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27 In past months, systematically higher levels of severe COVID-19 illness and death among individuals
28 belonging to migrant or ethnic minority groups have been reported in several countries, including the
29 US, the UK, Sweden, Brazil, Spain, and South Africa. In particular, racialized populations tend to have
30 less access to testing, higher rates of severe disease, higher mortality rates, and worse sequelae
31 when they survive the infection (1-5). The interacting social, behavioral and biological pathways
32 underlying these disparities are doubtlessly complex, but the hierarchy of social advantage in
33 racialized societies drives health status, exposure, housing, employment and access to healthcare,
34 and undoubtedly plays the dominant role (6).

35 Yet, with the notable exception of the United Kingdom, European countries do not report COVID-19
36 statistics according to migrant status or ethnicity (i.e. individuals' country of origin, nationality or
37 membership of an ethnic minority group), faced with the complexity of collecting and using such
38 information for public health purposes (7). To exemplify the issues at stake and suggest a way
39 forward, we wish to take the case of France, which has a substantial immigrant population and is to
40 date amongst the European countries hardest hit by the COVID-19 epidemic.

41 In France, immigrants make up 10% of the population and descendants of immigrants 12%
42 (<https://www.insee.fr/fr/statistiques/4238373?sommaire=4238781#:~:text=En%202018%2C%207%2C5%20millions,le%20m%C3%AAs%20pays%20d'origine.>), with recent immigrants most frequently
44 originating from an African country (47%). Data show that compared to the native population,
45 persons who are foreign-born had on average double the rates of all-cause mortality between March
46 and April 2020, some of which were due to COVID-19, however that exact proportion is not known
47 (8). Specifically, while mortality increased by 22% among the native-born, it rose by 54% among
48 individuals born in North Africa, 91% among those born in Asia, and 114% among those born in Sub-
49 Saharan Africa. This trend is also reflected in geographic inequalities in mortality, with an 118%
50 increase compared to the preceding year in Seine-Saint-Denis, a district North of Paris which is the
51 poorest in France and where 30% of the population is immigrant, compared to a 96% increase in

52 Paris itself (9). However, the full extent of inequalities between migrants and members of ethnic
53 minority groups and the rest of the population can only be assessed if population-wide data on
54 morbidity and health care are collected by ethnic and migrant status. The stark reality of the
55 available statistics, in conjunction with a climate of condemnation of structural racism following the
56 death of George Floyd and associated worldwide mobilizations, has given rise to a renewed public
57 discussion about the risks and benefits of “ethnic statistics”. Similar debates in this area are taking
58 place in other European countries
59 ([http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=SDD/DOC\(2018\)9&docLa](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=SDD/DOC(2018)9&docLanguage=En)
60 [nguage=En](http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=SDD/DOC(2018)9&docLanguage=En)).

61 The European regulations regarding data protection such as the General Data Protection Regulation
62 (GDPR) restrict the collection of research or administrative data making it possible to identify
63 individuals’ “racial or ethnic origins” at the same level as information on political opinions, labor
64 union membership, sexual orientation, and genetic background, unless specific law or adequate
65 safeguards are in place ([https://ec.europa.eu/info/law/law-topic/data-protection/reform/rights-](https://ec.europa.eu/info/law/law-topic/data-protection/reform/rights-citizens/how-my-personal-data-protected/how-data-my-religious-beliefs-sexual-orientation-health-political-views-protected_en)
66 [citizens/how-my-personal-data-protected/how-data-my-religious-beliefs-sexual-orientation-health-](https://ec.europa.eu/info/law/law-topic/data-protection/reform/rights-citizens/how-my-personal-data-protected/how-data-my-religious-beliefs-sexual-orientation-health-political-views-protected_en)
67 [political-views-protected_en](https://ec.europa.eu/info/law/law-topic/data-protection/reform/rights-citizens/how-my-personal-data-protected/how-data-my-religious-beliefs-sexual-orientation-health-political-views-protected_en)). Likewise, for instance, in the United Kingdom, data on individuals’
68 migrant status and ethnicity are regularly collected in national surveys, making it possible to
69 ascertain disparities with regard to health as well as in other domains, particularly as regards the
70 BAME (Black, Asian, and Minority Ethnic) groups
71 ([https://dataingovernment.blog.gov.uk/2019/06/27/how-were-helping-people-understand-](https://dataingovernment.blog.gov.uk/2019/06/27/how-were-helping-people-understand-ethnicity-data/)
72 [ethnicity-data/](https://dataingovernment.blog.gov.uk/2019/06/27/how-were-helping-people-understand-ethnicity-data/)). In France, on the other hand, a deliberate choice has been made to implement
73 these regulations in a strict sense, regulatory authorities being directly called upon each time a
74 decision upon the inclusion of any information on migrant/ethnic background is to be made. Indeed,
75 for each survey employing sensitive data (ethnicity and country of birth, religion, sexual orientation
76 ...), special authorisations are to be exceptionally delivered. These special rules are the legacy of a
77 strict interpretation of Article 1 of the French Constitution, which states the prohibition of distinction

78 of citizens on the bases of race, origin or religion, and is meant to protect individuals from possible
79 data misuse and discrimination.

80 However, there are several flaws to the above argument. First, it is obvious that racism and
81 discrimination exist even in the absence of reliable statistics to measure them. In France, as in other
82 European countries, researchers and the Ombudsman's office have repeatedly documented
83 disparities in domains such as access to education, housing and employment
84 ([https://www.defenseurdesdroits.fr/fr/etudes-et-recherches/2020/06/inegalites-dacces-aux-droits-](https://www.defenseurdesdroits.fr/fr/etudes-et-recherches/2020/06/inegalites-dacces-aux-droits-et-discriminations-en-france)
85 [et-discriminations-en-france](https://www.defenseurdesdroits.fr/fr/etudes-et-recherches/2020/06/inegalites-dacces-aux-droits-et-discriminations-en-france)). However, discrimination with regard to health and health care have to
86 date received little attention. Second, while it seems reasonable to limit collection of data on
87 individuals' geographical, racial and religious background for administrative purposes, absence of
88 such information in health surveys makes it impossible to quantify disparities, barring the possibility
89 of reducing sources of discrimination and lost opportunities for members of minority groups (10). For
90 instance, demonstration of an increased risk of HIV among immigrants originating from Sub-Saharan
91 Africa in several European countries including France, was used to inform the design of specific
92 prevention strategies and adapt screening and treatment procedures, directly involving members of
93 communities most at risk to improve their effectiveness. This type of benefit has lead international
94 institutions such as WHO and ECDC to provide recommendations on ways of collecting information
95 on individuals' health according to migrant status, with regard to the risk of COVID-19 as well as
96 other health problems (<https://www.who.int/migrants/en/>;
97 <https://www.ecdc.europa.eu/en/methods/specific-populations/migrant-and-ethnic-groups>). Third,
98 in the absence of a balanced public discussion about the pros and cons of assessing the health of
99 migrant and ethnic minority groups, the taboo relative to measurement of geographical origins is
100 such that even for research projects specifically designed to address health disparities, obtaining
101 authorization to collect information on participants' geographical region of origin can prove
102 impossible.

103 The demonstration of elevated rates of health problems – particularly infectious diseases – among
104 migrant or racialized populations does carry risks, the greatest likely being that of stigmatization.
105 Such stigmatization can of course be deliberate, and if it leads to actual discrimination, consistent
106 with the European Union’s Charter of Fundamental Rights, is it prohibited by law. Lack of
107 contextualization can lead to racialized characterization of behavior instead of visualizing and
108 detecting the structural and economic inequalities and the structural racism of society and of health
109 systems that are the fundamental drivers of the disparities. However data on health disparities can
110 also be misinterpreted, as when observed differences are mistakenly attributed to genetic makeup
111 (6). There is therefore need not only to collect data making it possible to observe and monitor
112 disparities, but also accompany such data collection and analysis with thoughtful interpretation. One
113 way of moving in that direction without doing wrong is most likely to get members of migrant and
114 ethnic minority groups directly involved in research which pertains to their health. Data should also
115 not only measure components late in the pathways of disease, morbidity and mortality, but capture
116 upstream disparities in exposure and mechanisms contributing to vulnerability, which include social
117 determinants of health and disease.

118 In France, the production of national mortality statistics according to immigration status during the
119 COVID-19 epidemic is a first step towards a broader discussion about the necessity to measure and
120 address inequalities in health between migrants -first, second, and third generation- and the majority
121 population . More generally, in Europe, further progress will necessarily require deliberate
122 consideration of discrimination with regard to health and health care, clarification of terms and
123 indicators (migrant status, ethnicity) to help physicians and public health professionals understand
124 how to interpret disparities based on social mechanisms of action and without falling into the
125 ‘*genetic trap*’. The COVID-19 epidemic may be an opportunity for a renewed public discussion about
126 the relevance of collecting and analyzing data on migrant status and ethnicity and health in Europe,
127 and a time to move forward with regard to politically and socially acceptable indicators to be used in
128 public health research and surveillance.

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169