (the number of guests against the number of beds) was assessed. It was observed that while the regional average of the saturation index, calculated among the centres where no positive case was observed, was 78.6%, the same index calculated among the centres where at least one positive case was observed was 87.7%.

However, in the public and political debate, following these events, the aforementioned rhetoric of the immigrant as a spreader of the plague has taken hold, emphasised by an ideological and instrumental use of language feeding unjustified fears, on which the President of the National Health Council, Franco Locatelli, had to comment, stating, on 20th August 2020:

25-40% of cases were imported by fellow citizens returning from trips or by foreigners residing in Italy. The contribution of migrants, i.e. people fleeing desperate conditions, is minimal, no more than 3-5% are positive and some become infected in reception centres (ed. note: particularly hotspots) where it is more difficult to maintain adequate sanitary measures. (De Bac 2020)

4 Conclusions

In this chapter, we have shown how the pandemic has highlighted how the lack and difficulty of having specific data on the immigrant population, both resident and recently arrived, relating to health status and socio-economic determinants, makes it difficult to support interpretations with adequate scientific evidence. Hence, the need to support the general framework of the analysis also with data from different national contexts. The centrality of the data and the issues in their collection and systematisation in relation to the immigrant population is well known and does not only concern Italy, so much so that several parties, also at an international level, have recommended the integration of variables such as “country of birth”, “citizenship”, “years since arrival in the country”, “country of birth of the parents”, in the routine data collection system and the promotion of data linkage.

Furthermore, we have highlighted how, in a broader international framework and from a global health perspective, it has been ascertained that the inequalities in the impact of the COVID-19 pandemic on the immigrant population are not justified from a biological point of view, but rather can be traced back to inequalities between this component of the population and the native population in the so-called determinants of health (behavioural, socio-economic, cultural, environmental factors, living and working conditions etc., that influence the state of health of an individual or a community), as well as in the access to services for the prevention, control and treatment of Sars-CoV-2 infection.

It is therefore necessary to address this aspect of the COVID-19 pandemic in a consistent reference to the Global Health approach, therefore integrated into research and action and aiming at giving full meaning and implementation to a vision of health as a state of bio-psycho-social well-being and as a fundamental human right, in which health and disease are considered as the results of not only biological but also economic, social, political, cultural and environmental processes, transcending and exceeding the perspectives, interests and possibilities of individual continents, individual nations, individual regions, individual local contexts.

The pandemic has revealed the deeper meaning of global health, not only showing a propagation that follows the routes of human exchange, but also highlighting the link that health has with other dimensions of our lives, such as the economy, work and the environment. (Carraro 2020)

Migration is also a specific declination of the global approach to health, with attention being paid to all those proximal, intermediate and distal determinants that build social unease and illness, and to the increasingly close interconnections between human beings, the environment, development and peace. Adopting international, national and local policies, collective and individual behaviours to strengthen the human capital of each and every one, to increase social cohesion, to leave no one behind is the only way out of this crisis and a real opportunity for change in a perspective of justice and health for all (Geraci, Affronti 2020).

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