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Health equity during COVID-19: A qualitative study on the consequences of the syndemic on refugees' and asylum seekers' health in reception centres in Bologna (Italy)

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ABSTRACT

Background: As coronavirus infection spread across the world, the dramatic consequences of Sars-CoV-2 and confinement measures highlighted the disparities within our society, impacting more severely on the wellbeing of the most disadvantaged groups of people, such as migrants. The structural characteristics of reception centres create many challenges in the implementation of measures to contrast the diffusion of the virus, putting refugees and asylum seekers (RAS) even more at risk. For these reasons, we carried out a qualitative study to analyze the impact of the syndemic on the health of RAS who reside in reception facilities in Bologna (one of the cities with the highest number of migrants in Italy) and the measures that were introduced to contrast the diffusion of Sars-CoV-2.

Methods: Between April and September 2020, we interviewed 25 professionals and volunteers who were critical in the management of the COVID-19 epidemic in reception centres. Key-informants were selected through a snowball sampling process and covered various professions (i.e. doctors, nurses, social workers, psychologists, cultural mediators, anthropologists, lawyers). The semi-structured interviews explored the consequences of COVID-19 on the health of RAS living in reception centres, the measures implemented to contrast the diffusion of the epidemic and the challenges that interviewees had in handling the emergency. After transcription, the interviews were analyzed using deductive and inductive approaches.

Results: All key-informants agreed to participate in the study. Even though various measures were implemented in reception centres (i.e. mass quarantine, supply of personal protective equipment, risk communication campaigns and specific governance tools) they often had a discriminatory approach towards migrants and only considered the biomedical aspects of COVID-19, excluding its social roots and repercussions. This factor, together with the lack of an effective governance system at both the local and the national level, was the most relevant issue associated with the management of the syndemic in reception facilities and affected all the social determinants that shape the health profile of RAS.

Conclusions: The study revealed the importance of social factors in the management of the syndemic in reception centres. It also highlighted how the underlying causes of the impact of COVID-19 are tightly correlated to the political and social approaches of local and national institutions to migration. In order to guarantee the well-being of society as a whole and successfully control the epidemic, it is necessary to consider migration as a human reality rather than an emergency, and demolish all the policies and bureaucratic systems that act as structural violence on RAS. This process brings into play different levels of responsibility and many action plans. We need to develop intersectoral collaborations for more holistic and interconnected practices, while investing the resources to build a worthy reception system and effective social protection programs. This way it will be possible to develop more inclusive approaches to public health and guarantee the conditions for RAS' empowerment.

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1. Introduction

The diffusion of SARS-CoV-2 and the introduction of measures to limit its transmission (Bhopal, 2020) impacted socioeconomic conditions on a planetary scale, exacerbating pre-existing health inequities and negatively affecting peoples' health (Marmot and Allen, 2020), especially of those on the move (Guadagno, 2020). Due to the socio-political systems that characterize our society, COVID-19 revealed and exacerbated the unequal distribution of social determinants of health (SDHs) (Chu et al., 2020) which, even before the health emergency, had a key role in the production of health and diseases, by limiting the agency of the people who occupy the most marginal positions within society (Farmer, 2004). These include living and working conditions, accessibility to healthcare facilities and many other aspects that are part of the broader concept of health (Marmot and Wilkinson, 2003), defined as a state of complete physical, mental and social well-being (WHO 1948). Evidence shows how these factors are unevenly distributed within society and represent one of the root causes of health inequalities (Irwin and Scali, 2010). Being migrants amongst the most disadvantaged groups in Europe, these factors have a particular impact on their health profile (PHM, 2017).

This phenomenon was emphasized by COVID-19, which highlighted how various social structural facilitators increase both morbidity and mortality in the pandemic, exposing the importance of local social environmental conditions and demographics in creating varying local syndemic expressions(Singer and Rylko-Bauer, 2021). Indeed, the disease configurations and effects of COVID-19 are demonstrating its syndemic nature, known as the synergistic interaction of two or more diseases or other health conditions which are then promoted or facilitated by social and environmental conditions (Singer, 2009).

Furthermore, the socio-political conformation of our society determined that the effects of the emergency were more dramatic for all the most marginalized groups of the population (Horton, 2020). Indeed, through the implementation of lockdowns, movement restrictions and the closing of public amenities, COVID-19 led to the diversion of resources and disruption of services which were previously crucial in the promotion of the wellbeing of the most vulnerable (Singer and Rylko-Bauer, 2021). These conditions also facilitated the action of the 'tools of oppression' that are internalised within bureaucratic systems and express themselves as 'structural violence', increasing social sufferance and consequently the overall burden of disease (Pursch et al., 2020). These circumstances also hinder the possibility of RAS' empowerment (*"the process by which people, organizations and communities gain mastery over their lives"*) hence undermining all efforts of health promotion ("*the process of enabling people to increase control over, and improve, their health*")(Labonte, 1990).

In this scenario the dynamic relationship between migration and health, becomes even more critical, given that while RAS are exposed to greater 'structural violence', various factors that characterize the living and working conditions of RAS in reception facilities (such as overcrowding, poor hygiene and barriers to accessing healthcare and social services) intensify the risk of exposure to the virus but also the development of worse outcomes if COVID-19 is contracted (Vonen et al., 2020). Beyond this, COVID-19 dramatically affected the already marginalized position migrants occupy in hosting countries, making them even more vulnerable to the negative impacts of SDHs.

Italy was the first country in Europe to respond to numerous cases of COVID-19, and is also the first point of access to the EU for many migrants. Since the confirmation of the first COVID-19 case in Italy on 21 February 2020, the national government implemented various measures to limit its spread, announcing a national lockdown from 9 March, which was slowly eased at first on 4 May and then on 15 June. Throughout this period many activities and services were interrupted, including the legal and administrative offices responsible for asylum applications, and often also healthcare services dedicated to migrants.

The aim of this study is to evaluate the impact of the COVID-19 crisis on the health of RAS who reside in reception centres in Bologna, one of the cities with the highest number of migrants in Italy (WHO 2020). The measures implemented in the reception centres were also analysed, with a view to highlighting their strengths and weaknesses in order to inform policy and improve future preparedness.

2. Material and methods

2.1. Setting, study design and research questions

The study was carried out through semi-structured interviews with front-line workers involved in the management of the COVID-19 emergency in ordinary and Emergency Reception Centres in Bologna (see Table 1).

2.2. Ethical considerations

The Bioethics Committee of the University of Bologna examined the bioethical profile of the protocol and provided ethics approval (reference 149,014).

2.3. Data collectionStudy design

Key-informants were selected through a snowball sampling process after a period of observation of the activities carried out in reception centres to face the COVID-19 emergency, between March and June 2020. A total of 25 people were interviewed between June and September 2020 covering:

- 7 of the 11 cooperatives which are responsible for the management of reception centres in Bologna;
- the Departments of Public Health and of Primary Care of the Local Health Authority;
- two European projects funded by the Asylum, Migration and Integration Fund and led by the Emilia-Romagna region - I.C.A.R.E (Integration and Community Care for Asylum and Refugees in Emergency) and Start-ER (Salute Tutela e Accoglienza per Richiedenti e Titolari di Protezione Internazionale in Emilia-Romagna - Health Protection and Reception for Refugees and Asylum Seekers in Emilia-Romagna) - which have the goal of supporting RAS in accessing physical and mental healthcare services;
- the largest national association focusing on legal aspects of immigration (ASGI - Association for Juridical Studies on Immigration);
- the women's clinic dedicated to foreign women and their children, run by the public healthcare system;
- the two clinics which provide healthcare to undocumented migrants, run by civil society organisations (CSOs);
- two CSOs which volunteer in a social centre, offering psychological support for traumatized migrants and guidance for accessing health services.

A dimension to which we gave particular attention was the multidisciplinarity of the interviewees, with the purpose of including the numerous aspects of migrant health. In order to include the numerous aspects of migrant health, we gave particular attention to the multidisciplinarity of the interviewees selecting people who had different backgrounds and professions (see Table 2). Overall, we interviewed 16 health workers (4 nurses, 1 gynaecologist, 3 general practitioners, 5 public health consultants, 1 psychologist, 1 psychotherapist and 1 respiratory and tropical medicine doctor), 6 social workers who operate in reception centres, 1 anthropologist, 1 lawyer and 1 cultural mediator. All interviewees, except two, had a long-term experience of working with migrants. All interviews were carried out in Italian.

Table 1
The reception system for refugees and asylum seekers in Italy[2].

Type of facility	Characteristics	Location	Services	% of places
Hotspots	Permanent, high capacity	Arrival port cities	Housing, first aid and identification procedures	5,4%
Reception Centres	Permanent, medium-small capacity	Throughout the country	Housing, medical assistance, psychological support and services to support integration (e.g. legal support, language courses, job placement…)	14,8%
Emergency Reception Centres	Temporary, high capacity	Throughout the country	Housing, medical assistance	79,8%

Table 2
Characteristics of the interviewees and location of the interviews.

Service/Organisation/Project	Professions covered	Interview location
Cooperatives	• Social workers • Doctors • Nurses	In-person/video call
Public Health Department	• Doctors • Nurses	In-person
Primary Health Care Department	• Doctors • Nurses	In-person
European Project I.C.A.R.E	• Doctors	In-person/video call
European Project Start-ER	• Doctors • Nurses	In-person
legal association	• lawyer	in-person
gynaecology centre for foreign women	• doctors • cultural mediator	in-person
CSO clinics	• Doctors • Psychologists • Anthropologists	In-person/video call
Psychological CSO	• Psychotherapists	In-person
Medical CSO	• Nurses	In-person

2.4. Data collection and analysis

The interview guide was designed to explore: 1) the consequences of the syndemic on the SDH and on the health needs of RAS living in reception centres; 2) the measures that were implemented to contrast the diffusion of the virus; 3) the challenges that interviewees had in handling the emergency; and 4) the role of health education as a tool for health promotion, in general and during the epidemic. The interviews were audio-recorded with the consent of the interviewees and were then transcribed verbatim. Subsequently transcriptions were analysed using the 'framework method', a deductive and inductive approach appropriate for multi-disciplinary health research (Gale et al., 2013). Firstly, the researchers coded the interviews, applying a label to the most relevant passages of the transcription. Secondly, the codes were grouped into categories, developing ~~8~~eight domains, which were then relinked to two main topics, as reported below (Fig. 1): a) evolution of the syndemic and health measures implemented in reception centres, and b) consequences of the syndemic on the health of RAS.

3. Results

The study was conducted in the city of Bologna, where there are 160 facilities which can house up to 2037 RAS: 1347 in Reception Centres that provide numerous services (see Section 2.1), while 690 in Emergency Reception Centres. As of June 2020, there were 1983 people residing in the reception system in Bologna. Of these, 60% were between 18 and 35 years old and approximately 71% were males and 29% females, of which 4 (0.2%) were trans women.

All 25 selected key-informants participated in the study. As all interviews were done in Italian, the findings will be presented with~~out~~ translated quotes. The interview transcripts are available from the corresponding author upon reasonable request.

3.1. Evolution of the syndemic and health measures implemented in reception centres

Following confirmation of the first COVID-19 case in Italy on 21 February 2020, long before the proclamation of the national lockdown (9 March), reception centres in Bologna introduced various measures to contrast the diffusion of SARS-CoV-2. In relation to the type of facility (either ordinary or emergency centres) and the management committee (as there are 11 different cooperatives that operate reception facilities in Bologna), each centre established its own rules, resulting in multiple and heterogeneous operating protocols. Interviewees reported that the restrictions imposed in reception centres were often more severe than those applied to the general population.

> *"We enforced a preventive lockdown one month before it took place nationally and we extended it until July 31, long after the re-opening at the national level. […] According to the provisions of the local authorities migrants could not exit the centre unless they had a medical or legal appointment" Social worker*

According to key informants this differential treatment was attributed to lack of personal protective equipment (PPE), challenges in maintaining physical distancing in overcrowded conditions and discriminatory preconceptions from the institutions regarding the more frequent adoption of promiscuous behaviour by RAS.

> *"in their point of view black people have to be supervised more strictly as they have a different culture" Social worker*

At the end of February, the two CSO clinics that provide healthcare to undocumented migrants (including RAS waiting for their residence permit[1]), were forced to interrupt or limit their activities due to the lack of PPE and volunteer professionals.

[1] RAS holding a residence permit are enrolled in the NHS and can therefore access all services provided to Italian citizens. However, the procedure to ob-

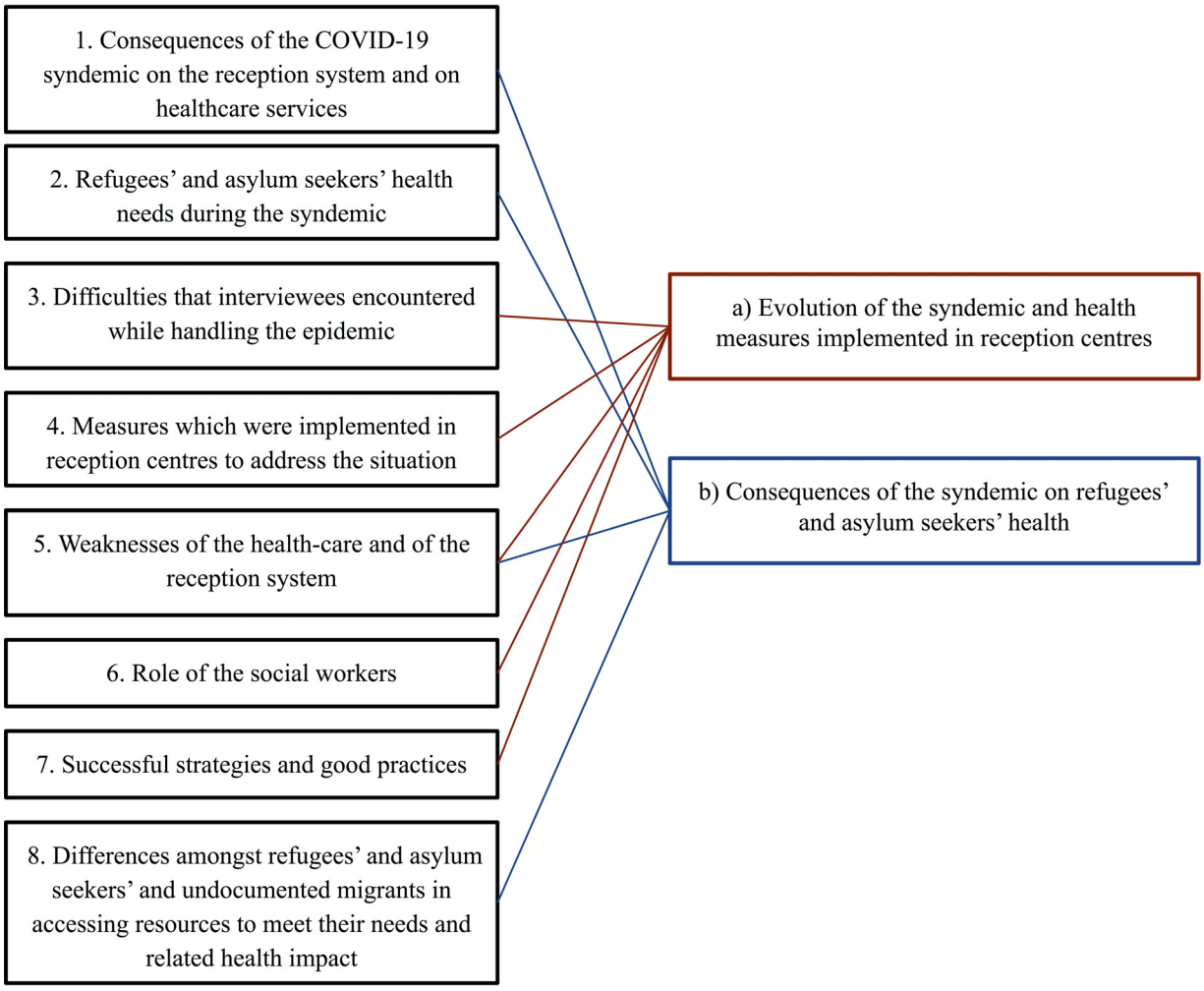

Fig. 1. Results of the analysis.

"we had to close our clinic for obvious reasons: for its structural characteristics, but especially because we didn't have PPE and didn't want to risk the health of our staff" Doctor

In reception centres, PPE was provided for residents and staff only from the end of March. However, key-informants pointed out many issues regarding the supply of masks, as local authorities and institutions did not contribute to purchasing PPE.

"we had to worry about finding PPE at a time when it was impossible, that aspect should have been taken care by someone on the upper floors" Social worker

Also due to the lack of resources, the masque supply for reception centres was often noted as inadequate in terms of quality and quantity, making it difficult for RAS and staff to properly protect themselves. Furthermore, the lack of support from local authorities caused delays in the supply of PPE and increased the workload of social workers who were already extremely overworked, also due to the additional responsibility of mediating between the medical staff and the residents of the refugee centres.

"I found myself having to act as a bridge between the patient and the general practitioner" Social worker

The research revealed that, from the beginning of the emergency, all reception centres devised risk communication programs. Their purpose was to give information regarding: a) national and international guidelines on how to restrict the spread of Sars-CoV-2; b) confinement measures that were introduced in stages by the national government; c) impact of the lockdown on asylum applications. These health education activities were carried out by the medical staff of the centre (where possible) or by the social workers who, in mid-April, were provided with training by the medical staff via the European project I.C.A.R.E. Thereafter, from the beginning of May, I.C.A.R.E. also organized risk communication webinars for the residents of the centres.

The information was delivered through different channels, including webinars, one-on-one sessions, videos, multidisciplinary sessions with psychologists and medical staff, and through the creation of 'news moments' during which RAS could collectively discuss international news. According to the interviewees, the most efficient way of transmitting the information was through peer-to-peer activities, or with the involvement of interpreters and cultural mediators.

"by involving migrants it was possible to exploit their ability to transmit the message with the other people who live in the centre" Social Worker

These approaches were particularly useful when they supported the establishment of trustworthy relationships and a climate of open dialogue, wherein RAS felt actively listened to and free to express their doubts and points of view.

tain or renew a residence permit is often long and complicated. RAS without a residence permit can access only emergency care and dedicated primary care facilities - often run by CSOs - just like undocumented migrants.

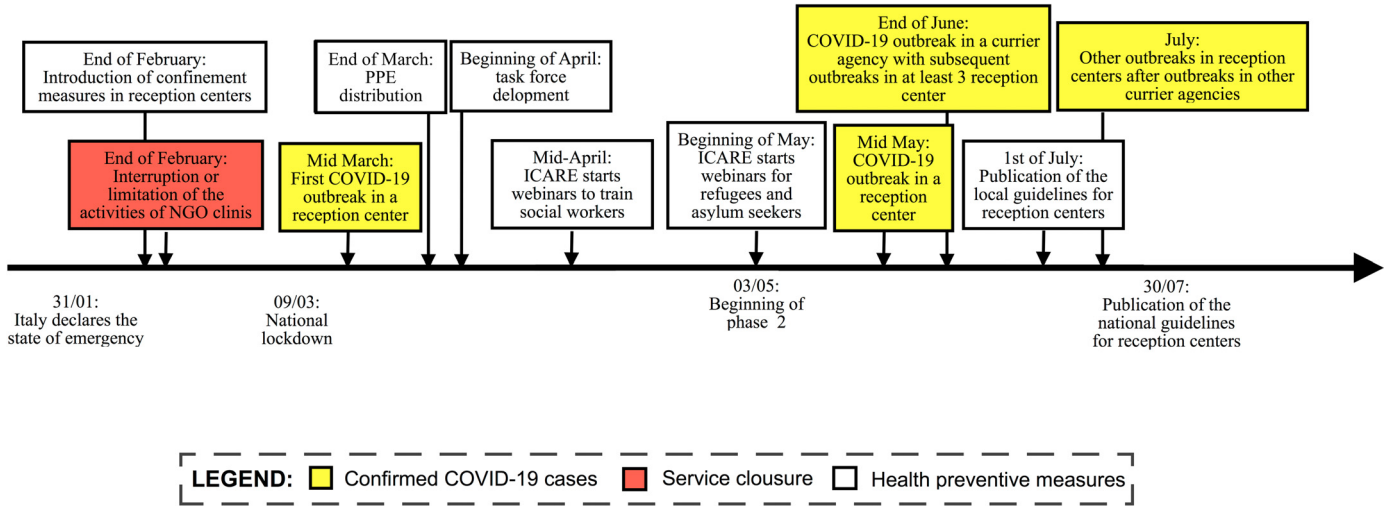

Fig. 2. Graphic representation of the evolution of the syndemic in reception centres in Bologna.

"it's not enough to make slides or videos, there is the need of a personal transmission of information, an in-depth analysis, because in many cases it's complicated information" Lawyer

The analysis revealed that these types of activities were mainly carried out by social workers and CSO representatives, while medical staff relied predominantly on top-down approaches.

On the other hand, health workers frequently reported many issues during the health education activities due to differing levels of health literacy amongst RAS.

"with Italians there was a greater level of acceptability and understanding with a different culture it's more difficult " Nurse

Other challenges were related to difficulties in engaging with RAS due to the constraint of performing risk communication activities remotely, or to the use of face masks which had a negative impact on the transmission of verbal and non-verbal messages.

From the beginning of April, local authorities developed specific governance tools to facilitate the management of the emergency in refugee centres. A task force was established, made up of staff of the Public Health and Primary Care Departments of the Local Health Authority, the European project I.C.A.R.E., the public Social Service Agency and led by the Director of the city Health District. The task force had the purpose of monitoring potential outbreaks, evaluating the criteria for testing people in reception centres, promoting the training of staff, and organizing risk communication activities for staff and RAS. Part of their mission was also to support social workers in managing the epidemic in the centres, by developing practical guidelines and giving medical advice. However, due to various factors, such as communication issues between the parties and challenges in identifying adequate spaces for the isolation of COVID-19 positive RAS, the first protocol on how to handle COVID-19 cases in reception centres was not published until 1 July.

"when you put together so many entities with completely different rules and procedures, the lack of common transmission systems, it's not easy, especially if you have build these instruments during a pandemic" Doctor

Despite the measures that were progressively implemented, key-informants reported that various outbreaks were registered in reception centres (Fig. 2), especially after the easing of containment measures and the resuming of work activities, suggesting most of the infections occurred in the workplace.

"their contacts are related to their work therefore the greatest risk of contagiousness is their occupation" Doctor

"the infections in the months of May, June and July were caused by infections in the workplace, such as the cases of the logistics company and the fruit and vegetable market, so most of the infections in refugee centres were due to the very precarious working conditions" Doctor

3.2. Consequences of the syndemic on refugees' and asylum seekers' health

Through the analysis of the responses it was also possible to gather information regarding the impact of the COVID-19 syndemic and of the measures that were introduced to contrast the diffusion of SARS-CoV-2, on the determinants that shape the health of RAS (Fig. 3).

Starting from the most distal factors, such as the general socioeconomic, cultural and political context, the interviews revealed that the social reaction to the syndemic intensified the level of discrimination that migrants experience on a daily basis. Social workers pointed out that, during all phases of the emergency, residents of the reception centres were often verbally attacked or treated differently because of the preconceptions people had due to the colour of their skin or country of origin. As noted in section 4.1, this was a behaviour that was exhibited also by institutions.

"from a social point of view I noticed a lot of racism, even more than before. My perception was that there was an altered vision a foreign people in the dynamics of the pandemic. 'He is a foreigner so due to his culture it is more probable he's a carrier.'" Social worker

Additionally, the measures that were introduced to reduce the spread of SARS-CoV-2 had a dramatic influence on proximate SDHs. Firstly, the lockdown led to the suspension of all legal appointments and to the closure of all migration-related offices, blocking the procedures for renewal of residence permits and initiation of asylum applications. Key-informants highlighted that these measures had serious repercussions on the mental well-being of RAS, as they did not know if they were going to be able to maintain their job and stay in the country.

"For them their occupation is very important, sometimes even more important than health itself, so adding even more uncertainty has been a strong impact for them. One can't live with the fear not knowing where they will go, it's then normal to develop psychiatric disorders" Doctor

Although the validity of residence permits was officially extended until the end of the emergency, employment agencies did not always acknowledge this, firing or not employing RAS.

"Often employers didn't have the correct information and demanded a renewed residence permit, which was impossible as the offices were blocked, some employers also took advantage of this situation." Lawyer

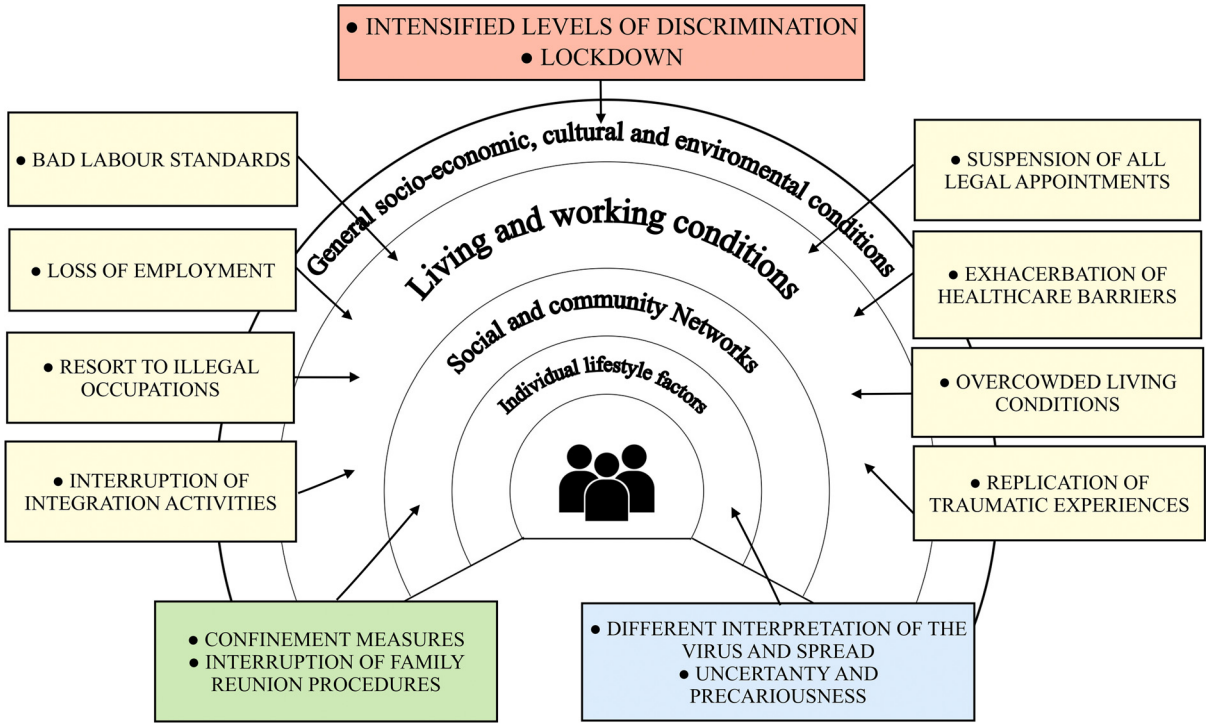

Fig. 3. Graphic representation of the consequences on the SDHs and vulnerabilities of RAS in reception centres.

According to the social workers who were interviewed, the loss of employment was exacerbated by the economic consequences of the lockdown. This was particularly frequent in migrants as they face significant barriers in gaining employment with decent labour standards. The loss of employment and, consequently, of income to sustain personal needs and - often - also families in the countries of origin, made many RAS resort to illegal occupations (such as prostitution), increasing the risk of negative health and legal consequences.

"Of the 20–25 working women, 16 of them lost their job […] the loss of work also led to an increase in prostitution in order to guarantee other sources of income." Social worker

These factors combined to increase the exposure risk to SARS-CoV-2 and to reduce access to residence permits (employment dependant, since the introduction of more restrictive immigration laws in 2002 and then in 2018).

Secondly, the national lockdown made it impossible for RAS to continue their integration activities, such as language classes, internships, etc. According to the social workers, this increased their sense of disillusion and uncertainty while favouring the development of depressive behaviours.

"There was a halt in their integration pathway which may have created a psychological distress" Social worker

Thirdly, the health emergency, combined with the consequences of the lockdown, exacerbated existing barriers in accessing healthcare and, in some cases, created new ones. Because of the suspension of all legal appointments RAS, especially if recently arrived, did not have access to residence permits, required in order to register with the NHS.

"The health enrolment offices don't accept expired documents, but almost all people have expired documents" Social worker

With low-threshold CSO clinics closed or working at a reduced capacity, it was impossible for many of them to access health facilities or testing procedures. This was particularly problematic, as these people could not undergo the screening measures that are required from the national guidelines for newly arrived RAS, but also COVID-19 testing, increasing health risks not only for them but also for the whole community.

"A centre received 20–30 people which had been in Italy just for a few weeks, even though they underwent a first visit all of the other testing procedures which are foreseen by national guidelines, such as the screening of active tuberculosis through chest x-rays, weren't performed and still aren't as migrants couldn't register with the NHS without a residence permit which was inaccessible as the offices were closed" Doctor

Key-informants also highlighted that, due to the overload of the NHS and the increase of language barriers, availability of many essential services, such as gynaecological facilities, was compromised even for those who fulfilled the access requirements. This made it difficult to provide care for women who were survivors of violence or sexual abuse and caused a peak in the number of sexually transmitted diseases.

"not being able to access these services led to a peak in sexually transmitted diseases and in the fear of being pregnant" Social worker

"there obviously are repercussions: if a person experiences some kind of violence, and can't immediately access support, the woman herself might lose the sense of the violent relationship and the relationship of trust with the doctor" Doctor

At the same time, the NHS local mental health centre suspended nearly all of its services, guaranteeing only emergency care. Consequently, RAS who needed psychological treatment relied on unqualified and overworked social workers, volunteer services provided by CSOs or assistance offered through the European project Start-ER, for psychological assistance.

"access to psychological support services, which is already challenging in the case of RAS became impossible during the emergency. Even those who were treated by the public service saw an abrupt and dramatic interruption of their course of treatment" Psychotherapist

According to the professionals who worked in reception centres, the unavailability of physical and mental medical care was critical not only

for RAS but also for the social workers and the medical staff of the centres, as they had more responsibilities and were forced to cover additional tasks beyond their professional roles.

"in 9 cases out of 10 social workers aren't experts of these dynamics, like the reactivation of previous traumas. Each one of us with our own level of empathy tries to put some patches but then we are the ones to experience psychological distress" Social worker

In addition, the study revealed how the living conditions in some reception centres were particularly critical, due to the lack of resources that caused overcrowding, and that the possibility of transferring RAS to other centres was granted only in the case of people who had particularly vulnerable conditions (such as COPD).

"We tried to reduce the number of people per room, in my point of view we should have done more, but for this you need to question the institutions who manage the reception system, the Public Health Department and local authorities. […] It was possible to ask the transfer of a person to another centre but most of the times the transfer never happened" Doctor

Confinement measures made it impossible for people to exit or enter the centres, reducing the social capital and community networks of RAS. This situation was further exacerbated by the interruption of family reunions because of closed borders and the suspension of legal appointments. In other cases confinement measures were perceived as a replication of the traumatic experiences that many migrants encountered during their journeys to Europe.

"During quarantine most migrants had a psychological reactivation of their traumas" Social worker

Key-informants also reported the diffusion of misleading beliefs amongst RAS, at times in the form of conspiracy theories. For example, as most of the testing procedures in reception centres were performed after the acute phase of the epidemic (from mid-May), many RAS thought the tests were not targeted to control the epidemic but they rather had the purpose of making profits out of them. Moreover, according to interviewees, risk communication campaigns often did not unravel these skepticisms but fostered their spread, due to the inconsistency between the indications that were given and the reality that RAS were experiencing in reception centres.

"If during risk communication campaigns you say that you need to guarantee a certain distance and then you put people in the position wherein it's impossible, they will be perceived as a joke, a deception, and this is very dangerous, as people won't believe you" Psychotherapist

These beliefs made it difficult for RAS to undergo testing procedures and respect quarantine measures, especially if their previous experiences with the NHS were not positive. When asked about the motivations of such difficulties, many healthcare providers spoke of cultural differences, related to the alleged difficulty in understanding the concept of "collective health" and in respecting the rules.

"They don't understand why they have to undergo long isolation periods and feel imprisoned. If you try emphasize its importance through the principle of collective health, there isn't such interest, they don't understand" Doctor

On the other hand, social workers mentioned the structural violence that characterizes the condition of RAS in reception centres. In particular, the high risk of getting fired if having to undergo quarantine measures, due to their impossibility of accessing jobs that guarantee re-employment after missing work days.

"Many people struggled as they have contracts with no rights and made an incredible effort to find a job." Social worker

Although undocumented migrants were not formally included in the study, many of the key-informants shared information on this group which is amongst their target population. According to their accounts, compared to RAS, undocumented migrants suffered even worse consequences of the syndemic as they have a lower level of legal protection and therefore access to services.

"not having any rights, a residence permit, a job and all that magnified and multiplied things in a thousand ways" Anthropologist

Firstly, due to the impossibility of accessing legal employment and income support schemes, they faced yet more severe economic hardship. Secondly, as CSO clinics had decreased or interrupted their activity, it was particularly challenging for them to access healthcare services, while they were also facing higher risks of contagion due to their unfavourable living environments. Finally, the law enforcement that was set up during the COVID-19 emergency increased the chances of controls by public authorities. According to the interviewees this was particularly problematic, as for the fear of being reported to the police undocumented migrants refrained from seeking care for medical conditions and from purchasing essential goods, including medications for chronic illnesses.

4. Discussion

The information obtained via the analysis of the interviews supports the argument that, even though some measures were implemented to preserve the health of RAS in reception centres, these mainly considered the biological dimensions of COVID-19 and overlooked the dramatic social consequences of what is now known to be a syndemic (Horton, 2020).

The data shows that some of the tools introduced during the epidemic had positive outcomes, such as the creation of the task force which allowed intersectoral collaboration across services dedicated to RAS.

However, the strategy developed by local and national institutions presented various limits, as it was mainly based on confinement measures and lockdown, which in some cases also had a discriminatory matrix, contrary to the international guidelines (WHO 2020). Furthermore the plan of action did not consider the impact of the emergency on mental health, not implementing psychological support services which are considered essential especially in camp-like settings (European Centre for Disease Prevention and Control 2020). The analysis also exposed the absence of measures to tackle the social issues generated by the syndemic.

This biomedical approach failed to consider RAS's social vulnerability (i.e. weak employment standards) which proved to be a weakness in controlling the epidemic. In fact, as reported in Section 3.1, most of the outbreaks that were registered in reception centres were likely secondary to infections occurring in the workplace, suggesting a low level of protection while at work. This reductionist approach also failed in tackling the main reason for which RAS refused to undergo testing procedures, namely the risk of being fired and consequently losing their access to a residence permit and a source of income.

Other issues regarding the management of the emergency were the inadequate communication and collaboration between professionals with different backgrounds in the task force, which was also responsible for the delay of the publication of guidelines. This can also be associated with the lack of protocols which - together with the absence of PPE - was determined by the complete unpreparedness of the NHS for an epidemic.

Although this affected the entire population, the impact was more dramatic for the most vulnerable, such as RAS, as the syndemic laid bare the structural inequalities and profound disparities that pervade our societies (WHO 2020). In fact RAS had a higher chance of encountering COVID-19 and being more seriously affected, due to their living and working conditions and the multiple barriers they have to confront in accessing healthcare, also in ordinary conditions (PHM, 2017).

These issues were accentuated during the emergency, as healthcare facilities and providers became even more inaccessible as they were

overwhelmed by the management of the epidemic. The increase in healthcare barriers triggered the immediate health impacts discussed in Section 3.2, but also failed in preventing and contrasting the indirect consequences of the looming post-epidemic crisis on health (Sani et al., 2020).

All together, these phenomena reflect the defunding and privatization policies in the Italian NHS in the past decades (Maciocco, 2018), which gave way to a corporate and reductionist approach to health. In the local context, this shift in health policies could have determined the inability of the NHS to handle the syndemic, and the consequent need to rely on European Projects and CSOs to provide essential services and manage public health interventions.

However, many of the indirect effects of the syndemic could be attributed to the events that already characterized the Italian reception system in the recent decades. For example, the absence of long-term planning and the promotion of increasingly restrictive immigration policies (Giovanetti and Zorzella, 2020) force migrants to live with the uncertainty of their legal position, which also undermines access to employment and healthcare, all aspects which were negatively impacted by the syndemic. The study revealed how many of the healthcare barriers that RAS had to face during the epidemic were due to bureaucratic reasons, which existed before the epidemic but were exacerbated by the lockdown. For example, access to the NHS (and consequently to GPs and testing procedures) was denied to all migrants who did not have a residence permit and - although permit expirations had been automatically prolonged - this was often not recognized by the local health authorities. From a public health perspective, not guaranteeing access to healthcare to all individuals living in a community may harm the health of the whole community, something which becomes particularly evident in a pandemic (Guadagno, 2020).

The changes in the reception system also undermined the management of the health emergency in reception centres. The budget cuts that were introduced in the past two years (Giovanetti and Zorzella, 2020) reduced the number of staff (especially medical personnel), making it challenging to meet RAS's needs even before the epidemic, and fostering overworking of employees during the epidemic. Furthermore resource constraints, together with lack of support from local authorities, made it difficult for cooperatives to procure equipment (such as PPE) and transfer RAS to other structures in order to apply physical distancing measures.

In the same way, a National decree law (113/2018) promoted drastic changes to the design of the Italian reception system, dismantling small, territorially distributed centres and creating large (and extensively overcrowded) facilities, which do not guarantee essential services (i.e. legal support, psychological assistance etc.) (Giovanetti and Zorzella, 2020). This new conception of the reception system may have enhanced the risk of COVID-19 outbreaks and, together with the restrictive immigration policies, contributed to the impossibility of guaranteeing the conditions for RAS's empowerment process (for example by not enabling them to act for their own health and impeding their participation in issues that personally regard them). These changes were also the main source of the troubles in respecting quarantine measures as they are tightly connected to the challenges of getting a reliable job, which could assure re-employment after quarantine.

Considering these factors it is possible to see how the reception system and the immigration policies currently act as strong structural violence promoters: contributing to the disadvantageous condition of migrants before the syndemic and increasing its impact on the social determinants that shape their health.

Although some of the key-informants pointed out that these conditions influenced RAS's behaviour, not all recognized these issues. While from the perspective of social workers the breaking of quarantine measures derives from the structural violence RAS experience, healthcare providers blamed "*cultural diversity*". This is not surprising, as it is known how in critical circumstances (such as health emergencies) blame for "inappropriate" behaviours can be projected onto those who are already disadvantaged, obscuring the failures of the system (Napier et al., 2014). These weaknesses were particularly prominent in risk communication campaigns, during which healthcare providers were unable to effectively communicate with RAS probably due to their lack of cultural competency training. Furthemore this study, in line with the available literature (Nezafat Maldonado et al., 2020), showed how public risk communication campaigns issued by national and local institutions were often not accessible for people in refugee camps (i.e. for language barriers). Similarly, the indications that were provided (i.e. physical distancing) were impossible to implement in the overcrowded living conditions of RAS, which - together with the continuous dissemination of misinformation - reduced the perceived reliability of the information that was given by public authorities (Lee et al., 2020).

On the basis of these arguments, it appears necessary to act on multiple levels to improve the general condition of RAS in reception centres and consequently manage future health emergencies more effectively.

Firstly, health systems should invest in strengthening their preparedness and response to pandemics. This requires increasing the resilience of the NHS and overall capacity of intersectoral actions, as well as developing specific measures such as protocols and risk communication campaigns.

In this regard, the research gave some useful insights to health education programs based on more effective and empowering modalities. To enhance communication with RAS, healthcare providers need to be aware of their own cultural values via the concept of 'cultural humility' (Tervalon and Murray-Garcia, 1998). Furthermore RAS should be directly involved in designing the activities and treated as equals (WHO 2018), also by promoting a two-way transmission of information using educational methods based on a "*problem-posing approach*" (Freire, 1968) rather than the top-down delivery of fixed information. These activities could raise awareness and transform the communication obligations into a two-way educative process, thereby becoming an instrument of empowerment and health promotion.

The principles of health promotion and 'cultural humility' should also apply to the organization of health services, so that they can be more inclusive (Napier et al., 2014). Indeed the adoption of inclusive policies is a key strategy for improving adherence and developing cost-effective public health systems (WHO 2018), whilst favouring the creation of honest and trustworthy relationships that can contrast the spread of misleading beliefs. Furthermore considering the interconnectedness between individual and collective health during the syndemic, inclusive public health efforts are crucial to effectively contain and mitigate the outbreak (Guadagno, 2020).

In addition, the response to critical situations (such as syndemics) exposed the broader realization that all public health programmes should shift towards a biopsychosocial approach to people's health, including the consequences of health emergencies on mental health and the SDHs. This could reduce the impact of crises on the most disadvantaged and tackle health inequalities on the long-term.

This could be achieved with the introduction of a health system based on comprehensive primary health care (WHO 1978), to cover the majority of a person's health needs. During pandemics, this system can help diagnose, track and stop the spread of local outbreaks while providing essential health services to communities (WHO 2020). This model also supports intersectionality, favouring the cooperation between different services and authorities, strengthening the management of future health crises and improving the well-being of RAS, and consequently the health of society (WHO 2018).

However, an effective governance system that is able to counteract the fragmentation of healthcare and the ambiguities generated by the complex legislative network that acts on the health of migrants in Italy also appears as necessary.

In this sense, it would be strategic to invest more resources on the reception system to be organized in small-scale facilities, distributed throughout the territory and able to provide all essential services. Migration policies should be more inclusive and overcome the bureaucra-

tized distinction between 'voluntary' and 'forced' migrants, as this view fails in recognizing the structural nature of migration (PHM, 2017), and played a key role in generating more serious consequences of the syndemic on undocumented migrants compared to RAS.

Subsequently, considering the interconnectedness between individual and collective health, primary care services should be accessible to all people, including undocumented migrants. This is an essential measure to reach universal health coverage (Legido-Quigley et al., 2019), guarantee the universal right to health (compelled by the Italian law) and tackle future health emergencies such as the COVID-19 syndemic (Devillanova et al., 11).

Governments should also incorporate the needs of migrants in national and local healthcare policies and plans. By applying a Health in All policies approach, that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, health equity could be improved (WHO 2014).

From a broader point of view, this process suggests a profound rethinking of health policies so that they are orientated by the real health needs of the population and not crushed by one-dimensional economic calculations. In this perspective, there is the urge to stop the privatization of health services and the dismantlement of public state-funded and government-run health systems (De Ceukelaire and Bodini, 2020). This could be done by embedding the core capacities of global health security into holistic, publicly financed universal healthcare systems, whilst contrasting the fragmentation of governance for health (Arush et al.).

5. Limitations of the study

The research was carried out in a period of time which partly overlapped with the events observed. Given the rapidity at which the events unfolded, details around the results may rapidly become historical. Secondly, due to time and resources constraints, it was not possible to interview more professionals involved in the healthcare and reception system of RAS (including GPs, local authorities and members of the public Social Service Agency). It was also not possible to interview migrants and RAS. The reasons behind this limitation, that we perceive as the most serious one, are two-fold: a) as the study did not receive any funding, we could not rely on the interpreters and cultural mediators that would have enabled us to conduct the interviews; b) the complexity of the syndemic situation made it extremely impractical to reach RAS, often confined in the reception centres and with very limited possibilities of virtual connectedness. When the epidemiological situation will improve, and if funding will be available, it will be important to complement our results with a specific study aimed at documenting migrants' perspective on their lived experience.

6. Conclusions

The preventive actions that were introduced in reception centres mainly addressed the biomedical aspects of COVID-19, often failing to consider the social aspects of the COVID-19 emergency such as their structural vulnerability. In addition, the syndemic, together with the measures implemented to control associated risks and spreading of COVID-19, had significant consequences on the social determinants that influence the overall health of RAS, exacerbating the structural violence they already encounter in their day-to-day life. Such consequences were even more severe on undocumented migrants.

Investigation of the management of the syndemic in reception centres exposed many of the structural issues that characterize the reception system for RAS and the services dedicated to this population group, including the modalities through which access to healthcare is ensured.

In order to guarantee the right to health and the health protection of the entire community, institutions need to develop a new approach to health and migration, shifting from a disempowerment and control approach to empowerment strategies, from a biomedical to a biopsychosocial model and starting to consider migration as a structural phenomenon that cannot be handled as an emergency. Subsequently, it is necessary that governments invest adequate funding into the health and reception system, whilst formulating specific plans to manage epidemics more effectively.

To support such a process, it is important to produce context-specific evidence on the dynamic relationship between migration and health, necessary in order to develop sustainable models of health and social care and preventative programs which are inclusive and effectively respond to the specific needs of refugees and asylum seekers.

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Declaration of Competing interest

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