



World Health
Organization

Global Evidence Review on Health and Migration

Refugees and migrants in times of COVID-19: mapping trends of public health and migration policies and practices



WHO Health and Migration Programme

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The GEHM series is an evidence-informed normative product of the WHO Health and Migration Programme to inform policy-makers on migration-related public health priorities. These reviews aim to respond to policy questions identified as priorities by summarizing the best available evidence worldwide and thereby proposing policy considerations. By addressing the data gaps on the health status of refugees and migrants, the GEHM series aims to support evidence-informed policy-making and targeted interventions that are impactful and make a difference in the lives of these populations.



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Abstract

Refugees and migrants have been disproportionately affected by both the direct effects of the COVID-19 pandemic and the restrictive migration measures put in place, which, in turn, have hampered coordinated and consistent public health responses. This report maps how the needs of refugee and migrant have been addressed in COVID-19 responses across countries and how these have varied considerably from inclusive policies to discriminatory practices. Many countries ensured access to health care for refugees and migrants regardless of migration status, and several countries also suspended forced returns and prioritized alternatives to immigration detention. An integrated approach to migration and public health policies covering protection-sensitive access to territories, a flexible approach to migration status and non-discriminatory access to health care is suggested as a policy consideration to uphold international conventions protecting the right to health without discrimination for refugees and migrants.

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Foreword

Refugees and migrants are the focus of intense political debate worldwide. Population movement, including forced migration, is a complex phenomenon and is a high priority for many WHO Member States. Health is a vital dimension of the necessary policy responses, now given renewed emphasis by the COVID-19 pandemic.

Responding to the health needs of refugees and migrants includes not only providing support during humanitarian emergencies, but also addressing the longer-term implications of large population movements and their ability to access services in host societies.

Refugees and migrants have a fundamental human right to the enjoyment of the highest attainable standard of health. They also have specific physical and mental health needs and vulnerabilities, which often go unrecognized and unaddressed, and which have been exacerbated during the pandemic. These include noncommunicable and communicable diseases; oral health; mental health; care for elderly people and people with disabilities; and trauma from injuries, violence, abuse and trafficking. Women and children, who may be unaccompanied, need special consideration.

Refugees and migrants may also experience challenges because of their highly insecure living conditions and lifestyles and can suffer discrimination, poverty, poor housing and education, poor employment practices, often without access to essential health and other services. Despite global efforts, they may also suffer poor access to COVID-19 vaccines.

The COVID-19 pandemic has shown us the consequences of vulnerability, with increased rates of infection and deaths amongst the poor and the disadvantaged, including refugees and migrants. Evidence suggests that during the COVID-19 pandemic, refugees and migrants have experienced high levels of xenophobia, racism and stigmatization. All these vulnerabilities have been further exacerbated by public health control measures and border closures.

WHO has developed agreed policies and interventions to promote and secure health rights for refugees and migrants. The 2019 WHO Global Action Plan: Promoting the health of refugees and migrants (GAP) provides a comprehensive overview of strategic actions aligned with the United Nations 2030 Agenda for Sustainable Development, the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration.

To help countries to promote the health of refugees and migrants, WHO is committed to developing norms, standards, guidance and tools on health and



migration, and to promoting a research agenda to generate evidence to support decision-making. There is a strong need to enhance research efforts to better understand the global trends and implications of migration and health, as well as how to address the related needs.

This first Global Evidence Review on Migration and Health will begin a series of evidence reviews aiming to identify and advocate for critical issues related to the needs of specific population groups.

The publication maps policies governing migration, borders and access to health care for refugees and migrants that have been adopted to respond to the COVID-19 pandemic. Policy considerations based on how governments have addressed the health of refugees and migrants in their response to COVID-19 are included to support international dialogue and knowledge-sharing among countries.

This report and those that will follow in the series are an opportunity to enhance communication between different stakeholders in the field of migration and health, including high-level health sector and government officials, health sector managers, health and non-health sector policy-makers, as well as public health professionals involved in planning, developing and implementing policies targeting refugees and migrants.

We hope this report will help countries to ensure that refugees and migrants can access health information and public health and health services. Health for all means all people in all circumstances, including refugees and migrants during pandemics.



Dr Tedros Adhanom Ghebreyesus
Director-General
World Health Organization



Preface

WHO's work is guided by the right to health and well-being laid down in 1948 in its Constitution. The right to health is universal, applying to all, including refugees and migrants. To this end, WHO now has an ambitious triple billion target for 2030, aiming to achieve a billion more people with universal health coverage, a billion more people protected from health emergencies and a billion more people with better health and well-being.

The Sustainable Development Goals contain a global expectation to leave no one behind. Identifying and responding to the needs, including health needs, of refugees and migrants are essential. The 2019 WHO Global Action Plan: Promoting the health of refugees and migrants aims to promote and secure health rights for refugee and migrants in the context of the human right to health and universal health coverage.

Progress needs to be equally shared if these expectations are to be met. Refugees and migrants have special needs and requirements in terms of their physical and mental health, and often face challenges in accessing public health and health care. Effective public health interventions and health-care services need to be provided to refugees and migrants in a culturally and linguistically sensitive way, with the avoidance of exclusion, stigma and discrimination.

The COVID-19 pandemic has brought these issues to the fore, showing that equity is of crucial importance in COVID-19 responses. During the pandemic, vulnerable populations are disproportionately affected, and pre-existing vulnerabilities exacerbated. Refugees and migrants have been more vulnerable to infection and death, through lack of financial protection, crowded living conditions, and informal and potentially dangerous labour settings; in addition, they often experience limited access to health care.

At the same time, the lives of refugees and migrants have been impacted by restrictive migratory policies adopted to counter the pandemic. Global mobility and international migration have been strongly affected by the pandemic, with many migrants being stranded abroad and unable to return to their home countries.

If at all levels the current health situation for refugees and migrants is to improve, the generation of evidence and analysis on migration and health are essential. To contribute to fulfilling this research agenda, the WHO Health and Migration Programme is launching the Global Evidence Review on Health and Migration (GEHM) series.

Global evidence on refugees and migrants has to date often been limited to migration flow and some demographic characteristics. To extend the evidence



that is available, this review series aims to inform policy-makers on migration-related public health priorities. Each review addresses a policy question related to refugee and migrant health, identified as a priority public health concern. This first publication looks at the complex nexus of public health and migration policies amid the COVID-19 pandemic.

Leaving no one behind means understanding and addressing the needs of refugees and migrants amid the pandemic. At country level, identifying refugee- and migrant-inclusive responses to the pandemic is important to inform policy-making and promote the right to health of refugees and migrants.

This report gives an overview of how countries have responded to the COVID-19 pandemic by mapping national migration and public health policies. It aims to identify practices on how refugees and migrants can be included in pandemic response in line with international law obligations.

Through publication of the first GEHM, we hope to raise awareness on the necessity to include refugees and migrants in COVID-19 responses. The pandemic is bringing to the fore the disproportionate impact on refugees and migrants and complex interaction of migration and public health policies. Pandemic responses need to be in line with human rights, including for refugees and migrants. Protection-sensitive access to territory, immigration status flexibility and non-discriminatory access to health care are needed.

We must commit to reduce inequities and launch inclusive responses to the pandemic, and we hope that this report will both inform and enhance communication between different stakeholders in the field of migration and health.



A handwritten signature in black ink that reads "D. Jakab".

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Technical development, review and publication coordination

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Document production

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Editorial team

With the overall objective of strengthening normative research and evidence and gathering works of the PHM, an Interdivisional Working Group has been established to support the overall production of the Global Evidence Review series. Representatives from Science and Data Divisions in the Interdivisional Working Group (focal points listed below) have kindly agreed to support this initiative from normative, methodological, research and data perspectives, and to advise technical staff from PHM and other relevant programme areas as appropriate in various stages of development of the Global Evidence Review series.

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Abbreviations

EU	European Union
GEHM	Global Evidence Review on Health and Migration (series)
IHR	International Health Regulations
ILO	International Labour Organization
IOM	International Organization for Migration
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the High Commissioner for Human Rights
PHM	WHO Global Health and Migration Programme
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund



Executive summary

The first report of the newly launched Global Evidence Review on Health and Migration (GEHM) series provides an overview of the complex nexus of public health and migration policies amid the SARS-CoV-2 (COVID-19) pandemic. It aims to map policies and practices adopted by countries to inform policy-makers on how the needs of refugees and migrants have been addressed in responding to the pandemic. This report aims to synthesize the available knowledge from the academic and grey literature published in English between November 2019 and November 2020. Three main categories of national adaptation policies were identified: border policies; migration policy responses to COVID-19 for foreigners within national borders; and public health policies on access to health care for refugees and migrants. The policies, trends and practices synthesized could inform responses both to the ongoing COVID-19 pandemic and to future health emergencies.

The COVID-19 pandemic has triggered a broad range of adaptation policies covering many different areas related to international migration that impact, directly or indirectly, public health. The overall picture remains, however, highly complex and disparate, as national reactions to the global pandemic vary considerably in both nature and scale, impairing, in turn, a truly coordinated and consistent public health response.

While countries are facing unprecedented challenges, the need for a comprehensive and integrated approach to migration and public health policies is as pressing as ever.

Yet, refugee- and migrant-sensitive policies coexist with discriminatory practices that compromise the rights of refugees and migrants. People on the move have been disproportionately affected by the pandemic itself or by the proliferation of restrictive measures at borders. At the same time, many governments have adopted inclusive policies to integrate refugees and migrants with their responses and protect them in due accordance with international law.

In investigating a broad variety of national adaptation policies, this report has identified a significant range of practices in line with international conventions protecting the rights of refugee and migrants, illustrated by the use of case studies. Based on the mapping of policies and practices, policy considerations are put forward for an integrated approach to migration and public health policies governing protection-sensitive access to territory, migration status flexibility and non-discriminatory access to health care.

This report underscores that many countries have ensured access to health care for all refugees and migrants, regardless of nationality and legal status. Numerous



countries have also adopted flexible measures with regard to administrative procedures and status, while several have suspended forced returns and prioritized alternatives to immigration detention.

Policy considerations

Protection-sensitive access to territory, such as for asylum seekers for international protection, is a main policy consideration. Also, flexibility of immigration status such as suspending forced returns to safeguard health, safety and human rights of migrants and non-discriminatory access to health care are highlighted as considerations that must guide policy-making in this area.

The refugee- and migrant-sensitive practices identified in this report may constitute the first step towards a responsive and inclusive approach, leaving no one behind in the spirit of the Sustainable Development Goals. The challenge in future will be to shore up these policy developments to ensure a consistent application across countries.

A truly comprehensive and inclusive response to COVID-19 requires, more than ever, safe, orderly and regular migration; it also requires sharing responsibility for refugees through enhanced cooperation in due accordance with international law, as envisaged in the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration. WHO has been working in close collaboration with the International Organization for Migration (IOM) and the Office of the United Nations High Commissioner for Refugees (UNHCR) to ensure effective coordination of health policies and to promote the adequate, timely and cost-effective provision of health services for refugees and migrants as well as for host populations.



1. Introduction

1.1 Background

As early responses to the COVID-19 pandemic have shown, limited coordination and unilateral actions have negatively impacted our interconnected world at an unprecedented scale.

While refugees and migrants face similar health threats from COVID-19 as their host population, the pandemic has exacerbated pre-existing vulnerabilities and generated new forms of vulnerability. The most vivid instances include obstacles in accessing health care, denial of protection because of border closure and rising racism, scapegoating, stigma and discrimination (1–3). Refugees and migrants who travel or live in unsafe conditions without access to water, sanitation and hygiene are obviously at greater risk. This includes migrants in an irregular situation, asylum seekers and those who are in immigration centres or confined in camps, as well as exploited migrant workers and victims of human trafficking.

The COVID-19 pandemic has made it clear that no one is safe until everyone is safe (4). Refugees and migrants tend to be more exposed to the virus than the general population because of their living conditions and inadequate access to water, sanitation, housing and health care; this is multiplied by the likelihood of being employed in the most essential sectors that are not subject to teleworking or even social distancing (Fig. 1). All these factors, defined as social determinants of health, lead to disproportionate impact of COVID-19 on refugees and migrants.













However, the proliferation of unilateral and uncoordinated measures does not mean that there is no international framework or legal rules to address migration and public health in an integrated and mutually beneficial manner (6). The human rights of refugees and migrants are guaranteed by a broad range of United Nations conventions whether related to human rights, refugee protection, labour migration, people smuggling or trafficking of migrants (7). They include most notably:

- International Covenant on Civil and Political Rights (8);
- International Covenant on Economic, Social and Cultural Rights (9);
- International Convention on the Elimination of All Forms of Racial Discrimination (10);
- International Convention on the Rights of the Child (11);
- International Convention and Protocol relating to the Status of Refugees (12);
- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (13);



- Migration for Employment Convention of the International Labour Organization (ILO) (14);
- Migrant Workers (Supplementary Provisions) Convention of the ILO (15);
- Protocol against the Smuggling of Migrants by Land, Sea and Air (16); and
- Protocol to Prevent, Suppress and Punish Trafficking in Persons (17).

Fig. 1. Compounding risks for migrants in the context of COVID-19

 <p>UNDOCUMENTED OR IRREGULAR STATUS Lack of legal status may create formal barriers or lead to a reluctance to access assistance due to fear of arrest, detention or deportation.</p>	<p>EXCLUSION Migrants may be de-prioritized or excluded in health care and prevention and response efforts.</p> 	<p>LIMITED OR NO ACCESS TO ESSENTIAL SERVICES Informal and formal barriers to accessing essential services like food, shelter, health care, psychosocial support, legal assistance and water, sanitation and hygiene services.</p> 
<p>COMMUNICATION BARRIERS Barriers in understanding or accessing key information on health care and challenges in reporting on health conditions.</p> 	<p>STIGMA AND DISCRIMINATION Increasing discrimination and stigma as well as blame for spreading the virus which can prevent people from seeking assistance and support.</p> 	<p>LOSS OF SOCIAL SUPPORTS Loss of contact with family and community networks due to quarantine and/or border closures which prevent return home and lead to anxiety due to isolation.</p> 
<p>GENDER DIMENSIONS Female domestic workers are often employed in isolated workplaces and increased risk of gender-based violence due to lockdown and movement restrictions.</p> 	<p>FINANCIAL BARRIERS Financial barriers to accessing health systems and support, including lack of insurance and high costs of care or cost of transport to health-care centres.</p> 	<p>POOR LIVING/WORKING CONDITIONS Overcrowding, such as in camp or detention settings, inadequate sanitation and hygiene and inability to isolate or physically distance.</p> 
<p>LABOUR EXPLOITATION AND HUMAN TRAFFICKING Epidemics and pandemics can exacerbate existing vulnerabilities and put people at a greater risk of exploitation and trafficking.</p> 	<p>SOCIAL, RELIGIOUS AND CULTURAL OBSTACLES Lack of familiarity and awareness of health procedures and available support and a lack of culturally appropriate services may prevent health-care access.</p> 	<p>PROTECTION AND SAFETY Migrants, including people seeking asylum and refugees, may be unable to seek safety due to border closures and travel or movement restrictions.</p> 

Source: International Federation of Red Cross and Red Crescent Societies, 2020 (5).

Among these 10 treaties, only two may be subjected to derogations under strict conditions in time of public emergency: the Covenant on Civil and Political Rights and the Convention relating to the Status of Refugees. All the other binding conventions listed do not provide such a derogation mechanism. Each of these conventions remains plainly applicable in the context of COVID-19. State parties are accordingly bound to protect the life and health of refugees and migrants within the scope of the relevant instruments. Refugee- and migrant-sensitive practices need to be in line with these conventions.

In parallel with the United Nations conventions governing the human rights of refugees and migrants, the 2005 International Health Regulations (IHR) provides



an overarching legal framework that defines the rights and obligations of State Parties in handling health emergencies that have the potential to cross borders. The IHR governs 196 countries (18), including the 194 WHO Member States. Its central purpose is to provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, which protect human rights and avoid unnecessary interference with international traffic and trade.

Particularly relevant for international migration, the IHR identifies the main measures to be adopted at ports, airports and ground crossings with the view of limiting the spread of health risks: (i) the least invasive and intrusive medical examination that would achieve the public health objective; (ii) vaccination or other prophylaxis; or (iii) additional established health measures that prevent or control the spread of disease, including isolation, quarantine or placing the traveller under public health observation (art. 31).

In addition to legally binding treaties governing migration, refugee protection and public health emergencies, the Global Compact for Safe, Orderly and Regular Migration adopted by the United Nations General Assembly in December 2018 offers a comprehensive and integrated approach to foster international cooperation alongside the achievement of the Sustainable Development Goals (19). States have committed to “ensure effective respect for and protection and fulfilment of the human rights of all migrants, regardless of their migration status, across all stages of the migration cycle” (para. 15). Among other related commitments endorsed in the Global Compact, States further agreed to “enhance availability and flexibility of pathways for regular migration” (objective 5), to “address and reduce vulnerabilities in migration” (objective 7), to “manage borders in an integrated, secure and coordinated manner” (objective 11) and to “provide access to basic services for migrants”, including health care (objective 15). The pandemic has emphasized the need for a comprehensive and integrated approach to migration and public health policies but has also jeopardized progress (20,21).

At the domestic level, the reactions to the global pandemic contrast drastically in both nature and scale. Positive policies coexist with those compromising the rights and dignity of refugees and migrants. Some countries have continued to take harsh immigration measures during the pandemic (including arbitrary detention, family separation and forced return), whereas a number of other countries have shown leadership and have demonstrated how inclusive and human rights-based measures are leading to better results (21,22).

WHO's core work and directions under the 13th General Programme of Work and targets for universal health coverage and emergency response actions specifically address the need to leave no one behind, to take a human rights-based and gender-responsive approach to address needs, and to provide evidence-informed and contextualized essential health services in acute and protracted emergencies.



As the COVID-19 outbreak and pandemic moves into a prolonged crisis, short- and longer-term actions need to be combined, particularly in reaching out to the most vulnerable, including refugees and migrants.

Against such a complex background, the objective of this report is to obtain an overview of national policy responses to COVID-19 within the interconnected areas of international migration and public health and to identify practices, in line with international conventions (8–17), to inform policy-makers on how the health of refugees and migrants can be addressed within COVID-19 responses. Definitions of refugees, migrants and asylum seekers are not always consistent in the domestic practice and Box 1 summarizes the definitions used in this report.

Box 1. Definitions of refugees, migrants and asylum seekers used in this report

Asylum seeker. An individual who is seeking international protection. In countries with individualized procedures, an asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognized as a refugee, but every recognized refugee is initially an asylum seeker (23).

Migrant. There is no universally accepted definition of migrant. For the purpose of collecting data on migration, the United Nations Department of Economic and Social Affairs defines an international migrant as “any person who changes his or her country of usual residence” (24). It includes any people who are moving or have moved across an international border, regardless of legal status, duration of the stay abroad and causes for migration. The IOM considers the term migrant as an umbrella term covering all forms of movement within and outside a State. IOM’s definition includes “a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons” (23).

Migrant in an irregular situation. A person who moves or has moved across an international border and is not authorized to enter or to stay in a State pursuant to the law of that State and to international agreements to which that State is a party (23).



Box 1 contd.

Refugee. According to the United Nations Convention relating to the Status of Refugees (12), a refugee is defined as “a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (art. 1A(2)). For State Parties to the African Union Convention governing the specific aspects of refugee problems in Africa, the term refugee also applies to “every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality” (art. 1(2)) (25).

1.2 Objective of the report

The intended purpose of this scoping report is twofold. First, it aims to give an overview of national adaptation policies in response to the COVID-19 pandemic in regard to refugee and migrant health by using secondary data sources. The research focuses on three types of national adaptation policies, which constitute, in turn, the main parts of the report:

- border policies
- migration policies for foreigners already within the territory of States
- public health policies on access to health care for refugees and migrants.

The report aims to address the question: “How has the COVID-19 pandemic has shaped national migration and public health policies regarding refugees and migrants?”

Secondly, the report aims to highlight refugee- and migrant-sensitive practices identified in national policies and to facilitate further implementation of human rights and international obligations in the age of global pandemics. It summarizes lessons learned from COVID-19 responses to inform policy-makers on how refugee and migrant health can be addressed in ongoing pandemic responses, as well as during future pandemics. The main target audience of this publication is policy-makers. For this reason, even though the research covers the period from November 2019 to November 2020, the mapping of policies and trends and the



key lessons learned are equally valid in the current stage of the pandemic and for future global emergencies. An update on the current situation, in particular in terms of access to COVID-19 vaccines, will be included in another GEHM that PHM is currently developing. This report does not intend to evaluate and assess individual country responses but rather to map policies and trends and highlight practices in line with international conventions (8–17).

1.3 Methodology

Research and data collection were carried out in a two-step process to answer the question: “How has the COVID-19 pandemic shaped national migration and public health policies regarding refugees and migrants?”

Due to the intersectoral nature of this report and its international law perspective, a specific research methodology was developed to adapt the search strategy. The research focused on the relevant reports and evidence gathered by regional and international organizations covering all geographical regions. It covers all WHO regions, although the coverage of all 194 Member States went beyond the publication’s scope. Particular attention was given to representative geographical coverage in all regions, as well as to countries with large refugee and migrant populations, by using the data of relevant international actors covering the regions and specific countries and additional research of subsidiary sources at the local level.

1.3.1 Step 1: data collection from literature and databases

Evidence was collected based on secondary data sources obtained by searching publicly available datasets as well as peer-reviewed and grey literature published from November 2019 to November 2020, with no restrictions on geographical scope or document type. Publications were found through a search in Cairn, Directory of Open Access Journals (DOAJ), Google, Google Scholar, HeinOnline, Official Document System of the United Nations, PubMed, Refworld, Scopus and the Social Science Research Network using the keywords “refugee”, “migrant”, “COVID19”, “border closure”, “border control”, “entry ban”, “entry requirement”, “visa”, “regularization”, “expulsion”, “forced return”, “asylum”, “mobility”, “resident permit”, “work permit”, “immigration detention”, “healthcare” and “discrimination”. Data relevant to migration and public health policies were extracted. A broad range of sources and relevant databases were also examined from various actors and stakeholders (governmental, intergovernmental, civil society and academia). The search identified 834 publications. Publications were excluded if they had no apparent connection to the topic of refugees and migrants in COVID-19 responses. After pre-screening, 532 were included:



- 45 academic publications (books, book chapters and journal articles);
- 30 reports, research/working papers and conference papers; and
- 457 publications, statements and guidelines of international and regional intergovernmental organizations and relevant nongovernmental organizations.

In addition, a broad range of online databases were examined, including academic sources as well as those of nongovernmental and intergovernmental actors (e.g. IOM (<https://migration.iom.int/>), UNHCR (<https://data2.unhcr.org/en/situations/covid-19>) and WHO (<https://www.covid19healthsystem.org/mainpage.aspx>) to obtain an overview of national policies. Online databases were found through a Google search using the keywords "database", "migrant", "refugee" and "COVID-19". Databases were used to identify country responses and further checked by other sources and secondary publications. They are quoted in the respective sections of the report.

From these sources, information on public health and migration policies in the context of COVID-19 were extracted to review policy trends as well as to identify refugee- and migrant-sensitive practices in line with international conventions (8–17). There were three main types of policy identified:

- border policies;
- migration policies for foreigners within national borders; and
- policies on access to health care for refugees, migrants and asylum seekers.

1.3.2 Step 2: analysis of national adaptation policies

In a second step, the identified trends in policies and practices were analysed. This data analysis was intended to (i) provide an overview of the migration and health policy responses, and (ii) identify practices that have been adopted in the context of COVID-19 to improve refugee and migrant health. In the discussion of the practices, the following dimensions were considered: (i) whether the practices are coherent with existing international obligations, and (ii) whether the policies consider or correspond to the guidelines and recommendations of international organizations (e.g. ILO, IOM, the Office of the High Commissioner for Human Rights (OHCHR), UNHCR or WHO).

1.3.3 Limitations

The report has two limitations. First, the main sources collected and analysed in this report were in English, since the research methodology needed to have consistent and comparable data from around the world. In addition, most online databases were only available in English and research in national sources in all



relevant languages was not feasible because of constraints in time for the analysis, language capacities and the dynamic context of the COVID-19 pandemic. To address this limitation, the research focused on the relevant reports and evidence gathered by regional and international organizations covering all geographical regions.

Secondly, due to the frequent changes in the context of the COVID-19 pandemic and the heterogeneity of countries' responses, it was not possible to derive exact numbers on how many countries adopted which exact policy, but rather to identify general trends. Accordingly, and because of the time frame of the research (a calendar year from November 2019 to November 2020), the findings in this report do not necessarily reflect the current practice at the time of publication. Irrespective of this, the refugee- and migrant-sensitive practices identified and lessons learned go beyond the time frame of research and can, therefore, be used for the policy considerations.



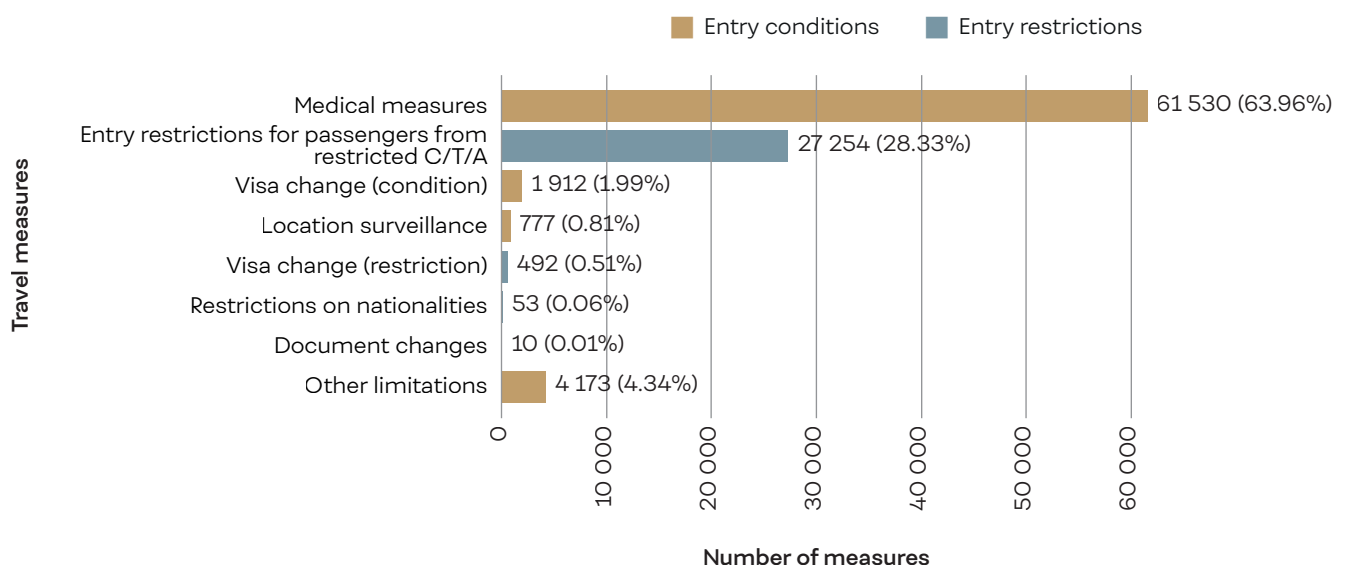
2. Mapping of policies and practices

2.1 Border policies in times of COVID-19

As of 26 October 2020, the IOM estimated that a total of 219 countries, territories or areas have issued 96 202 travel-related measures (26). Out of those, 27 800 were entry restrictions and 68 402 were COVID-19-related conditions for authorized entry (26). These figures highlight an important pattern of policies: entry conditions were more prevalent than entry restrictions.

As illustrated in Fig. 2 for 26 October 2020, medical measures were the most common entry conditions, representing 64% of the total, whereas entry restrictions for passengers from certain countries, territories, or areas represented 28%.

Fig. 2. Most commonly imposed restrictions and conditions for entry, 26 October 2020



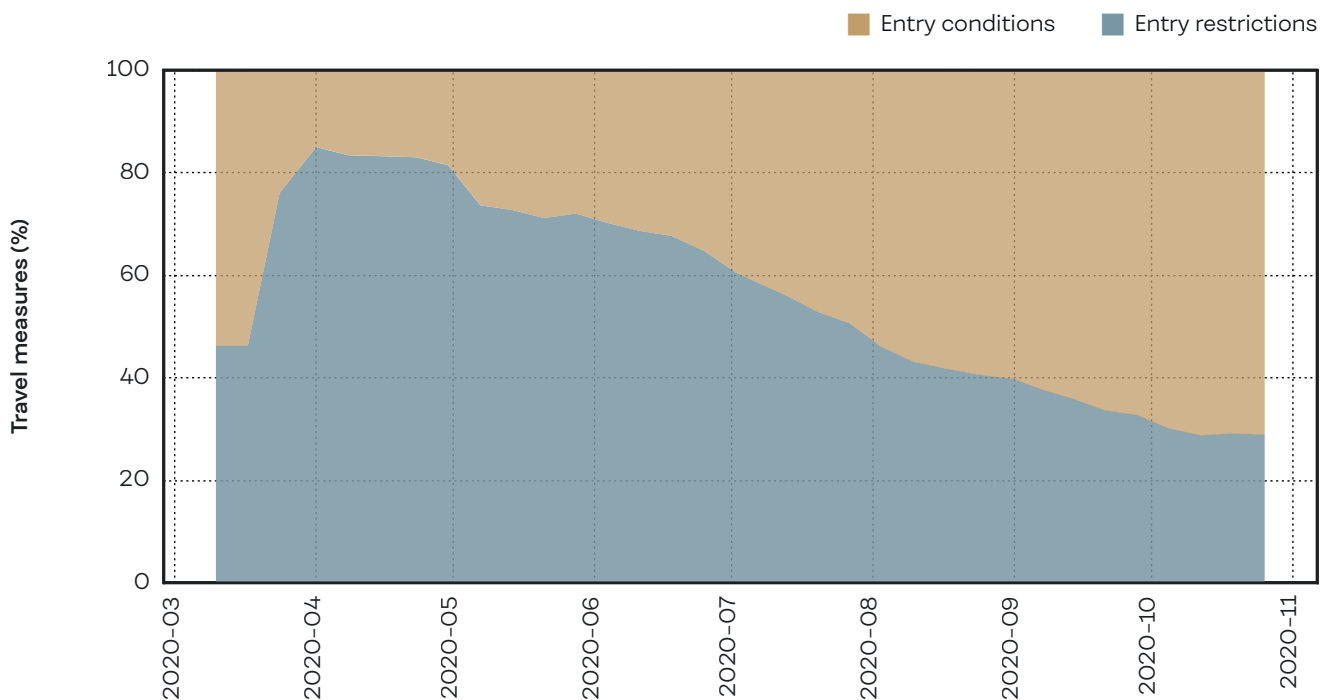
Note: The information is sourced from IATA, IOM and media. The information is correct to the best of IATA's and IOM's knowledge at the time of publication and is being reviewed and updated on an ongoing basis. Given the rapidly evolving nature of the international response to the COVID-19 outbreak, IATA and IOM cannot guarantee its accuracy and can accept no liability for any errors or omissions. IOM reserves the right to add or change information at any time.

C/T/A: countries/territories/areas.

Source: IOM, 2020 (26).

Entry restrictions have been following a decreasing trend since July 2020; in April 2020 around 80% of travel-related measures were entry restrictions (Fig. 3).

Fig. 3. Global entry restrictions versus conditions for authorized entry, March–October 2020



Note: The information is sourced from IATA, IOM and media. The information is correct to the best of IATA's and IOM's knowledge at the time of publication and is being reviewed and updated on an ongoing basis. Given the rapidly evolving nature of the international response to the COVID-19 outbreak, IATA and IOM cannot guarantee its accuracy and can accept no liability for any errors or omissions. IOM reserves the right to add or change information at any time.

Source: IOM, 2020 (26).

As demonstrated in Fig. 3, practices were much more nuanced than a complete border closure. Overall, entry conditions were more common than entry restrictions. Furthermore, even countries that opted for the latter had entry bans in most cases subject to several exceptions. By the end of October 2020, 681 exceptions were issued by 167 countries (26). The top five countries issuing the highest number of exceptions were the United States of America (17), Bulgaria (15), Italy (14), South Africa (14), Canada (13) and the United Arab Emirates (13).

Exceptions to entry ban covered a broad range of foreign nationals, including residents and their family members, students, business workers, diplomatic personnel, seafarers and passengers in transit (26). Most countries also provided exemptions to entry bans for migrant workers in essential sectors, particularly agriculture (Case study 1) and health care, and implemented expedited processing of work visas.

Case study 1. Selected national policies on entry facilitation of seasonal migrant workers

Canada. The Government waived recruitment requirements for hiring foreign workers in key occupations related to the agriculture and agrifood sectors until 31 October 2020, while the processing of visa and work permit applications was prioritized.

Germany. After an initial suspension, the entry of foreign seasonal workers was re-authorized in April and May 2020 for a total of 80 000 people, mainly from Bulgaria and Romania.

Greece. Entry was re-authorized 1 May 2020 for seasonal workers from countries outside the European Union (EU) and exempted from entry visa requirements (e.g. Albania), upon an employer's request.

Sources: IOM, 2020 (27); Scarpetta and Dumont, 2020 (28).

Another important exception to entry bans concerns asylum seekers and others in need of international protection. As observed by UNHCR, allowing asylum-seekers to lawfully enter and be registered at borders, followed by appropriate quarantine or movement restrictions, has facilitated control of infection more effectively than if irregular movement and entry at unofficial border points continued (29). Yet, UNHCR registered a 33% fall in the number of asylum applications logged in the first half of 2020 because of entry restrictions (30).

While many countries of asylum enabled access to protection and documentation during the pandemic, the overall pattern of national practices remained uneven and worrisome. According to the UNHCR, 156 countries had implemented full or partial border closure by September 2020, with 75 providing no exceptions for people seeking international protection (29). Denying entry to asylum seekers contradicts international refugee law (Box 2). It is also inconsistent with the fact that asylum applications were still processed in most countries. In October 2020, at least 112 State asylum systems were fully (58) or partially (54) operational, while only 19 were not (29).



Box 2. Border closure breaches international refugee law

UNHCR has stated: “denial of access to territory without safeguards to protect against *refoulement* cannot be justified on the grounds of any health risk ... States have a duty *vis-à-vis* persons who have arrived at their borders, to make independent inquiries as to the persons’ need for international protection and to ensure they are not at risk of *refoulement*. If such a risk exists, the State is precluded from denying entry or forcibly removing the individual concerned” (31).

Denying access to territory and asylum procedure also blatantly contradicts international law and many other provisions of the Geneva Convention relating to the Status of Refugees of 1951 and its Additional Protocol of 1967 (32). This includes the prohibition of any penalties for irregular entry under Art 31 and the derogation clause contained in Art 9. While granting States Parties the right to adopt temporary measures in times of emergency, Art 9 does not allow suspending asylum procedure. On the contrary, the wording of this provision makes it clear that access to protection remains binding even in such exceptional circumstances, for provisional measures do apply “pending a determination by the Contracting State that that person is in fact a refugee”.

Furthermore, when denial of access to territory targets asylum seekers from a particular country, this breaches the principle of non-discrimination under Art. 3 of the Geneva Convention and many other similar provisions of human rights treaties (including Arts. 2 and 26 of the International Covenant on Civil and Political Rights (8)).

Many governments, most notably in the Americas, Europe, the Middle East and north Africa, have adapted their national asylum procedures in order to ensure compliance with social distancing and other prevention measures (29). The adaptive measures include remote or online submission of asylum applications and the use of video-conferencing or phone interviews, automatic or remote extension of validity of asylum documents, and adjustments to facilities in accordance with public health guidelines.

2.2 Migration policy responses to COVID-19 for foreigners within national borders

A broad range of adaptation policies have been taken by countries with the view of mitigating the manifold consequences of COVID-19 for foreigners already residing



in their territories. Beyond the broad variety of adaptation policies adopted by governments, the overall pattern highlights five practices:

- extension of visas, residence and work permits
- facilitation of access to the labour market in essential sectors
- regularization of undocumented migrants
- release of migrants and asylum seekers from detention centres
- suspension of forced returns.

These are discussed below.

2.2.1 Extension of visas, residence and work permits

The most common measure adopted by many countries was to extend the duration of visas, residence and work permits to prevent their holders from falling into an irregular situation.

While being adopted by most countries across the world, national policies followed three different models.

- In a majority of countries, this extension was granted on an automatic basis for a certain period of time (most frequently for the duration of the health emergency). This was notably the case in Angola, Argentina, Bahrain, Botswana, Bulgaria, China, Colombia, Croatia, Gabon, Greece, Hong Kong Special Administrative Region (China), Hungary, Ireland, Italy, Japan, Luxembourg, Mauritius, New Zealand, Nigeria, Poland, Portugal, the Republic of Korea, Romania, Saudi Arabia, Slovakia, Spain, Sri Lanka, Thailand, the United Arab Emirates, the United Kingdom, the United Republic of Tanzania and Zimbabwe (28,33–35).
- In some countries, the extension was not automatic but provided upon application through an expedited procedure, such as in Australia, Austria, Azerbaijan, Belgium, Canada, Chile, Finland, Germany, India, Indonesia, Israel, Kenya, Mexico, Mozambique, the Netherlands, the Russian Federation, South Africa, Sweden and Switzerland (28,33–35).
- In other countries, whether the extension was automatic or upon request depended on the nature of the immigration document (34). In France, for example, an automatic extension for six months was granted for residence permits but not for short-term visas, whose holders had to submit an application for this purpose. The practice in Czechia was the opposite: short-term visas were automatically extended whereas an application was required for extending residence permits.



2.2.2 Facilitation of access to the labour market in essential sectors

The main measure adopted for access to the labour market was to extend the right to work in essential sectors to a few categories of foreigners. This was particularly the case for foreign students, who were allowed to work beyond the legal limitation of working hours in several countries, including Australia, Belgium, Canada, France, Ireland, New Zealand and the United Kingdom (28,33–35). In some countries (e.g. Belgium, Cyprus, Germany, Finland and Spain), asylum seekers were allowed under some conditions to work in agriculture with the view of addressing the shortage of labour in this essential sector (28,33–35).

While these measures were mainly confined to students and asylum seekers, they were temporary and subject to varying conditions from one country to another. In contrast, undocumented migrants already present in most territories were left alone. One rare exception was in Greece, which established a temporary fast-track procedure allowing employers to hire, under certain conditions, third-country nationals in an irregular situation already residing in the country to help to address urgent labour needs in agriculture (28,33–35). Italy also implemented targeted regularization for third-country nationals who had been employed in agriculture and livestock, fisheries, long-term care and domestic work (28,33–35).

In addition to granting a right to work for very limited categories of foreigners, the other measures aimed at facilitating access to the labour market were rather technical and limited. Relevant best practices included three types of facilitation (28,33–35):

- allowing migrant workers to change employer and sector (e.g. Czechia, Finland and Saudi Arabia);
- expediting the recruitment of foreign health workers in national health services (e.g. Argentina, Chile, France, Italy, Peru and Spain); and
- accelerating the recognition of foreign qualifications of health professionals (e.g. Belgium, Germany, Ireland, Lithuania, Luxembourg, Spain and Switzerland).

2.2.3 Regularization of undocumented migrants

Regularization of undocumented migrants was recommended by several United Nations bodies and documented by scholars as one of the most efficient tools to ensure access to health services with the view of mitigating the spread of COVID-19 among the whole population (4,36–39).

In fact, most countries refrained from adopting any specific policies on the regularization of undocumented migrants. Nonetheless, a small number of countries implemented temporary measures of regularization for some targeted groups of undocumented migrants (33,34). In Portugal, all foreigners with a



pending application at the Foreigners and Borders Service were granted time-limited residency status with the view of ensuring access to health care, public services and the labour market. Likewise, the Government of Peru announced that, for the duration of the emergency, all foreigners pending regularization would be considered as in a regular situation. Spain relaxed the requirements for its regularization programme, regarding notably employment and minimum income. Other temporary measures of regularization were adopted in Greece and Italy but only for undocumented migrant workers in some essential sectors (see section 2.1).

Other countries adopted more targeted adaptation policies through a limited amnesty for irregular migrants (e.g. Bahrain and Kuwait) and the waiver of administrative sanctions and financial penalties for those who were unable to leave the territory because of travel restrictions (e.g. the Russian Federation, South Africa and Uganda) (33,34).

2.2.4 Release of migrants and asylum seekers from detention centres

National policies have varied in terms of release of migrants and asylum seekers from detention centres during the pandemic but did fall into two opposite policies. On the one hand, a number of countries released migrants and asylum seekers held in immigration detention and avoided new placements in detention centres. This practice was implemented in several countries of destination, including Austria, Belgium, France, Germany, Italy, Spain, Sweden, the Netherlands and the United Kingdom (28,34). On the other hand, many other countries continued immigration detention despite the pandemic and the risk of contagion. This was the case, for example, in Australia, India, the Republic of Korea, South Africa, Thailand and the United States (40,41). The United Nations makes clear recommendations on conditions of immigration detention, including responses to the pandemic (Box 3).

Box 3. United Nations recommendations on conditions of immigration detention

Detailed guidance and practical recommendations on the conditions of detention during the pandemic have been issued by the Inter-Agency Standing Committee (42), the United Nations Children's Fund (UNICEF) and the Alliance for Child Protection in Humanitarian Action (43) and WHO (44). UNICEF and the Alliance for Child Protection in Humanitarian Action adopted detailed guidance and practical recommendations on the conditions of detentions for migrants (43), including the following standards:



Box 3 contd.

- ensuring that migrants in detention have access to the same standard of health care as is available in the community, including facilities, goods and services;
- improving water, sanitation and hygiene in places of detention;
- guaranteeing that migrants in detention have regular access to information on COVID-19 developments and on preventive health measures to protect themselves;
- making available adequate spaces for quarantine and self-isolation, ensuring that any decision to resort to containment measures in the context of COVID-19 is fully guided by public health purposes and regulations, is non-discriminatory and safeguards migrants' dignity and confidentiality;
- preserving family unity to the extent possible, ensuring that the best interests of the child are the primary consideration in any decision to temporarily separate families for health-related reasons and considering alternative ways to keep the family in close contact, including through telephone or video;
- adapting safeguarding policies to protect children from violence, abuse and exploitation; and
- ensuring that migrants in detention continue to have access to family visits, legal counsel, social workers and other support services, including by using remote communication modalities by audio or video that are adapted to the realities of COVID-19.

2.2.5 Suspension of forced returns

The pattern of national policies was mixed for forced returns and followed three main trends: suspension because of the pandemic (e.g. Canada, Chile, Czechia, Finland, Ireland, Latvia, Lithuania, Luxembourg, Malta, the Russian Federation, Slovakia and Spain), reduction of forced returns but not suspension (e.g. Austria, Belgium, Bulgaria, Colombia, Croatia, Estonia, France, Germany, Greece, Israel, Italy, Norway, New Zealand, Portugal, Slovenia, Sweden and Switzerland), and continuation of forced returns despite the pandemic (e.g. the Republic of Korea and the United States) (28,34).



2.3 Policies on access to health care for refugees, migrants and asylum seekers in times of COVID-19

2.3.1 Health-care coverage and accessibility of services

The overall pattern of national policies on health-care coverage and accessibility of services shows that many countries recognize the necessity to provide equal access to health care to the whole population, including refugees and migrants (Case study 2). There is also a tendency to lift the financial burden from the individual patients and cover COVID-19-related services. Nevertheless, the adopted measures still lack universal or even regional cohesion. Another typical feature is that the adopted policies in some cases tend to be rather generic and do not explicitly mention refugees, migrants or asylum seekers.

Case study 2. Examples of health-care coverage

In Albania, under domestic law, there is no out-of-pocket payment for COVID-19 care (45). Similar measures were adopted in several State and territory Governments in Australia (28), and several provinces of Canada (33). Other countries, such as Belgium and France, continue providing free universal access to health care (28). Turkey also provided universal access to health care to all refugees and migrants regardless of their status (46). The Government of Peru adopted a decree establishing the temporal affiliation of refugees and migrants to the health insurance system specifically for those suspected or confirmed as having COVID-19 (33). Nepal provides free health care to everyone infected by COVID-19 (47). Chile introduced a policy of free access to necessary treatment for COVID-19 irrespective of the legal status of an individual (48). Colombia provides free medical services to refugees and migrants regardless of their status if they develop COVID-19 and also confirm that no data would be shared with immigration services (34). Similarly, the Republic of Korea suspended the obligation of medical facilities to report irregular migrants to the immigration authorities. Testing and treatment are available for everyone in the country; however, patients need to pay fees that apply for both migrants and citizens (28).

This trend of providing undocumented migrants with access to emergency health services related to COVID-19 free of charge is also seen in Belgium, Croatia, Cyprus, Estonia, Greece, France, Finland, Israel, Italy, Lithuania, Luxembourg, Malta, Mexico, Spain, Poland, Slovakia, Slovenia, Sweden and Switzerland (34,35).



Case study 2 contd.

In Argentina, the Republic of Korea, Thailand and 20 Member States of the EU, basic or emergency health care is guaranteed to migrant workers irrespective of their status (49).

Some countries, however, continue providing medical services for fees or with a requirement of further reimbursement. Such an approach is taken by Czechia (28). In some countries, such as Egypt, Iraq, Jordan, Lebanon and Tunisia, free access to health care for refugees and migrants is guaranteed under national legislation but is not always provided in reality (50).

2.3.2 Communication policies facilitating access to health care

A number of countries have launched communication campaigns to improve the accessibility of health care for refugees and migrants, for example disseminating information on emergency health care and other available services and raising awareness about COVID-19 and related preventive measures (Case study 3) (51–55). The marginalization of refugee and migrant communities, in conjunction with limited language skills, places them among the hardest to reach when it comes to the dissemination of essential information regarding COVID-19 treatment and preventive measures (51).

Case study 3. Examples of communication campaigns

Canada widely disseminates COVID-19-related information through the media channels of the Immigration, Refugees and Citizenship Service and the Public Health Agency, which provides updates in multiple languages (48). In Turkey, the Government has published brochures on COVID-19 in Arabic and other languages, such as Farsi, French and Urdu, and distributed them in places frequently visited by refugees and migrants as well as in refugee health centres (52). In Denmark, COVID-19-related information for refugees and migrants is available in 25 languages (53). Similar measures and campaigns have been launched in all the EU and Organisation for Economic Co-operation and Development (OECD) countries (35), as well as in Saudi Arabia (54), South Sudan (55) and Zimbabwe (55).



2.3.3 Camps and camp-like settings

A number of countries have also taken a variety of measures to improve protection and decrease the virus transmission in refugee camps and camp-like settings of migrants.

There is a common trend in national policies to implement preventive measures aimed at creating preparedness and minimizing the risk of contamination (Case study 4) (56). These policies correspond to the general recommendation of mapping the areas that are most at risk and taking mitigating measures prioritizing the vulnerable population (56). If adopted universally, such best practices may help to avoid numerous casualties among the population in camps and camp-like settings.

Case study 4. Efforts to decrease virus transmission in refugee camps and camp-like settings

Djibouti. The Government of Djibouti, in cooperation with the IOM, provides emergency medical care, food, water, tents, counselling and COVID-19 awareness and prevention advice to migrants who returned to Djibouti due to mobility restrictions (57).

Greece. The Government of Greece with the support of the EU took measures to improve hygiene conditions in refugee camps (58).

Indonesia. The Ministry of Social Affairs also provided pandemic-related care and, in cooperation with UNHCR, delivered soap to promote handwashing to 5000 refugees (59).

Panama. Masks and personal protection equipment were provided by the Government in shelters in Darien and Gualaca (33).

2.3.4 Migrant workers

A number of countries have launched initiatives to increase migrant workers' protection in the time of COVID-19. Such measures fall into two main groups. The first group includes short-term solutions, such as providing protection equipment and other preventive measures at the workplace (Case study 5). The second group related to mid- and long-term solutions and implies involvement of health insurance and social protection policies (Case study 6). Migrant workers can face a number of challenges in accessing quality health care, including a lack of health insurance because of legal status or financial obstacles.



Case study 5. Provision of personal protection equipment in the workplace

Bahrain. The Bahrain Ministry of Labour and Social Development set out the requirements for employers to adopt measures ensuring social distancing in labour accommodation and at the workplace, increased sanitation facilities, and provision of isolation facilities for those with confirmed COVID-19 (60).

India. The Supreme Court specifically mentioned that medical facilities should be ensured for migrant workers at relief camps and shelters across the country (61).

The Association of Southeast Asian Nations. According to an ILO survey on measures taken in the 10 member countries (Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam), the situation of migrant workers was quite diverse and depended on the country. Overall, 67% of the migrant workers were provided with masks and hand sanitizer while 33% did not get any personal protective equipment at all (62).

Case study 6. Examples of health insurances and social protection of migrant workers:

As a general practice, in Argentina, the Republic of Korea, Thailand and 20 Member States of the EU, basic or emergency health care is guaranteed to migrant workers irrespective of their status (49). In the Maldives, migrant workers received increased protection and access to necessary health services irrespective of their work permit or legality of their status (63). In Oman, formal migrant workers covered by health insurance can benefit from the expansion of free medical services related to COVID-19, while migrant workers without health insurance have their COVID-19 health expenses covered by the Government (64). Similar measures were taken in Saudi Arabia, where free screening and testing were provided to migrant workers independently of their legal status (60). In Singapore, the State has covered treatment expenses of migrant workers who have fallen sick with COVID-19 for all long-term pass holders, including work pass holders, holders of in-principle approvals, letters of eligibility and temporary work permits (65).



Many countries have acted in line with the ILO and WHO recommendations to provide migrant workers with access to health care irrespective of their legal status (66).

2.3.5 Access to COVID-19 vaccine

At the time of writing this report, countries were still launching their vaccination campaigns and there were ongoing debates as to who should primarily benefit. There was still not yet enough clarity on countries' COVID-19 vaccination plans; nevertheless, some positive dynamics of cooperation between countries and international organizations regarding the inclusion of refugees and migrants were already identified. In Djibouti, UNHCR joined a national committee for the COVAX Initiative (the vaccine pillar of the global Access to COVID-19 Tools (ACT) Accelerator collaboration) to contribute to the equitable inclusion of refugees and migrants in the national plan for vaccination. The Greek Ministry of Health has already confirmed that refugees and migrants will be included in national vaccination plans (55).

Nevertheless, the terms of reference for this report did not cover vaccine-related issues as at the time of the research vaccines were still under development, and countries were in the early stages of preparing for the deployment of vaccines as they became available. However, several vaccines have been developed as we reach publication and have been deployed around the world. PHM is developing another GEHM on this issue, which will be released soon.



3. Discussion

3.1 Border policies in times of COVID-19

The first policy measure that most countries put in place in response to the COVID-19 pandemic focused on border restrictions with the hope of mitigating the spread of infections from abroad. Although, in retrospect, these measures were unable to contain the pandemic, the vast majority of countries have put in place restrictions on the admission of foreigners with the exceptions of a few countries such as Mexico.

Entry restrictions and entry conditions vary depending on whether they are total or partial restrictions on entering the territory of a foreign State:

- entry restrictions refer to bans on entry of foreigners from certain countries and, more exceptionally, complete border closure; and
- entry conditions are partial limitations in the form of specific requirements upon which entry is incumbent, primarily medical requirements in the form of polymerase chain reaction testing, quarantine, medical forms and/or medical screening upon entry.

This difference between entry restrictions and entry conditions echoes an important distinction in migration law and policy between border control and border closure. In the current context of the pandemic, States have the right and indeed the duty to protect public health and carry out border control accordingly. Yet border control does not mean border closure. The former regulates and monitors admission to the territory through immigration processing, identity check and health assessment, whereas the latter is a categorical ban of entry against any non-nationals or those coming from specific countries (32).

The shift from entry restrictions to entry conditions is consistent with WHO recommendations for international traffic in relation to the COVID-19 outbreak. According to WHO, evidence shows that “denial of entry to passengers coming from affected areas are usually not effective in preventing the importation of cases but may have a significant economic and social impact” (67). In contrast to entry bans, entry conditions “may prove temporarily useful” and may be justified “at the beginning of an outbreak, as they may allow countries to gain time, even if only a few days, to rapidly implement effective preparedness measures. Such restrictions must be based on a careful risk assessment, be proportionate to the public health risk, be short in duration, and be reconsidered regularly as the situation evolves” (67).

Prioritizing entry conditions over entry restrictions is grounded on three key considerations: scientific evidence, policy coherence and legal considerations.



- Scientific evidence has demonstrated only a modest effect of entry restrictions on the spread of COVID-19, as stated by WHO (67). As documented by several studies on COVID-19 and previous pandemics, travel restrictions alone do not constitute an effective response, whereas other public health measures (e.g. social distancing, hygiene practices, testing, tracing and quarantine) provide much more efficient tools to mitigate the spread of contagion (68–71).
- From a policy angle, an entry ban is counterproductive and even dangerous in addressing the pandemic for two main reasons. First, it encourages irregular migration without any health assessment and follow-up (72–74). Secondly, it deprives countries of a much-needed human resource as a large percentage of migrants work in sectors considered essential to address the pandemic, including: health; agriculture; delivery services; cleaning; and care for children, people with disabilities or older people (60).
- From a legal perspective, banning entry to any foreigners or those of a particular nationality is, by essence, a collective and automatic denial of admission without any other form of process. As such, it cannot be reconciled with the absolute guarantees in times of emergency, including the principle of non-refoulement, the prohibition of collective expulsion, the best interests of the child and the principle of non-discrimination (32). The IOM, OHCHR, UNHCR and UNICEF all have stated that no public health consideration can justify a denial of access to territory without proper safeguards to guarantee the best interests of the child and to protect against refoulement, collective expulsion and discrimination (1,36,75).

In stark contrast with border closure, border control can and must be adapted to protect public health with due respect for the rule of law. From this viewpoint, entry conditions, instead of entry bans, allow countries to carry out, within their own immigration and asylum processing, health screening or testing at borders and, where required, quarantine.

While activating the mechanisms provided in the IHR, WHO has produced a broad range of technical guidance to assist States in carrying out border control with due regard to public health objectives in the context of COVID-19. They include:

- management of ill travellers at points of entry (76);
- refugee and migrant health in the WHO European Region (77);
- preparedness, prevention and control of COVID-19 for refugees and migrants in non-camp settings (78);
- public health considerations while resuming international travel (30 July 2020) (79);
- considerations for a risk-based approach to international travel (80); and
- diagnostic testing in the context of international travel (81).



The WHO technical guidance to assist States in operationalizing border control in times of COVID-19 was further reinforced and refined by a broad range of practical recommendations adopted by many other United Nations agencies within their own mandate and in due accordance with international law:

- UNHCR, practical recommendations and good practice (82);
- OHCHR, COVID-19 and the human rights of migrants (36);
- ILO, protecting migrant workers during the COVID-19 pandemic (60);
- United Nations, joint guidance on the impacts of the COVID-19 pandemic on the human rights of migrants (37); and
- United Nations Office for Disaster Risk Reduction, reducing vulnerability of migrants and displaced populations (2).

3.2 Migration policy responses to COVID-19 for foreigners within national borders

Many countries have adopted migration policies that extend the duration of visas, residence permits and work permits. This adaptation in policy was prompted by the practical impossibility of renewing immigration documents and/or leaving host countries at their expiration because of travel restrictions, lockdowns and the closure of immigration services.

In parallel to the extension of visas and permits, a number of countries have facilitated access to the labour market for foreigners already residing in their territory. This policy measure was taken to address labour shortages in essential sectors (particularly agriculture and health care), as a result of border restrictions. The record of national policies remains, nonetheless, mixed and disappointing (see section 2.2) with most countries adopted proactive policies to prevent holders of visas and residence permits from falling into an irregular situation while many of them were much more timorous regarding migrants who were already undocumented before the pandemic.

Furthermore, as evidenced by OHCHR and WHO, migrants and asylum seekers are at high risk of infection in immigration detention centres because of the confined conditions in which they live for prolonged periods of time, possible overcrowding and lack adequate health care, sanitation and hygiene (44,83).

Releasing detained migrants and asylum seekers is triggered by both public health and legal considerations (Box 4; see also Box 3). Under international human rights law and as restated in the Global Compact for Migration, resort to immigration detention is circumscribed by three sets of particularly demanding requirements.



- Deprivation of liberty can only be imposed as an exceptional measure of last resort following an individual assessment of each case. As the United Nations Working Group on Arbitrary Detention underlined, this first requirement establishes “a particularly high threshold to be satisfied in the context of a pandemic or other public health emergency” (83).
- Immigration detention is prohibited under international law when deprivation of liberty is arbitrary, unnecessary, disproportionate or without a clear legal basis (7). This may be the case in a variety of situations. For example, detaining migrants and asylum seekers is clearly disproportionate when sanitary conditions in the places of detention are unable to protect them from infections. Likewise, there is no legal basis for immigration detention where there is no realistic prospect of removal within a reasonable time, including through travel restrictions imposed by countries of origin in response to COVID-19.
- Immigration detention is lawful if and only if other less-coercive measures cannot be applied effectively (7). States are accordingly bound to prioritize non-custodial alternatives to detention, including arrangements and accommodation in the community or restrictions to freedom of movement (e.g. registration of residence requirement, reporting mechanism, designated residence system, bail, bond and surety options or a supervision system).

Box 4. United Nations calls for the release of migrants and asylum seekers from detention centres

The United Nations Network on Migration’s Working Group on Alternatives to Immigration Detention, COVID-19 and Immigration Detention stated (84): “In view of the current COVID-19 pandemic, the United Nations Network on Migration calls on States, working in partnership with relevant stakeholders, to:

1. Stop new detentions of migrants for migration- or health-related reasons and introduce a moratorium on the use of immigration detention.
2. Scale-up and urgently implement non-custodial, community-based alternatives to immigration detention in accordance with international law.
3. Release all migrants detained into non-custodial, community-based alternatives, following proper safeguards.
4. Improve conditions in places of immigration detention while alternatives are being scaled up and implemented.”



Box 4 contd.

The United Nations Special Rapporteur on the Human Rights of Migrants and the United Nations Committee on the Protection of the Rights of All Migrant Workers and Members of their Families have called on States to “implement mechanisms to review the use of immigration detention with a view to reducing their populations to the lowest possible level, and immediately release families with children and unaccompanied or separated children from immigration detention facilities to noncustodial and community-based alternatives with full access to rights and services, including health care” (37).

A related policy measure concerns the suspension of forced returns. Such a measure is triggered for a variety of reasons, including public health considerations (risk for both migrants and State personnel as well as limited capacity of health systems in countries of origin), legal impediments (including the prohibition of returning migrants when there is a real risk of death, torture and other cruel, inhuman and degrading treatment or punishment or other irreparable harm) or practical obstacles (e.g. reduced availability of staff and of commercial flights and border closure introduced by countries of origin) (85).

3.3 Policies on access to health care for migrants, refugees and asylum seekers in times of COVID-19

The COVID-19 pandemic has demonstrated the relevance and importance of universal health coverage and the role of properly functioning medical services accessible for everyone regardless of legal status and nationality. At the same time, the global pandemic is simply another example, albeit a very persuasive one, showing that no one can be neglected or compromised when it comes to access to health care.

Access to health care is not only a temporary necessity in the time of pandemic but also a permanent legal obligation under international law for the States that are parties to the relevant international treaties. The right to health is enshrined in a significant number of legally binding treaties as well the WHO Constitution (Preamble) (86). These international treaties include the International Covenant on Economic, Social and Cultural Rights (art. 12) (9), the International Convention on the Elimination of All Forms of Racial Discrimination (art. 5(e)(iv)) (10), the Convention on the Elimination of All Forms of Discrimination against Women (arts. 11(1)(f) and 12) (87), the Convention on the Rights of the Child (art. 24) (11), the Convention Relating to the Status of Refugees (art. 24(1)(b)) (12) and the



International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (arts. 25(1)(a) and 28) (13).

More recently, States have reinforced their obligations towards migrants by having committed under the Global Compact for Safe, Orderly and Regular Migration to ensuring safe access to basic services for all migrants regardless of their legal status (objective 15) (19). The basic services include an affordable and non-discriminatory health-care system with reduced communication barriers and culturally sensitive ways of delivery.

As stated by the Committee on Economic, Social and Cultural Rights in General Comment No 14: The Right to the Highest Attainable Standard of Health (art. 12), “every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity” (88). Like any other human right, the right to health presupposes the existence of a three-fold duty of the State: obligations to respect, protect and fulfil. States are under an obligation to provide for equal realization of the right to enjoy the highest attainable level of health to all people in a non-discriminatory manner (88). However, the definition of the right to health, as explained in this General Comment, is not legally binding for Member States. Hence, approaches to the right to health may vary in national legislation. The Committee stressed that States are bound to refrain from denying or limiting equal access to asylum seekers and irregular migrants and abstain from discriminatory policies and it also highlighted the existing joint and individual responsibility of the State to cooperate in providing relief and assistance to refugees in times of emergency (88).

According to this international normative framework, all refugees, migrants and asylum seekers should benefit from the right to health in the host State. The State’s obligations are not dependent on the legal status of an individual and should be performed in a non-discriminatory, barrier-free manner ensuring the highest attainable level of health. In the context of COVID-19, all refugees, migrants and asylum seekers, therefore, have the right to access all relevant health-care services, such as testing, diagnostics, care and treatment, referral and the COVID-19 vaccination once it becomes available (51).

This normative framework has been operationalized through a number of practical recommendations adopted by several United Nations bodies, including WHO, the Inter-Agency Standing Committee and the United Nations Network on Migration (56).

Many countries in their COVID-19 pandemic response have adapted their health-care strategies to the needs of refugees, migrants and asylum seekers. Acting in line with WHO recommendations and guidelines (78), many governments have increased the accessibility of health-care services not only for their nationals and regularly resident foreigners but also for any other individuals within their territory



regardless of legal status during the COVID-19 pandemic. There is also a global consensus on the importance of the dissemination of information and reaching out to isolated communities. Proper communication strategies are not only vital for refugees and migrants who are in need of COVID-19 treatment but also an essential prevention tool to protect vulnerable communities from the spread of the virus.

Nevertheless, the COVID-19 pandemic has also unveiled a number of challenges faced by migrants in relation to health care. Undocumented migrants in particular often lack quality access to health care but also fear to seek medical services as they do not want to have their status exposed to immigration authorities. Although COVID-19 response in many countries has proved to be quite inclusive and flexible to the needs of the population, its implementation has to be subject to scrutiny and periodic revision. Refugees and migrants need to have real access to health care, as does the core population of the country, free from financial, linguistic, cultural, administrative or bureaucratic barriers.

WHO recommends every country to implement measures to reduce both COVID-19 transmission and its economic, public and social impacts (89) while always being fully respectful of dignity and human rights of individuals (90). To ensure appropriate public health outcomes, it is, therefore, essential that responses to COVID-19 consider the needs of refugees and migrants. Countries are currently adopting different specific policies and actions to respond to the COVID-19 pandemic with respect to vulnerable groups, including refugees and migrants. Often basic public health measures, such as social distancing, proper hand hygiene and self-isolation, are not possible or extremely difficult to implement in camps and camp-like settings. Migrants living in urban settings can be affected by income and job loss, health-care insecurity and the consequences of delays in making decisions on their legal status, as well as interruption of legal and administrative services.

In terms of access to health care, this report shows that policies adopted by countries in some cases tend to be rather generic and do not explicitly mention refugees and migrants or asylum seekers. Such an approach may create obstacles for people with irregular status when seeking medical assistance (50). It is importance that undocumented migrants are included in free-of-charge health-care coverage for COVID-19 and that this information is properly communicated to the entire population; however, it should be remembered that some countries may experience extra financial burden in this case and may require additional support (50,91).

The countries that have launched communication campaigns have adopted a twofold approach. First, they diversified sources of information and dissemination sessions and made them available to the widest circles possible. Second, they ensured the accessibility of information in multiple languages. What is essential in



multilingual campaigns launched by countries is the attention paid to the languages spoken by the refugee and migrant communities present in that country.

It is worth noting that no universal approach to health care for refugees, migrants and asylum seekers in times of COVID-19 is possible since the specific conditions of refugees and migrants, their countries of origin as well as the communication channels of the host countries need to be considered. However, a common trend was identified in that many countries that had adopted measures to improve access to health care of vulnerable groups, including refugees and migrants, acted in line with the recommendations issued by a number of United Nations agencies: they addressed the special needs of refugees and migrants, tried to overcome existing language barriers and mitigated any limits on access to information.

Refugees and migrants also have some specific areas of vulnerability. If they are living in camp or camp-like settings, they are particularly exposed to disease transmission through overcrowding, regular arrival of new members and poor nutritional and sanitary conditions. Lack of social distancing and personal protective equipment leads to increased risks of being infected with COVID-19. In terms of work, many refugees and migrants traditionally work in sectors with a higher risk of COVID-19 transmission, including health care, transport, services, construction, and agriculture and agrifood processing (Table 1) (48,60).

Table 1. Share of migrants among the employment in selected service sectors, 2018

Sector	percentage of total employment		
	Canada (%)	EU (28 Member States) (%)	United States (%)
Hospitality	31	25	24
Health	27	11	17
Retail trade	28	12	15
Security and cleaning services	30	21	30
Total (all sectors)	25	13	18

Source: OECD, 2020 (48).

On a number of occasions, the ILO and WHO have stressed the crucial importance of social protection and quality access to health care for front-line migrant workers. Indeed, the specificity of these essential jobs does not allow working from home and cannot always fully adapted to social distancing requirements.

Social protection and access to health care is an essential measure for irregular migrants, who do not normally have health insurance and often work in difficult conditions. Guaranteeing equal and affordable access to health care is crucial



for preserving and improving the public health of the whole country. Ensuring that all migrant workers occupied in essential jobs have sufficient personal protection equipment is yet another important measure in preventing COVID-19 transmission. Unfortunately, there is no universally adopted approach to organizing the workplaces of migrant workers to avoid overcrowding, ensure social distancing and ensure regular disinfection of commonly used surfaces. Protective measures in the workplace are at the core of the COVID-19 pandemic response. Refugees and migrants should not experience any discrimination and should have equal access to personal protective equipment (92).

Special attention should be paid to workplaces where undocumented migrants work, since they tend to be particularly vulnerable because they often have poor living conditions and they frequently suffer from stigmatization, which may prevent them from seeking medical assistance or asking for sick leave (91). Implementation of WHO's considerations for public health and social measures in the workplace in the context of COVID-19 (92) can contribute significantly to preventing further transmission of COVID-19.

There is always a high risk that the most vulnerable groups of society, such as refugees, asylum seekers and undocumented migrants, will be left at the back of the queue (93), even if they are not technically excluded. States are, however, legally bound to respect and ensure respect for the right of all people to enjoy the highest attainable level of health in a non-discriminatory manner. Refugees, migrants and asylum seekers have, therefore, the same right of access to the COVID-19 vaccine as any other individuals. The UNHCR Human Rights Experts Group issued a statement saying that "It is imperative that access to COVID-19 vaccines and treatment is provided to all without discrimination and prioritized for those who are most exposed and vulnerable to the risk of COVID-19" (94).

The IOM and UNHCR jointly addressed States urging them to ensure refugees and migrants are included in vaccine allocation and distribution plans. The same message has been imparted by the International Federation of Red Cross and Red Crescent Societies (93) and the International Committee of the Red Cross (95), which stressed that refugees, migrants and asylum seekers must be included in national vaccination campaigns. The Parliamentary Assembly of the Council of Europe also urged Member States that vaccines are for the "global public good ... immunisation must be available to everyone, everywhere" (96).

In order to facilitate the development of national strategies, WHO's Strategic Advisory Group of Experts on Immunization has released two key documents: The Values Framework for the Allocation and Prioritization of COVID-19 Vaccination (97) and The Roadmap for Prioritizing Population Groups for Vaccines against COVID-19 (98). These documents provide for the allocation and prioritization of populations to receive COVID-19 vaccines and explicitly include refugees, migrants and asylum seekers as groups requiring prioritization of vaccination.



4. Policy considerations

The COVID-19 pandemic has prompted countries to adopt a broad range of adaptation policies covering many different areas related to international migration and public health. The overall picture remains highly complex, as countries' reactions to the global pandemic vary considerably in both nature and scale. The proliferation of unilateral measures and the resulting lack of coordination have impaired a truly collective and consistent global response and produced much confusion and unpredictability.

Based on this report and considering existing international conventions (8–17), as well as guidelines and recommendations of international organizations (e.g. ILO, IOM, OHCHR, UNHCR or WHO), the following policy considerations are suggested.

- **Border policies: protection-sensitive access to territory**
 - prioritizing entry requirements over border closure to carry out medical screening on the basis of a careful and evidence-informed risk assessment; and
 - enabling access to territory and asylum procedure for people in need of international protection.
- **Migration policies for foreigners within national borders: immigration status flexibility**
 - foreseeing the extension of the duration of visas, residence and work permits to prevent their holders from falling into an irregular situation;
 - facilitating access to the labour market for foreign residents to address labour shortages in essential sectors;
 - facilitating regularization of undocumented migrants to ensure safe and lawful access to health services;
 - releasing migrants from detention centres and implementing non-custodial, community-based alternatives to immigration detention with proper safeguards; and
 - suspending forced returns, when the health, safety and human rights of migrants cannot be safeguarded.
- **Policies on access to health care for refugees, migrants and asylum seekers: non-discriminatory access to health care**
 - providing equal access to health care for all refugees and migrants, regardless of status, nationality, gender or ethnicity;



- launching communication campaigns to disseminate essential information to refugees and migrants concerning COVID-19, health services and other related preventive and preparedness measures;
- implementing preventive measures aimed at minimizing the risk of contamination in refugee camps and camp-like settings;
- protecting the occupational safety and health of all migrant workers and providing them with personal protective equipment to prevent COVID-19 transmission in the workplace; and
- ensuring access to COVID-19 vaccines and treatment for all refugees and migrants without discrimination and prioritizing those who are most exposed and vulnerable to the risks of COVID-19.

It is imperative that WHO works alongside national authorities and key partner agencies as well as with other international organizations to collectively take note of these policy considerations to uphold the human right to health for all refugees and migrants.

When taken together, these policy considerations illuminate the central components of an integrated approach to migration and public health policies governing protection-sensitive access to territory, migration status flexibility and non-discriminatory access to health care. The key challenge will be to shore up these policy developments to ensure a consistent application across countries. This report underscores the considerable variations from one country to another in implementing refugee- and migrant-sensitive practices. Moving towards an integrated approach to migration and public health policies calls for broad replication of these practices to build upon the lessons learned from the pandemic.



5. Moving towards an integrated approach to migration and public health policies

People on the move have been disproportionately affected by the pandemic itself and by the measures adopted by countries at their borders. In many instances, the human rights of refugees and migrants have been compromised and their vulnerability exacerbated through discriminatory practices, abuses and exclusions. At the same time, the COVID-19 pandemic has highlighted the positive contribution of refugees and migrants as valued members of our societies and providers of essential services. It has also emphasized the vital importance of building more inclusive and sustainable solutions for refugees, migrants and their host communities.

Many governments have adopted policies to ensure that refugees and migrants are included in their responses and adequately protected in accordance with international law. Significantly, many countries have ensured access to health care for all refugees and migrants, regardless of nationality and legal status. Numerous countries have also adopted flexible measures with regard to administrative procedures and status as well as access to the labour market, while several have also suspended forced returns and prioritized alternatives to immigration detention.

The COVID-19 pandemic is both a challenge for public health and migration policies and an opportunity to integrate these policies. The challenges, be they political, economic, humanitarian or operational, are huge and manifold. Yet when viewed from a distance, the pandemic may be an opportunity to devise coherent and evidence-informed policies leaving no one behind in the spirit of the Sustainable Development Goals. The policy considerations identified in this report constitute the first steps towards a responsive and responsible approach to protecting both public health and the rights of refugees and migrants in a mutually reinforcing way.

The COVID-19 pandemic also underscores the need for a truly collective response through enhanced international cooperation, for no country can fight the virus alone. The potential of the IHR must be fully exploited to channel information sharing and facilitate the coordination of response measures. While States are entitled to verify and manage public health risks at their borders, all such measures must comply with international law. They must be non-discriminatory, as well as necessary, proportionate and reasonable, with the aim of protecting public health.

Human rights must form the backbone of any integrated approach to public health and migration policies. In all circumstances, the primary consideration is to treat refugees and migrants with respect for their dignity. Their human rights must



be fully acknowledged and duly respected, including due process guarantees, the principle of non-refoulement, the right to seek asylum, the prohibition of collective expulsion, the best interests of the child, the right to privacy and to family life, removal of discrimination and the prohibition of arbitrary detention.

While governments are facing unprecedented challenges, the COVID-19 pandemic is a wake-up call to the international community. It urges for a strengthened commitment to global solidarity through an inclusive and human rights-based approach. A truly collective and comprehensive response to COVID-19 requires safe, orderly and regular migration more than ever, as well as responsibility sharing for refugees through enhanced cooperation in compliance with international law, as envisaged in the Global Compacts.

The United Nations Secretary General in a statement in June 2020 said “The COVID-19 crisis is an opportunity to reimagine human mobility” at the launch of the Policy brief on COVID-19 and People on the Move (99). The Policy brief (4) states “This crisis is an opportunity to reimagine human mobility for the benefit of all, while advancing our central commitment of the 2030 Agenda to leave no one behind. It is fitting to build on the recognition of the vital role played by people on the move to redouble our efforts to combat discrimination against them; to ensure that those in need of protection are able to safely and promptly access it; to health-proof human mobility systems; and to strengthen global migration governance and responsibility sharing for refugees, as already envisaged by the Global Compacts on Refugees and for Safe, Regular and Orderly Migration and as spelled out in relevant international human rights and refugee instruments.”



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