

## Stuck and Exploited

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

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# The Coronavirus Crisis and the Consequences of COVID-19 Pan-Syndemic on Racial Health Inequalities and on Migrants

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**Abstract** After examining the ecological-social origins of the novel Coronavirus and the features of Coronavirus crisis, the text analyses at the global level the COVID-19 related racial health inequalities and the impact of the pandemic on the health and working conditions of immigrant workers, asylum seekers, migrants. The text highlights a syndemic situation affecting them, which exacerbated and transformed inequalities that already existed, generating new ones, intertwining the old and the new.

**Keywords** Novel Coronavirus. Ecological rift. Inequalities. Health disparities. Syndemics. Racial inequalities. Migration. Asylum seekers. Immigrant workers.

**Summary** 1 The Ecological-Social Origins of SARS-CoV-2. – 2 The Coronavirus Factor. – 3 The Great Equalizer Joke: COVID-19 and Inequalities. – 3.1 Syndemics and Global Health Inequalities. – 3.2 COVID-19 and Racial Disparities in Health. – 4 The Impact of Coronavirus Crisis on Migrants. – 4.1 Immigrant Workers: More Exposed, More Precarious, More Exploited. – 4.2 Asylum Seekers between Confinement and Abandonment, and the Odyssey of Emigrants. – 5 Conclusion.

## 1 The Ecological-Social Origins of SARS-CoV-2

It is now accepted that the 2019 novel Coronavirus (SARS-CoV-2) has ecological-social origins. This fact is nothing new since most epidemics have been the result of major environmental and climate changes, partly and sometimes linked to human activity. The H<sub>1</sub>N<sub>1</sub>/1918 influenza virus, which gave rise to the largest and deadliest modern



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pandemic, the Spanish flu, found in particular ecological-social conditions the favourable conditions for spillover, from migratory birds to humans, remaining endemic there ever since (Burgio 2020, 22-3). These conditions consisted mainly in marked environmental, biological, ecological-social imbalances, and in particular in the (early) large intensive livestock farms,<sup>1</sup> in the conditions produced by the First World War. In addition to H<sub>2</sub>N<sub>2</sub> in 1957 (Asian flu) and H<sub>3</sub>N<sub>2</sub> in 1968 (Hong Kong flu), between 1997 and 2005 there were other influenza viruses (e.g. H<sub>5</sub>N<sub>1</sub> avian flu) with spillover from avian species (migratory and sedentary) to human species; however, these pathogens, although very virulent, were not very contagious because they had not completed the necessary mutations to engage the human respiratory tract and consequently zoonosis<sup>2</sup> was rather limited.

Things change in 2002, when a new Coronavirus (SARS-CoV) appears in China, attacking the lungs and causing Severe Acute Respiratory Syndrome (SARS) (Burgio 2020, 24). Due to significant instability, this Coronavirus fails to spread on a large scale, however, its origin from a different reservoir-species, the bat, raises much concern, as the bat is a mammal, on the phylogenetic level it is closer to humans and therefore bat viruses may have an easier evolutionary adaptation towards human airway receptors, spillover into humans and cause zoonosis (Andersen et al. 2020). Concerning this reservoir-species, the great environmental changes occurred in the last decades in South-East Asia have expelled from their natural habitat a great number of frugivorous bats (Pteropodidae) pushing them towards the outskirts of cities, where they come into contact with other animal species with which they exchange viral strains, thus facilitating their adaptive evolution.

This last observation raises several relevant questions, which refer to the ecological-social origins of the current SARS-CoV-2 Coronavirus pandemic, which is the result of the spillover of a bat virus causing a very serious, often lethal, disease in humans: COVID-19 (CORonaVIRUS Disease 2019, acute respiratory disease from SARS-CoV-2). Such origins are manifold and have a name: climate changes, environmental disruption, deforestation, agribusiness, mass urbanisation and capitalist-led urbanisation. Better yet: capitalism's attack on man and nature. Therefore, Burgio's assertion that this is not a sudden and random biological accident, but rather the symptom of a chronic and rapidly progressive disease affecting the entire biosphere<sup>3</sup> should be carefully considered. This disease is the result

1 Particularly in the USA.

2 The transmission of infectious diseases from animals (other than humans) to humans (or vice versa), either directly or indirectly.

3 E. Burgio, "The First Pandemic of the Anthropocene", *WSIM*, 18-03-2021, <https://wsimag.com/science-and-technology/65247-the-first-pandemic-of-the-anthropocene>.

of the *metabolic rift* produced by the capitalist economy (Clark et al. 2019; Foster et al. 2011), a fracture that the turbo-capitalism of the neo-liberal era has radically exacerbated. The statement “to heal humanity and contemporary society we must heal the planet” is right, but it is not complete: to heal the planet we must heal humanity and contemporary society.

Wallace’s studies (2016) have been instrumental in shedding light on these links. He points out that the emergence of “new” dangerous viruses is linked first and foremost to the processes of deforestation and human penetration into the last primary forest. Land-grabbing, the disappearance of small-scale agricultural land working for the local market, and extractivism in the primary forest release new pathogens that for millennia have been held in check by the forest ecosystem. The irruption of agri-business into virgin ecological systems brings pathogens out of the deepest hinterland. Through some reservoir-species (birds, bats, etc.) they are transported out of the forest into neighbouring, peri-urban areas where human settlements and livestock are present, with the consequence that “the functional diversity and complexity these huge tracts of land represent are being streamlined in such a way that previously boxed-in pathogens are spilling over into local livestock and human communities” (Wallace 2020, 33). Besides, the impoverishment of local communities brought about by advancing land grabbing and agribusiness is forcing local people to go even deeper into the remote forest to collect food (wildlife), thereby increasing their encounters with new pathogens. After that, the passage to urban peripheries, to big cities, through the internal and international movements of things, animals and men, is a relatively easy thing to do; the globalisation of world trade and international migration do the rest, in the sense that they facilitate, feed, and widen the circulation and spread of the virus. Still, in these exchanges and passages of environments and hosts, pathogens mutate and develop more virulent and infectious phenotypes: “the basic logic of capital helps to take previously isolated or harmless viral strains and place them in hyper-competitive environments that favour the specific traits which cause epidemics, such as rapid viral lifecycles, the capacity for zoonotic jumping between carrier species, and the capacity to quickly evolve new transmission vectors. These strains tend to stand out precisely because of their virulence” (Chuǎng 2020).

Deforestation and forest penetration are closely linked to the industrialisation of agriculture, in which hyper-intensive, concentration-based animal production constitutes, Wallace points out, a nursery for more or less dangerous viruses, a veritable breeding ground for zoonotic diseases: “growing genetic monocultures of domestic animals removes whatever immune firebreaks may be available to slow down transmission. Larger population sizes and densities facilitate greater rates of transmission. Such crowded conditions depress the

immune response. High throughput, a part of any industrial production, provides a continually renewed supply of susceptibles, the fuel for the evolution of virulence” (Wallace 2020, 34). In destroying ecosystems, agri-industry pools together living beings expelled from their natural habitat with intensive livestock farming; these contacts are the source of spillover of viruses - which are not coincidentally given animal names (swine, cattle, avian). At the margin of agribusiness, the incubation of Coronaviruses (MERS-Cov, SARS-CoV, SARS-CoV-2) takes place: “agribusiness is so focused on profits that selecting for a virus that might kill a billion people is treated as a worthy risk [...] Agribusiness as a mode of social reproduction must be ended for good if only as a matter of public health” (34). Referring to H<sub>5</sub>N<sub>1</sub>, Wallace noted that “rural landscapes of many of the poorest countries are now characterised by unregulated agribusiness pressed against periurban slums. Unchecked transmission in vulnerable areas increases the genetic variation with which H<sub>5</sub>N<sub>1</sub> can evolve human-specific characteristics. In spreading over three continents, fast-evolving H<sub>5</sub>N<sub>1</sub> also contacts an increasing variety of socio-ecological environments, including local-specific combinations of prevalent host types, modes of poultry farming, and animal health measures” (2016, 52). Referring, for example, to the recurrent Ebola epidemics in Africa, Wallace highlights the continuity of the link between the expansion of primary industries, the penetration of agribusiness, the destruction of local eco-systems, the displacement of populations, the attraction of reservoir species and epidemics. Thus, while there was a cotton-related outbreak in Sudan in the mid-1970s (Wallace, Wallace 2016, 60), in recent years palm oil industrialisation appears to be responsible for recent Ebola outbreaks in Guinea (Wallace et al. 2016; Wallace, Wallace 2016), where deforestation and environmental devastation have facilitated the microbiological processes described above.

Moreover, ever greater masses of the human population live in highly degraded environmental and rural contexts or are crowded into the suburbs of large cities. This factor is certainly not a primary cause, but it facilitates the stabilisation and circulation of viruses. In China, SARS-Cov-2 was born at the intersection of capitalist economics and epidemiology (Chuǎng 2020); Wuhan (capital of the Hubei province, 11 million inhabitants), Chongqing (36 million inhabitants), Nanjing (capital of Jiangsu province, 8.5 million inhabitants), Changsa (capital of Hunan, 7 million inhabitants), are “four furnaces” below which there is an evolutionary pressure cooker made of hyper-urbanisation and agri-business. Therefore, the latest great epidemics (avian flu, SARS-Cov, SARS-Cov-2) originated in China not so much because of some mysterious Chinese specificity, but rather because, in this country, the historical and social conditions for the emergence of these phenomena have concentrated in recent dec-

ades, as was the case in past centuries for other geographical areas for other epidemics (plague, cholera, smallpox, etc.).

Therefore, the emergence of new pathogens and the resulting pandemics is not random, there are specific and structural causes. The SARS-CoV-2 Coronavirus pandemic, Pirrone observes, is

the result of this continuous attack on nature by capitalism, which has led to the erosion of those barriers that nature has put in place, over billions of years of history, to protect biodiversity and relations between species [...]. Sars-Cov-2 thus turns out to be an epiphenomenon of the neoliberal capitalist domination of the planet [...]. Its appearance is as much a consequence of the keys possessed by biotechnology to open the gates that nature had placed in defence of living species as of the environmental disasters brought about by the application of these biotechnologies to agri-food systems. (2020, 118-19; transl. by the Author)

## 2 The Coronavirus Factor

If the novel Coronavirus is a symptom of the current state of the environment and a *sign* of the progressive disease affecting the biosphere, the Coronavirus crisis is a *litmus test* and a mirror exposing the structural problems of contemporary societies, highlighting the major crisis of our times. The pandemic is a metaphor for the structural crisis of capitalist society, pre-dating the virus.

Among the many examples, national health systems may be mentioned: in the last decades, in several countries of the world, they have undergone a progressive deterioration or have been the object of strong attacks in the wake of neoliberal policies that – through the new public management, the stigmatisation of the public service (an inefficient bandwagon that would poison the population with universalism) – have imposed a profound transformation under the banner of privatisation/semi-privatisation, individualisation and corporatisation.<sup>4</sup> In the so-called “first pandemic wave”, several health systems were overwhelmed by the pandemic due to the surprise effect, but also as a result of decades of state disengagement in public health, budget cuts, staff reduction, abandonment of territorial medicine, the concentration of medicine in large hospitals, distancing from a genuine concept of public health and social medicine. The so-called ‘second pandemic wave’, which occurred in the fall of 2020, confirmed that the problems in national health systems were and, obviously, still are structural and could not be attributed to the surprise effect

<sup>4</sup> For Italy, which had a high mortality from COVID-19, see Prante et al. 2020.

alone. So much so that Joe Biden, for example, both during his campaign and after the election, had to include among his goals the (albeit minimal) expansion of American public healthcare because fully private healthcare has had devastating and highly unequal effects.

The Coronavirus crisis has also been a formidable *social accelerator*, a potent factor in accelerating social trends that existed before the pandemic. It has expanded, generalised, and structured several social processes that predate the pandemic, entrenching them in the social structures and daily life of many countries. In addition to the “year of the global pandemic” or the “year of fear”, 2020 should also be titled the “year of the great acceleration”. Among the many examples, suffice it to mention home food deliveries through apps and digital platforms, distance learning, the increased militarisation of society and control over daily lives. All these phenomena predate – by far – the Coronavirus crisis, yet it gave them new momentum, making a real leap in quantity that has sometimes turned into a leap in quality (think of online education, which has transformed the nature of teaching). In particular, the Coronavirus crisis has been an element of acceleration of social processes of a neo-liberal nature, for example, the individualisation of education, which through the massive use of information technology has given a strong impetus for distance learning; or the social atomisation magnified by the enormous growth of the web and digital labour (i.e. work from home). Above all, we should mention the sharpening of social inequalities and social polarisation, the structural casualisation of work, the increase in the number of working poor, all phenomena that preceded the pandemic but were extended and aggravated by it.

Moreover, the Coronavirus crisis provided the capital with an *opportunity* to expand further, to penetrate even more deeply into all spheres of social and natural life; to reorganise and at the same time subject society to the laws of capital even more stringently. It has been an occasion to expand its field of action and control even further, to expand its social and natural boundaries. As already happened in the past, in times of crisis the capital reorganises itself, and in doing so it transforms the whole of society, depending on capital – starting from the labour market, the workplaces, and the economic processes. In practice, this process consists in redefining and lowering the conditions of life of the class-that-lives-of-work (Antunes 2020), in redefining social rights, in redesigning the role of the state according to the commands of the world market and capitalist accumulation.

Last but not least, the Coronavirus crisis has also been a *social detonator*, a detonating factor. Both in its role as a litmus test and social accelerator, the Coronavirus crisis has converged and entangled pre-existing social contradictions, exacerbating social hardships and inequalities, increasing social risks. On the one hand, this can fuel social chaos, from which negative solutions can emerge; on the oth-

er hand, it can revive social struggles, in favour of equality and social justice, the environment and public health.

### 3 The Great Equalizer Joke: COVID-19 and Inequalities

The double - economic-social and ecological - crisis, predating the novel Coronavirus, is accompanied by the health crisis and by a racial crisis, combining in a triple crisis (the crisis of the crises?) that has affected all spheres of the social life of the populations and the countries of the world, and that has had multiple consequences on the economic, social, political and cultural levels. The pandemic and the health crisis have affected social classes, economic sectors, professions, genders, countries and territories differently. The assertion that the virus is a great equaliser (so defined, for example, by the Governor of the State of New York in March 2020) is not true: the possibility of contracting it, COVID-19 prevention and treatment, its severity and mortality, daily life at the time of the pandemic, are elements related to social class, to the position in the social structure and system of social relations.

As for virus *transmission*, wealthy classes had a lower risk of becoming infected by enjoying the possibility of protecting themselves more and better or keeping a physical distance (availability of big houses, private cars, devices, paid services). During the lockdowns of the first wave, people in many countries were told to “stay home”, but housing conditions are quite unequal - some people live in crowded, small houses with little equipment, and some people have no house at all. The transmission of the virus has been conditioned by socially unequal housing conditions. In terms of *exposure* to the virus, a large proportion of the working class could not avoid going to work, could not work from home as they were employed in essential jobs (shop assistants, nurses, cashiers, public transport, cleaning or personal care workers), could not work in a protected manner; for these categories of workers exposure to virus was particularly strong and prolonged. Working-class and deprived groups were found to have more *susceptibility* to COVID-19 due to worse social, economic, and environmental conditions. In short, the resources available within the storm of pandemics have been differentiated and unequal; it is not true that “we are all in the same boat”, if anything, we navigate rough sea with very different boats, some people do not even have a boat at all.

### 3.1 Syndemics and Global Health Inequalities

It is well known that COVID-19 has more severely affected the elderly and individuals suffering from other diseases (diabetes, cardiovascular disorders, tumours, diseases of the immune system). However, such diseases are the result of inequalities in the social determinants of health. They are linked to social factors (profession, income, education), the living conditions of the individual, their class condition. Thus, not only the possibility of contracting the virus but also the possibility of suffering serious complications or dying from COVID-19 is linked to the position occupied in the social structure, in the historically given system of social relations. This position is manifested in the social gradient of health and affects the vulnerability to COVID-19.

Gravlee (2020, 1-2), while recalling that “pandemics always follow the fault lines of society”, underlined that COVID-19 presented the conditions of the syndemic (Singer 2009),<sup>5</sup> which is the result of the combination of disease concentration (“the co-occurrence or clustering of multiple epidemics as a result of large-scale, political-economic forces and adverse social conditions”) and disease interaction (“the ways that overlapping epidemics exacerbate the health effects of adverse social conditions, either through biological interactions between disease states or through interactions between biological and social processes”). With COVID-19 there was a syndemic – “a set of closely interrelated endemic and epidemic conditions (e.g., HIV, TB, STDs, hepatitis, cirrhosis, infant mortality, drug abuse, suicide, homicide, etc.), all of which are strongly influenced and sustained by a broader set of political-economic and social factors” (Singer 1996, 99) – resulting from the interaction between infectious disease (contracted differently according to the social gradient) and non-communicable diseases (unequally distributed according to the social gradient). Thus, as it has happened in the past and recently during other influenza epidemics (Mamelund 2019), COVID-19 affected the population differentially; morbidity and mortality were unevenly distributed across the factors of class, race, gender, age, territory. For the sake of space, I will give just two examples, focusing on the British context and the Italian context.

In England, regarding admissions for COVID-19 “45% of patients were from the most deprived 20% of the population” while regarding mortality from COVID-19

death rates were highest amongst men employed in elementary occupations [...], caring, leisure and other service occupations [...],

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**5** “The presence of two or more disease states that adversely interact with each other, negatively affecting the mutual course of each disease trajectory, enhancing vulnerability, and which are made more deleterious by experienced inequities” (*The Lancet* 2017, 881).



process, plant and machine operatives occupations [...]; administrative and secretarial occupations [...], sales and customer service occupations [...], skilled trades occupations [...] death rates were lowest among men employed as managers, directors, senior officials and in professional occupations. (SAGE 2020, 11-12)

As far as positive cases are concerned, the picture is the same: a study covering the period 1 March 2020-9 May 2020 highlighted that

diagnosis rates were highest in the most deprived quintile (over 300 cases per 100,000) – for both men and women – almost double that of the least deprived quintile (around 200 cases per 100,000). Indeed, the rate in the most deprived quintile was 1.9 times the rate in the least deprived quintile among men and 1.7 times among women. (2020, 14)

In Italy – historically characterised by strong health inequalities (Costa 2015) manifested in the chronicity, life expectancy and mortality levels – COVID-19 traced the national fault lines, which were already manifested in March 2020 in a certain over-representation (relative and absolute) of the working classes in the increases in mortality rates (ISTAT 2020a, 88). This trend was confirmed in the following months: until the end of May 2020, a higher level of mortality was recorded among the population with a low level of education, not only the elderly (ISTAT 2020a, 89). In the first three months of 2020, 37% of the deceased (14,324 cases) had at least one co-morbidity with some pathology (ISTAT 2020b); medical records of a group of 4,738 deceased showed that 13.3% had one pathology, 19.6% had two, and 63.6% had at least three chronic diseases diagnosed before they were infected with SARS-CoV-2 (ISS 2020).

### 3.2 COVID-19 and Racial Disparities in Health

Many studies have confirmed that the unequal impact of COVID-19 on population health is related to the ‘race’ factor, to racism as a social relationship of exploitation and as an ideology of legitimization of exploitation.<sup>6</sup> Everywhere racial inequalities in health emerged for COVID-19, which are the result of systemic racism and structural ra-

<sup>6</sup> In some of these studies the term racism is associated with the adjective ‘systemic’ or ‘structural’, or the notion of ‘racial capitalism’ is used; but these adjectives seem somewhat ‘superfluous’ since racism, insofar as it is a material relationship of domination justified by a racial ideology that legitimates and perpetuates domination, is by definition a structural element of capitalist society, it is congenital, organic and vital to capitalism (Basso 2016). A child of colonialism, typical of the modern world, racism is structural and functional to the system of inequalities of the capitalist society as a system of inequalities.

cial inequality. I will quickly dwell on three contexts: United States, England, Brazil.

Gravlee noted a peculiar syndemic situation in the United States. In terms of social factors, racism had very significant weight on the health impact of COVID-19, with somewhat worse consequences for the African-American population. The general social condition of black people, historically the object of systematic exclusion, discrimination, violence, and social inferiority, has been the humus in which the COVID-19 syndemic has developed, characterised by a more severe COVID-related health condition among blacks (but also among Latinos and Native Americans). The racism that structurally pervades the U.S. society (from work to income, from education to the judicial system, from housing to urban planning, even to the air we breathe [Novick 1995]) has constituted “a fundamental cause of racial inequities in disease concentration. This perspective sees the social patterning of hypertension, diabetes, and now COVID-19 as culminating from a system of racial oppression” (Gravlee 2020, 4). Laster Pirtle emphasised the importance of racial capitalism in COVID-19’s production of differential effects, of heavier consequences for blacks: “racism and capitalism mutually construct harmful social conditions that fundamentally shape COVID-19 disease inequities because they [...] replicate historical patterns of inequities within pandemic” (Laster Pirtle 2020, 504).

Much like the uprisings that followed G. Floyd’s murder, the disparities in levels of positivity, co-morbidity, severity, and mortality from COVID-19 are the result of broad and deep racial (and class) inequalities that historically and structurally plague the African American population in all areas of social life – from employment to economic status, from housing to education, from health to the justice system, from birth to death.<sup>7</sup> With the great crisis of 2008, in addition to a strong social class polarisation, there was a violent impoverishment of the black population, which has further increased with the Coronavirus crisis. It has widened and deepened racial inequalities in various spheres of social life beyond the realm of health. So Laster Pirtle is right when she states that “COVID-19 is showing us who we are... again” (p. 506).

In a country where access to health care is class-based and where even before the pandemic, there was exponential growth in the level of worker indebtedness due to healthcare costs, infections and COVID-19 mortality were characterised by strong racial disparities (Bassett et al. 2020; Chin-Hong al. 2020, Zelner et al. 2020). Already at the start of the pandemic we saw “une surmortalité importante de

<sup>7</sup> Conley 2010; Harris, Lieberman 2013; Massey, Denton 1993; Oliver, Shapiro 2006; Wright, Rogers 2015, 312-63.

la population noire (33% des décès contre 18% de la population générale des états pour lesquels l'information est disponible [...]) Dans la ville de New York, de loin la zone la plus touchée par l'épidémie (avec 30% de l'ensemble des décès par Covid-19 enregistrés sur le territoire national au 1er mai 2020), le taux comparatif de mortalité pour cette cause de décès atteint 92 pour 100.000 dans la population noire et 74 dans la population hispanique, contre 45 dans la population blanche et 35 pour la population asiatique [...] plus de 50% des cas et presque 70% des décès par Covid-19 identifiés à Chicago, dans l'Illinois et en Louisiane concernent des individus appartenant à la population noire alors que celle-ci n'y représente qu'un tiers au plus de la population totale" (Barbieri 2020, 11). This trend continued even more sharply in the months that followed: through mid-August 2020, there were 2.6 more cases among African Americans than among the white population, 4.7 more hospitalisations, and 2.1 more deaths (CDCP 2020).<sup>8</sup> The second wave saw a worsening of mortality disparity, with "Black, Indigenous and Latino Americans all have a COVID-19 death rate of triple or more White Americans, who experience the lowest age-adjusted rates".<sup>9</sup> Over-represented in essential, low-skilled, dangerous and demeaning jobs (salespersons, transportation operators, cleaners, food delivery workers, babysitters, etc.), African Americans – most affected by COVID-19 – are also most affected by diabetes, cancer, and cardiovascular disease; they died more from COVID-19 and these diseases, i.e., from pre-existing comorbid conditions (syndemics).

A similar situation has been recorded in England. A study by the Office for National Statistics on deaths between 2 March 2020 and 28 July 2020 found that (based on a statistical model adjusting for age and excluding care home residents):

the rate of death among Black African males was 3.8 times higher than those of White background, while for Black African females the rate was 2.9 times higher; all ethnic groups other than Chinese females were at higher risk of COVID-19 mortality than the White ethnic population [...] ethnic differences in mortality involving COVID-19 are most strongly associated with demographic and socio-economic factors, such as place of residence and occupational exposures.<sup>10</sup>

<sup>8</sup> Data as of 18-08-2020. <https://www.cdc.gov/Coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html#footnote01>; <https://covidtracking.com/race>.

<sup>9</sup> <https://www.apmresearchlab.org/covid/deaths-by-race#counts> (last update 22-12-2020).

<sup>10</sup> ONS UK, <https://www.ons.gov.uk/releases/explainingethnicbackgroundcontrastsindeathsinvolvingcovid19england2ndmarchto3rdjuly2020>.

In Brazil – despite an image of a multicultural country in which harmony between whites, blacks and browns dominates – the colonial, slave and racist past of this country is more alive than ever and is still ingrained in its social structure and daily life (Fernandes 2008; Gorender 2010; Moura 1988). Over the past three decades, some changes and progress have produced a slight improvement in the living conditions of black populations and a relative decrease in black-white inequalities (Marcia, Prates 2019), however, deep racial inequalities are still present today and affect black and brown people (in particular the women), Indigenous populations at all levels: access to the labour market, jobs, unemployment rates, incomes, health status, housing.<sup>11</sup> Whites hold 70% of managerial positions. The relative poverty rate is 15.4% among whites and 32.9% among blacks and browns (IBGE 2019). In prisons, which are filled with a black population, 68% of incarcerated women are black, half of whom have not completed elementary school and are very young (Borges 2019). Blacks have great difficulties in accessing the health system and health protection.

This racial system has been reflected in COVID-19 infection and mortality: higher levels of COVID-19 infection and mortality have been reported among the black population, which is highly present in essential and informal services (Baqui et al. 2020; Goes et al. 2020; Oliverira et al. 2020; Santos et al. 2020).<sup>12</sup> A study of 29,933 cases registered up to 18 May 2020 found a mortality rate of 55% among blacks and browns and 38% among whites, across all age groups and education levels; a gradual decrease in mortality rate as education level increases; a mortality rate of 80% among unschooled blacks and browns versus a mortality rate of 19% among whites with higher education (Batista et al 2020). The largest epidemiological study conducted in the country found that the poorest populations (including Indigenous people, who have long been experiencing an increase in cardiovascular and metabolic diseases) are twice as likely to become infected compared to the richest population (Halal 2020). Poorer regions (Nordeste, Norte and Centro-Oeste) had higher mortality rates.<sup>13</sup>

<sup>11</sup> Gonçalves 2018; Heringer 2002; IBGE 2018; Paixão et al. 2010.

<sup>12</sup> Results immediately highlighted by the press: <https://www.abrasco.org.br/site/noticias/desigualdade-racial-por-que-negros-morrem-mais-que-brancos-na-pandemia/49455/>; <https://revistagalileu.globo.com/Sociedade/noticia/2020/05/na-pandemia-de-covid-19-negros-morrem-mais-do-que-brancos-por-que.html>; <https://www.cnnbrasil.com.br/saude/2020/06/05/negros-morrem-40-mais-que-brancos-por-Coronavirus-no-brasil>.

<sup>13</sup> *Coronavirus Brasil*, <https://covid.saude.gov.br/>.

## 4 The Impact of Coronavirus Crisis on Migrants

The Coronavirus crisis exposed the social problems and inequalities that already existed, while at the same time amplifying and reinforcing them. It is accepted that it has sharpened social polarisation within countries and global inequalities. It has increased inequalities in employment, economy, education, consumption, use of time, hitting harder the working classes, women, young people, minorities. At the same time, the Coronavirus crisis has transformed inequalities and the system of inequalities, changing old ones, generating new ones, intertwining the old and the new, following the class division of society.

A test of these processes, in particular of the differentiated impact of the crisis, can be observed in migration. Just as in the great economic crisis of 2008, during the pandemic, immigrants and migrants suffered very heavy consequences, due to the double penalty of migrants, to their dual status as wage earners and foreigners. During the pandemic, they experienced conditions and problems similar to those of the native population, yet often more severe. As will be seen, for many reasons, immigrants and migrants have been particularly vulnerable to the pandemic and its economic and social effects; specifically, because of the conditions, they have a high level of exposure, susceptibility and vulnerability to the virus and at the same time have suffered serious consequences at the labour and administrative levels, just to mention a few.

#### 4.1 Immigrant Workers: More Exposed, More Precarious, More Exploited

Let's see in detail the impact of the Coronavirus crisis on some dimensions of migrants' social life,<sup>14</sup> distinguishing between immigrant workers residing in a foreign country, asylum seekers, emigrants in travel.

Concerning the former, two points must be made. Firstly, they reside mainly in the large urban and industrial centres of Europe, the Americas, South-East Asia and the Gulf, in other words, in the most populated and crowded areas of the planet. According to the International Organization for Migration (IOM) in 2014, about 20% of international migrants lived in twenty major cities (from London to New York, Shanghai to Buenos Aires), where they accounted for a fifth of the population (but they were 83% in Dubai, 62% in Brussels, 46% in Toronto).<sup>15</sup> Secondly, they constitute an essential part of the workforce employed in key-sectors; in 2017, they constituted 20.6% of workers in North America, 17.8% of workers in Northern, Western and Southern Europe, 40.8% of workers in the Arab States (ILO 2018, XII), primarily employed in low-skilled, dangerous, demeaning but essential jobs for so many economic sectors: workers in logistics, transport, business and personal services (riders, retail, cleaning, domestic work, care work), healthcare (in hospitals, nursing homes, families), the tourist-hotel and restaurant sectors, construction, food processing, agricultural. Low-skilled immigrant workers are over-represented in several essential jobs; in Europe about 13% of key workers are migrants (extra-EU migrants or EU mobile citizens), but in some jobs such as cleaners or helpers, they account for more than a third (Fasani, Mazza 2020, 1, 10); in the United States, 69% "of all immigrants in the US labour force and 74% of undocumented workers are essential workers [...] the percentage of undocumented essential workers exceeds that of native-born essential workers by nine percentage points in the 15 states with the largest labour force. In the ten largest MSAs, the percentages of undocumented and naturalised essential workers exceed the percentage of native-born essential workers by 12 and 6%" (Kerwin, Warren 2020, 1).

Due to their specific position in the labour market and their professional status, but in particular, due to their concentration in essential sectors and manual jobs, most immigrant workers were not

<sup>14</sup> On risk factors and areas of vulnerability see OECD 2020a.

<sup>15</sup> IOM (23-11-2020). <https://migrationdataportal.org/themen/migration-data-relevant-covid-19-pandemic>. According to the IOM, as of 3 November 2020 immigrants "accounted for at least 4.5% of the population in 12 of the 20 countries with the highest number of COVID-19 cases, and this share is more than 10% in 8 of these countries".

able to work remotely, they were not able to abstain from work, they had to accept any working conditions to safeguard their residence permit or their job, they worked in places where anti-COVID precautions were not always applied, they continued to perform jobs characterised by close contact with colleagues or the public. Due to their general condition, they often use public transport and live in poor and densely populated areas, in dwellings with limited overcrowded spaces in which children, parents, grandparents and uncles live together. For these reasons – in particular for the combination of labour segregation and housing hardship – they had high exposure to the virus, which more than a few times resulted in a high level of infection, concentrated in outbreaks that broke out in specific workplaces such as slaughterhouses, logistics hubs, food companies. This situation was compounded by a significant susceptibility resulting from general living and health conditions (syndemic).

At the moment,<sup>16</sup> data on the diffusion of COVID-19 among immigrants are limited, inhomogeneous, and difficult to compare, also because of the different survey systems and demographic compositions. Nevertheless, we do have some initial indicative studies. In Sweden (Valeriani et al. 2020; the study covers the period March 13–May 7, 2020) and in Norway,<sup>17</sup> twice the incidence of COVID-19 was reported among the immigrant population compared to the native population. In Spain (Guijarro et al. 2020), in France (Papon, Robert-Bobée 2020), in the Netherlands (Kunst et al. 2020, 14), in Sweden (Hansson et al. 2020), the significant susceptibility to the virus produced by general living conditions and difficulties in accessing health services<sup>18</sup> has resulted in medical complications and sometimes excess mortality among the immigrants. In Italy, a national study updated to April 2, 2020, has highlighted that the casuistry regarding foreign-born people presents a different demographic and clinical structure from the casuistry of those born in Italy. Among the former, the female component is higher (56.4% vs 50.8%), the average age is lower (46 years vs 64), there is a greater concentration in the Northwest (72.8% vs 57.5%) and urban areas (52.1% vs 31%). Above all, there is a higher risk of hospitalisation and admission to intensive care (1.4 times). There are more severe manifestations of the disease even in terms of age – due to delays in diagnosis and the use of health services (IDOS 2020, 251).

As was the case with the economic crisis ten years ago, the Coronavirus crisis has had a harsh impact on the work of immigrants, who have been among the hardest hit by precarity, unemployment

<sup>16</sup> November 2020.

<sup>17</sup> University of Bergen, <https://www.uib.no/en/globalchallenges/139119/being-healthy-and-working-new-country>.

<sup>18</sup> Due to language difficulties, lack of residence permit, etc.

and underemployment, worsening working conditions, and impoverishment. Although the impact on the employment of all workers has been heterogeneous (depending on national contexts or geographical areas; in terms of unemployment, underemployment, inactivity), in the OECD area, the worst consequences have fallen on immigrant workers (OECD 2020b, 11-12), for several reasons: the strong presence in sectors affected by the crisis (hotel, restaurant, domestic work) or in sectors with a high level of informality, irregularity and precarity; the concentration in low-skilled jobs, the first to be affected in times of recession and unemployment; an often unstable administrative condition, deriving from the link between work contract and residence permit; partial fruition of social rights, as they are linked to the migratory status. Workers who are structurally precarious by definition and de facto, precisely because of their concentration in precarious jobs, have been among the first to be affected by unemployment and more acute precariousness, falling into a kind of “precarity loop”. Moreover, the pandemic has enlarged and amplified their over-education and under-classification. In the context of high unemployment and harshening of migration policies, to find or keep a job enabling them to obtain or renew their residence permit, immigrants have been forced to accept a lower classification. In some national contexts, they were penalised in enjoying social safety nets and there have been cases of discrimination in welfare.

As far as unemployment is concerned, Hispanic women in the United States (-21% compared to other women or men), immigrants (-19% compared to 12% US-born), young adults and the less educated were most affected by job loss (Kochhar 2020); immigrants - especially Latinos and women - were more acutely affected by unemployment than US-born citizens (16.5% vs 14%) (Capps et al. 2020). In Canada, in March-April 2020, recent immigrants - who are concentrated in short-term, low-paying jobs - were more affected by unemployment than Canadian-born workers and long-term immigrants (job-to-unemployment transition rates of 17.3%, 13.5% and 13.5%, respectively) (Hou et al. 2020). The impact on the employment of immigrant women (regardless of education level) was particularly harmful. Between March and May 2020, the unemployment rate for immigrant women increased by about 7% compared to 4.5% for Canadian-born workers and immigrant men.<sup>19</sup> In Germany, unemployment grew faster among immigrant workers in the period March-June 2020 (27% vs 20%).<sup>20</sup>

<sup>19</sup> A. Ferrer, B. Momani, “The startling impact of COVID-19 on immigrant women in the workforce”, *Policy Options*, 21-10-2020, <https://policyoptions.irpp.org/magazines/october-2020/the-startling-impact-of-covid-19-on-immigrant-women-in-the-workforce/>.

<sup>20</sup> J. Nasr, “COVID-19 pandemic derails Germany's push for migrant integration”, *Reuters*, 20-07-2020, <https://www.reuters.com/article/idUSL5N2EZ0XS>.



In some economic sectors or geographical contexts, there have been situations of worsening exploitation of workers, of exacerbation of discrimination at work. In Italian agriculture, for example, the area of severe labour exploitation has widened, working conditions have worsened with the increase in irregular work, the lengthening of working hours, the intensification of work rhythms, the reduction of wages and break times, the reduction of labour disputes (IDOS 2020, 289).<sup>21</sup> In Spain, in the agricultural sector of Huelva, female farmworkers from a bleak pre-COVID condition have plummeted into a hellish condition.<sup>22</sup>

#### 4.2 Asylum Seekers between Confinement and Abandonment, and the Odyssey of Emigrants

During the pandemic, asylum seekers suffered severe consequences - at health and social level - due to their structural vulnerability and poor social status, which predated the pandemic. At the moment there are no systematic and updated data on infections among asylum seekers. However, various sources (specialised organisations, press, etc.) indicate that the reception centres and refugees camps were not able to ensure physical distance and public health; the crowding of the centres and refugees camps was, if anything, a significant factor of contagion. The dramatic case of the Moria camp in Lesbos, between COVID-19 and detention, was one of the darkest pages of the refugee tragedy but also an example of the inadequacy of the camp model. Not only because these facilities are severely overcrowded and it is not possible to maintain distancing, but also because very often, the infected were not evacuated from the facilities and were quarantined within them, spreading the virus to the entire facility.

This type of management has occurred more than a few times in Italy. With the dismantling of the widespread reception system and the concentration of asylum seekers in large reception centres, the ground has been prepared for the spread of the virus. A study carried out in June 2020 on 195 reception centres scattered throughout the country highlighted that the management of PCR-positive guests very often implied the adoption of uneven and improvised measures

<sup>21</sup> An international journalistic investigation has documented a worsening of the conditions of foreign labourers in several European countries <https://www.euronews.com/2020/07/17/invisible-workers-underpaid-exploited-and-put-at-risk-on-europe-s-farms>.

<sup>22</sup> A. Márquez Tejón, H. Wilson, "Protecting migrant women workers in food supply chains during COVID-19", *OpenGlobalRights*, 14-08-2020, <https://www.openglobalrights.org/protecting-migrant-women-workers-in-food-supply-chains-during-covid>.

with DIY solutions.<sup>23</sup> Using a special “saturation index” of reception centres, another national study conducted on 5,038 facilities between May-June 2020 confirmed the close correlation between overcrowding and risk of infection. The same study showed that the isolation of positive subjects ordered by the health authority took place in a quarter of the cases at the same facility. Only half of these cases were in a single room with exclusive services.<sup>24</sup>

Often, and in many parts of the world, to add insult to injury, the victim-blame effect applied: these structures and their “guests” have been singled out as spreading the epidemic, the carriers of the virus. Thus, to the traditional public image of the asylum seeker as a slacker, scrounger and underdeveloped, the element of “asylum seeker as a health hazard” was added. With the pandemic, we witnessed the appearance - not new - of the link between otherness-health emergency-security policies, which was followed by exclusion practices and racism in the name of health security (also through the distinction between “native virus” and “foreign virus”).

At the moment, there are still no systematic studies on the impact of the pandemic on the work of asylum seekers. Yet, from various sources (reports, press articles, etc.) it has emerged that in many parts of the world, they have lost their jobs, have had great difficulty in finding new ones, and have seen an increase in irregular work. This situation led to an increase in inactivity and monotony in reception centres, especially during lockdown periods, during which these facilities became veritable prisons in which inactivity, discouragement, forced overcrowding and a sense of abandonment took over. On the other hand, those who did not lose their jobs faced the problem of a high risk of infection by being employed in low-skill jobs in essential sectors.

In addition to the loss of jobs, there was the uncertainty of their residence status due to: the suspension of asylum applications and residence permits, the weakening of legal status caused by the state of emergency, the closure of borders and humanitarian corridors, the interruption of the provision of reception and integration services (especially during lockdowns), the absence of specific interventions in favour of this category in times of pandemic, the difficult access to social and health services and poor health care at a time when

<sup>23</sup> E. Camilli, “Covid19. Prassi improvvisate e difformi: ecco cosa è successo nei centri d'accoglienza”, *Redattore sociale*, 01-07-2020, [https://www.redattoresociale.it/article/notiziario/covid19\\_prassi\\_fai\\_da\\_te\\_improvvisate\\_e\\_difformi\\_ecco\\_cosa\\_e\\_successo\\_nei\\_centri\\_d\\_accoglienza](https://www.redattoresociale.it/article/notiziario/covid19_prassi_fai_da_te_improvvisate_e_difformi_ecco_cosa_e_successo_nei_centri_d_accoglienza).

<sup>24</sup> An emblematic example is a reception centre in the province of Treviso (Italy) in August 2020: after discovering two cases of positivity, instead of taking out or isolating the infected, the residents were let to be infected, resulting in 250 people testing positive in a few days.

the health systems of many countries have been in crisis, the worsening of housing conditions. All this further aggravated a situation that was already compromised and deteriorated by forced migration, poor mental and physical conditions due to the journey and life in the camps, repressive and punitive migration policies, and the anti-migrant propaganda that has long raged throughout a large part of the world. These elements have negatively affected their exposure to the novel Coronavirus. They have damaged the first steps of integration and rooting, throwing thousands of people into limbo and negatively impacting those who have not obtained humanitarian protection or asylum and on those who have left the reception and international protection systems, especially undocumented.

With the arrival of the pandemic, almost all the countries of the world (about 195) closed their borders, strengthened controls, imposed more restrictions. If most of the times these measures were due, sometimes the pandemic was a pretext to apply ultra-restrictive measures and migration policies not justified by the pandemic. Of course, these elements have reduced migratory movements and limited departures. However, since the structural causes of emigration have not changed - on the contrary, with the Coronavirus crisis they have become even more profound in poor countries - emigration has continued, albeit in a more difficult, more uncomfortable, more dangerous, and more costly manner.

The closure of borders, ports,<sup>25</sup> and legal channels, the worsening migration policies, and health restrictions have worsened migration conditions for both those who already on their way and those setting out during the pandemic. More than a few times, migrants have been stranded in transit countries, at border crossings, along the way; stranded with no means of livelihood, little access to services, with little public attention. The worsening conditions of migration have made them even more vulnerable; with the pandemic, they have seen an increased risk of inhuman treatment and have suffered escalated mistreatment, rape, violence. The reports and documentation regarding migration in different parts of the world - for example, the Colombian-Venezuelan area, Central America, the Mexico-US border, India, the Balkan route, the sub-Saharan route, the Mediterranean route - have painted a very gloomy picture; a large part of the migrations have slipped into a foggy limbo, passing even more into the hands of traffickers and criminal organisations that have often operated undisturbed. In the situation of closed borders, forced vacuum (absence of NGOs, journalists, rescues, public authorities) and state of emergency, migrations have become even more irregular,

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**25** In the Mediterranean, quarantine ships have also been added, fully-fledged floating hotspots on which hundreds of people have been kept at sea for days on end.

new services related to smuggling have arisen, smuggling activities have changed adapting to the new context, traffickers have changed routes and modes adapting to the new situations, finding new solutions (Sanchez, Achilli 2020).

## **5 Conclusion**

The Coronavirus crisis has taken place in a context of structural growth of inequalities in the four corners of the planet in recent decades. A context in which all forms of inequality have become more acute. Globalisation of neo-liberal policies and ideologies has transformed social inequalities and the system of inequalities, modifying the old ones, generating new ones, intertwining the old and the new. Social, health, environmental inequalities have been modified and exacerbated because of the considerable ongoing environmental crisis and the deep metabolic rift - which, in combination with the very acute economic crisis and the SARS-Cov-2 health crisis, have unified into a colossal triple crisis of capitalist society.

The pandemic has aggravated racial inequalities. Racialised groups were strongly penalised by it in all spheres of social life: in health (a higher rate of contagiousness, linked to material factors such as the job carried out), in work (increased unemployment, underemployment, precariousness, deskilling), in housing (poor availability of spacious housing). Some social groups, such as emigrants and immigrants, who were already highly vulnerable and disadvantaged, have been hit very hard by their dual status as wage earners and foreigners. Many migrant women have seen their living and working conditions worsen dramatically as a result of the triple oppression that constantly weighs on them.

The pandemic have exposed the role and the condition of migrants within the world labour market, the nature of migration policies (organic to it), the utilitarian (or pathological) conception of immigration in many countries. For this reason, the Coronavirus crisis is, could be - and should be - an opportunity to rethink migration policies, to review the dominant conception of the immigrant as a man/woman bearer of needs for social emancipation.

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