CHAPTER 9

THE IMPACTS OF PANDEMICS ON MIGRATION

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ABSTRACT

Pandemic emergence through migration of tightly connected populations materialized in late 2019 with a novel coronavirus (COVID-19). Global spread was catalyzed by business, education, tourism, family and medical-related travel leading to swift international restrictions on movement and closed borders. Two-thirds of the worldwide migrant population journey for job opportunities and to access healthcare; many move internally in low-income countries. While migration has been a driver of global prosperity, it also places individuals in situations that impact their physical and mental wellbeing; many become vulnerable and marginalized in their communities. However, it is those same migrants that play a role in shaping the context and response to COVID-19. They have the dual burden of being more vulnerable to infection but also play a critical role in response working frontline jobs in public services and health. This chapter analyzes the relationship between pandemics and migration by first looking at migration as a driver of the pandemic and then at the effects of the pandemic on both migrants and the communities that host them. We conclude by analyzing the policy implications of the two-way relationship between migration and the pandemic.

Keywords: Migration, health, public policies, pandemic

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1. Introduction

Migration is one of the principal characteristics of our globalized world. The latest figures indicate that there are 272 million international migrants – defined by the UN as those living outside their country of birth for at least one year (UN DESA 2019). As a percentage of the world’s population, international migration has increased from 2.9 percent in 2005 to 3.5 percent in 2019. Overall, migration has contributed to global development and prosperity; while making up less than 4 percent of the world’s population, the McKinsey Institute (2016) estimates that migration contributes almost 10 percent of global GDP. The international flow of remittances – now estimated at \$550 billion annually (World Bank 2019, xvii) -- dwarfs both international development assistance and foreign direct investments; remittances are generally credited with alleviating poverty, increasing food security, enabling education and social mobility in the country of origin (World Bank 2020). In addition to its economic impact, international migration has contributed to cultural diversity in countries which receive the migrants.

While most international migration is safe, orderly, and regular, around 10 percent of the world’s migrants are forced to leave their homes, many of whom are recognized as refugees. The UN High Commissioner for Refugees (UNHCR) estimates that there are around 26 million refugees, another 4 million people who are seeking asylum and over 3 million Venezuelans who have left their country because of its political and economic situation (UNHCR 2020). Of the world’s refugee population 85 percent live in developing countries with almost 68 percent originating from just five countries: Syria, Venezuela, Afghanistan, South Sudan and Myanmar (UNHCR 2020). While COVID-19 is having a particular impact on refugees and on those displaced within the borders of their countries by conflict, this chapter focuses primarily on migrants who have traveled to their countries for other reasons – in search of better job opportunities, education, or to be with family, for example. While we will focus on the impacts on international migrants, the number of internal migrants, particularly those moving from rural to urban areas, is estimated at around 740 million people – or 3 ½ times the number of international migrants (IOM 2018). In particular, China has over 280 million rural migrant workers who travel within its borders for employment and who have been hardest hit by as a result of socioeconomic disparities. Of particular importance to this analysis is the fact that international migrants tend to work in sectors at heightened risk to the virus: in the service sector – ranging from child and eldercare to restaurants and the hospitality industry to gig workers -- as well as factory employees and farm workers. This has increased their risk of contracting the virus as well as their vulnerability due to limited access

to health care. Undocumented workers in particular are at risk – both because they work in occupations where they may be exposed to the disease and because of national policies, financial restrictions and fear of discrimination or deportation.

In particular, this chapter focuses its analysis on the consequences of COVID-19 and the policy measures taken to respond to the pandemic on international migrants and both their communities of origin and destination. But before turning to the main portion of our research, we offer some analysis of migration as a driver of pandemics with specific reference to COVID-19.

2. Migration as a driver of the pandemic

In December 2019, a pneumonia of unknown etiology was reported to the WHO China Country Office; within two weeks a virus (SARS-CoV-2) was isolated, characterized and sequences were shared on global scale. On 30 January, one month from the formal reporting and after cases were reported across five WHO regions, WHO declared the novel coronavirus (2019-nCov)¹ a Public Health Emergency of International Concern (PHEIC) as outlined in Annex 2 of the International Health Regulations (IHR) 2005 (WHO 2005). This novel virus emerged from an unknown animal reservoir host, spilling over to humans during a time of national and international travel for Chinese residents – the annual Spring Festival which includes the Lunar New Year. In fact, travel during this period – with an estimated three billion trips – is the largest planned human migration in the world. In 2020, the emergence of the virus came right in the middle of the Spring Festival (10 January – 18 February). Although the city of Wuhan went into lockdown on 24 January curtailing some travelers, many had already left their homes traveling to other provinces or countries. As Thailand and Japan are among the most popular destinations, it was no surprise that Thailand was the first country outside of China to report a case on 13 January.

There are many factors, including but not limited to: environmental, host-pathogen, geographic, and socioeconomic, that play into the emergence, re-emergence and spread of diseases. Global cities are hubs for international travel, trade and tourism where they continue to attract international migrants and students in search of economic and educational opportunities. They are also the gateway for disease importation and onward community transmission, especially for novel and emerging respiratory pathogens. This situation placed many of the globe's best-connected countries at highest risk in the early phases of the COVID-19 pandemic. As a result, the global cities most affected: New York, Madrid, and

1 It wasn't until mid-February that the disease was named COVID-19 (WHO 2020a)

the Lombardy region in Italy, to name a few, are all centers for business, trade, tourism and have a higher-than-average migrant presence, according to a recent report by the International Organization for Migration (IOM) (Guadagno 2020). It is important to note that the IHR (2005) take a preventative approach focusing on strengthening capabilities to confront all potential public health emergencies of international concern when and where they occur. States Parties commit to core public health capacities to achieve compliance, building networks that can prevent local public health crises from becoming international catastrophes. The IHR were established with the objective of maximum prevention of the spread of infectious diseases with minimal disruption of travel and trade. While legally binding, they lack a formal enforcement mechanism for failing to comply with recommendations so, despite compliance to the IHR, many countries close borders or restrict travel in an attempt to prevent disease from entering their borders, in complete opposition of the IHR and against WHO recommendations.

The role of migration in the transmission and dissemination of respiratory infections has been examined for a number of pathogens. In the face of emerging disease threats, countries implement phases of containment, typically (and ideally) before cases have been reported within their borders. However, the question of the degree to which mobility restrictions are able to achieve containment at the source, or in the early stages of an epidemic, especially in combination with timely mitigation policies in the country of origin, has been questioned. We can look at historical, impactful pandemics like the 1918 influenza pandemic which led to over 50 million deaths worldwide, targeting a vast majority of young adults during a world-war, and can see how mobilization and density of a susceptible population led to rapid and global spread. However, in order to model how migration in today's world can impact epidemic and pandemic spread we need look no further than the last eleven years and analyze events such as the 2009 H1N1 influenza pandemic (pH1N1 2009), the 2014 and 2018 Ebola epidemics, and on-going epidemics of MERS (2012), Zika (2014) and COVID-19 (2019).

On 18 April 2009, under the obligations of the IHR, the US and Mexico reported cases of a novel influenza A virus H1N1 to the WHO's regional Pan American Health Organization (PAHO) Office. Mexico's first case was confirmed on 17 March and eleven days later the first case was confirmed in California. While the US and Mexican authorities were quick to report and characterize the novel influenza virus, it was not until 25 April that WHO declared a PHEIC. It took six more weeks for WHO to declare a pandemic (11 June). By this time, the CDC estimated that roughly one million cases had occurred in the US. During the early stages of the outbreak, some countries implemented travel restrictions to Mexico which appeared to have had no real effect on the spread of H1N1. In three months, the virus spread across the

globe resulting in over 254,000 cases and at least 2,800 deaths on six continents (WHO 2009). Viral spread was in large part due to international travel and subsequent human-to-human transmission at each destination. Retrospective research indicates that the travel restrictions were too small in magnitude to make any impact (Bajardi et al 2009). Based on the ease of aerosol transmission, a completely immunonaive population, and ever-increasing population mobility, it was unlikely that travel restrictions could have been used effectively during the 2009 H1N1 pandemic and many experts at the time indicated the case would be the same in a similar future pandemic event.

Like H1N1, the global spread of the 2014 Ebola epidemic was due at least in part to people traveling between countries. In 2014 three countries in West Africa battled an old virus in a new setting. Ebola was first detected in Guinea in December 2013 and rapidly spread across Sierra Leone and Liberia due to a cadre of factors including limited health systems and high population mobility across porous borders. The epidemic, which lasted for two years, was responsible for widespread urban transmission and at least 11,300 deaths across the three countries. In late July 2014, an infected Liberian man landed in Lagos, Africa's most populous city and a major hub for travel and trade, and initiated a chain of transmission in Nigeria that infected a total of 19 people resulting in 7 deaths (WHO 2014b). On Aug 8, 2014, WHO eventually declared a PHEIC citing the unprecedented scale of the outbreak, geographical range, and the observed international spread of Ebola virus into Nigeria (WHO 2014a). In response to growing concerns of travel-associated cases, a number of airlines canceled routes through Conakry, Monrovia, and Freetown and countries closed their borders in complete opposition to recommendations and guidelines outlined under the IHR. Retrospective studies indicate that exit screening of travelers at airports (which was eventually implemented and required international support) proved the best method to assess health status of travelers and to prevent onward transmission and that border closures, at the time of implementation, did very little to prevent spread out of West Africa (Bogoch et al 2015). Mobility restrictions and border closures can impact trade, restrict access to food and medical support (consumables and personnel). Given the relatively low passenger volume across the capital cities' international airports, their localized economies, and the mode of transmission for Ebola the travel bans placed a larger burden of response on the countries themselves and inadvertently increase rates of transmission and infection in the most at-risk groups in each country.

Middle East respiratory syndrome coronavirus (MERS-CoV), has been reported in twenty-seven countries since it was first reported in Saudi Arabia in 2012. Travel-associated outbreaks have been a key factor in the spread of the virus outside the Middle East. In 2015, a single

passenger who acquired the virus abroad and sought treatment at a tertiary-care hospital in Seoul, created a cascade of exposures and infections in the Emergency Room and hospital where he sought treatment. Epidemiological investigations pinpoint a contact of the index patient to have played a major role in transmission, being dubbed a super spreader. In total, patient 14 was linked to 82 cases, or nearly 45 percent of the total cases in South Korea. In the end, 186 people were infected, 36 died and thousands were quarantined in a city of 25 million. The outbreak lasted only a few months (May-June) but the economic toll was so severe the central bank had to cut interest rates (Cho et al 2016).

Novel and emerging diseases, particularly those that spread effectively via aerosol droplets, are very challenging to contain in a mobile and interconnected global population. Keys to containment of an infectious disease include identification of infected individuals, subsequent treatment (and potential isolation of patients), and contact tracing in order to break transmission cycles. Time and time again we have seen that travel restrictions and border closures on their own cannot prevent an epidemic or pandemic. However, it is the potential and risk of disease spread associated with migration that has led governments to adopt restrictionist policies.

3. Policy responses to migration in light of pandemics

Displacement – the forced movement of people – occurs in every other type of humanitarian crises whether resulting from conflict or natural hazards. Displacement is a survival strategy as people seek to distance themselves from threats in their communities, but in the case of infectious disease, governments usually impose restrictions on population movements – both within their countries and at their borders – in an effort to limit the spread of disease (Edelstein et al 2014). From the plague in fourteenth century Europe through the 2014 outbreak of Ebola, governments have closed their borders to travelers from disease-affected areas while taking measures to prevent people from moving from disease-affected areas to other parts of their countries (Kenny 2020). More recently, with the Ebola outbreak in the Democratic Republic of Congo in 2018, governments of neighboring Uganda (IOM 2019) and Rwanda instituted hygiene and temperature checks on travelers; Rwanda closed and reopened its border during one day in August 2019 (WHO 2019).

As noted above, WHO's IHR (2005) do not recommend travel restrictions during epidemics, citing evidence that restricting international travel is not only ineffective in controlling disease outbreaks, but may divert resources from other, more effective interventions and prevent movement of health personnel and supplies. Restricting international travel also

has economic consequences which typically affect populations already suffering from poverty and marginalization. Nor does WHO see temperature screening – a popular measure used in some countries – as effective in controlling disease spread (WHO 2020b). Nonetheless, restrictions on movements of people were one of the first and most-frequently applied policy responses to COVID-19. In fact, as Chishti and Pierce note, “In just a few months, the world has experienced the largest and fastest decline in global human mobility in modern history” (Chishti & Pierce 2020b).

As noted above, China officially reported a cluster of cases of pneumonia on 31 December, attributed them to a new coronavirus on 9 January 2020 and on 23 January, locked down Wuhan (population 11 million) – the site of the disease’s outbreak (Holshue et al 2020). On 20 January 2020, the US recorded its first case of coronavirus, a patient who had recently returned from Wuhan. Eleven days later, on 31 January 2020, the US instituted a ban on entry of non-US citizens who had been in China during the previous 14 days (US White House 2020). Although heralded by US President Trump as a bold response to the crisis (Kessler 2020) it was too little too late; experts noted that the ban excluded some 40,000 people who returned from China in the two weeks following the ban (Eder et al 2020). US restrictions on entry of those from Iran were imposed on 29 February, followed on 11 March by restrictions on travel from Europe’s Schengen countries and on 14 March by restrictions on travelers from the United Kingdom and Ireland (Chishti & Pierce 2020a). On 17 March, Italy imposed a strict requirement for 14 days of quarantine on anyone entering the country (Italy Ministry of Infrastructure 2020). The US and Canada mutually agreed to close their borders to each other on 21 March; US and Mexico agreed to close their border to non-essential travel on the same date (US, DHS 2020). US, Mexico and Canada subsequently agreed to extend these border restrictions through 20 August 2020 and again until 21 November 2020 (Tate et al 2020; US DOS 2020).

As of 8 June 2020, 220 countries, territories, or areas had issued travel restrictions (IOM 2020b). These travel restrictions impacted international trade and limited the ability of humanitarian actors to access countries and people in need of assistance as a result of the virus. They have also devastated the travel industry – and the millions of people, including migrants, who work in those businesses. According to the UN World Tourism Organization, by 20 April 2020, 100 percent of tourist destinations had travel restrictions (UNWTO 2020). In early June, some countries – such as Norway and Italy had begun allowing some international travelers to enter. Some countries – such as New Zealand -- were geographically better able to control international travel.

In addition, many governments imposed internal travel restrictions. By 11 July 2020, about one-third of US states had instituted travel restrictions or quarantine requirements for those entering their territories from COVID-19 impacted states (Schwartz 2020b). India experienced the largest recorded internal movement as 6.5 million Indian migrants were told to return to their communities – mostly moving from urban to rural areas – by late May (IOM 2020c). Other governments, such as Australia, began imposing internal border controls as a result of increasing numbers of COVID infections some six months after the initial outbreak. It is worth noting that governments with centralized health systems – such as New Zealand and Norway – were able to set and implement policies across their entire countries whereas governments, like the US, which left pandemic response to subnational authorities had more difficulties in developing a comprehensive response. A particularly challenging situation emerged for those travelers who were in international waters when the pandemic was declared, leading to cruise ships being prevented from docking at points of entry and passengers from disembarking as well as a decline in rescues of migrants crossing the Mediterranean Sea.

While these measures were clearly intended to contain COVID-19, there is little solid evidence that travel restrictions do in fact limit the spread of the pandemic. For example, Askitos et al (2020), using sophisticated modeling techniques, find no effects of international travel controls, public transport closures and restrictions on movements across countries and regions on the spread of COVID-19. But they did find that cancelling public events, and stay at home restrictions do have an impact on the spread of the disease. Similarly, surveillance, testing, and contact tracing are effective tools in identifying community clusters followed by direct interventions to slow the spread of the disease and provide education and awareness to at-risk populations.

While the vast majority of countries in the world have implemented border closures, travel restrictions on arrivals from certain areas or quarantine requirements, these measures failed to prevent a global outbreak. And the measures have had many negative impacts.

Of particular concern is the impact of travel restrictions for people seeking asylum or other forms of international protection. In reviewing the provisions of such travel restrictions, UNHCR and IOM (2020) found that by April 2020, almost 60 governments made no exception in those travel restrictions for people seeking asylum. UNHCR and IOM noted growing instances of governments refusing to allow disembarkation of asylum-seekers rescued at sea and increasing cases of collective expulsions of migrants in the name of protecting public health. The US effectively ended asylum by “invoking the power given to the Surgeon-General in 1944 to block entry of foreign nationals who pose a public health risk,” by preventing asylum-seekers

from entering the country to ask for protection. Many experts argued that this reflected the Trump administration's long-stated policy of controlling the border rather than reflecting a genuine concern with health (Human Rights First 2020). The US has justified restrictive policies toward immigrants not just because of their potential in spreading disease but because of their economic impact. Thus, the US suspended granting visas to certain categories of permanent immigrants who "present a risk to the US labor market during the economic recovery following the COVID-19 outbreak." While unemployment in US was 3.5 percent in February 2020, by April it had reached 14.7 percent (Chishti & Pierce 2020b). In March the US State Department suspended in-person consular interviews and visa processing for the vast majority of immigrants intending to move to the US. The US now bans all travel from 31 countries while its citizens are prohibited from traveling to all but around 20 countries in the world – the result of the summer surge in COVID-19 cases in mid-2020 (Schwartz 2020a).

Other governments have justified their imposition of travel bans and crackdowns on immigrants on public health grounds but in ways that support long-held efforts to restrict immigration and asylum-seekers. Thus, the Greek government has leveraged fears about the spread of coronavirus to justify plans to build closed camps for asylum-seekers. Viktor Orbán, prime minister of Hungary, blames foreigners for COVID-19: "our experience is that foreigners brought in the disease, and that it is spreading among foreigners" (Banelescu-Bogdan et al 2020) in ways reminiscent of his long-time efforts to blame migrants for terrorism (Kaminski 2015).

Policy responses toward migrants already living in countries varied. In Portugal, the government announced that all foreign nationals with pending immigration applications, including asylum-seekers, would be temporarily treated as permanent residents (except for seasonal migrant workers and some unauthorized migrants). The UK automatically extended the residence permits of some temporary workers (doctors, nurses etc.) as did China. In the US many immigrants are explicitly excluded from federal COVID-related benefits (though some states have stepped up) (Chishti & Pierce 2020b).

Although the European Union reports that the number of arriving asylum-seekers had sharply diminished as a result of COVID-19 restrictions (European Asylum Support Office 2020), the UN Office for Drugs and Crime (UNODC) reports that border restrictions imposed by COVID-19 may lead to an increase in smuggling and trafficking of migrants (UNODC 2020). It also seems that the harsher backlash against undocumented immigrants – now ostensibly on health grounds – is leading undocumented migrants to go even further underground – and to stay away from accessing health services. Given their increasingly

precarious economic situations, it also may be leading them to continue to go to work – even if they have symptoms of COVID-19.

These pressures for travel restrictions are likely to continue in spite of the lack of evidence that they are effective measures to prevent the spread of COVID-19. UNHCR has issued legal guidance on dealing with people in need of international protection (UNHCR 2020b). IOM has issued guidance on such issues as consular relations and mobility corridors or bubbles (IOM 2020a).

4. Effects of pandemic on migrant populations: Singapore, US, other cases

The novel coronavirus pandemic has underscored the vulnerability of migrant workers as an occupational group. Travel bans, lockdowns and social distancing have impacted local and global economies, hitting migrant populations hardest. As noted above, there are almost 300 million international migrants in the world. A significant number of migrants are low or semi-skilled workers, who live in crowded housing environments with inadequate sanitation and hygiene - all of which make a favorable environment for disease spread among workers and their families. Not only does the migrant population have an increased risk of exposure and infection they also are particularly at risk of losing employment, wages, and health insurance coverage as a result of the loss of businesses and services.

Migrants living in rural locations or in segregated communities may lack communication networks to the larger community, miss early, crucial messages on infection prevention control and can underestimate their exposure risks. Low-literacy resources on hand-washing, social distancing and other containment measures has been limited outside humanitarian settings. Migrants may be discouraged to find care or request help and face barriers to getting basic health needs met due to cultural and language barriers, financial constraints, and/or ineligibility for programs. The effect of epidemics and pandemics on undocumented migrants is a global issue but it falls beneath many political and social radars. Undocumented migrants lack basic legal rights to residence in their host country so while they fall into similar risk categories as other migrants, they have no relationship or mode of communication with the healthcare sector, no source of treatment or care and could be additionally burdened by underlying health conditions as a result of the lack of healthcare (Bhopal 2020).

Migrants provide a range of skills and professions that are essential to a community in routine day-to-day, during a pandemic they become crucial to response and recovery. These

sectors include healthcare workers, store clerks, cooks and agricultural workers, among many others. In the U.S. for example, 30 percent of doctors and 27 percent of farm workers are foreign born. In Australia, 54 percent of doctors and 35 percent of nurses are immigrants (Foresti 2020). The effects of the pandemic and resulting economic impact also affect the families and communities of migrants' origin. The World Bank estimates that the flow of remittances will decrease by 20 percent in 2020 as a result of the pandemic and resulting shut-downs affecting all regions of the globe. The drop, due to a decrease in wages and increase in unemployment of migrant workers, represents a major blow to low and middle-income countries (LMICs) and a loss of financial support for many vulnerable households. Remittances alleviate poverty in LMICs, improve nutritional outcomes, are associated with higher spending on education, and reduce child labor in disadvantaged households (World Bank 2020).

As a small nation of 5.7 million, Singapore was one of the first to detect cases of COVID-19 in early February and enact measures to effectively contain the virus within its borders. While cases grew in March, mainly due to citizens and residents returning from other countries; these individuals were subsequently quarantined or issued a stay-at-home notice for 14 days upon returning. However, a surge in April was linked to local transmission. The majority of new cases were found among migrant workers living in dormitories, a population overlooked by the Singaporean government in its containment efforts. By early May, 88 percent of all cases were from migrant dormitories with a single dormitory, of 13,000 workers accounting for 12.5 percent of all cases in the country (Singapore, Ministry of Health 2020). The reason for Singapore's surge was that national testing strategies failed to consider the over one million migrant workers who live and make up a significant portion of the workforce in the city state. Most migrants are employed in construction, manual labor, and housekeeping. Of these, an estimated 200,000, mainly males from South Asia, live in 43 purpose-built dormitories with an estimated 10 to 20 residents in each house who share toilet and shower facilities, eat in common areas, and sleep feet away from each other. The larger dormitories, which house up to 25,000, were built for communal living and include on-site groceries, recreational facilities, and remittance services and are managed by operators regulated by the Ministry of Manpower (Singapore, Ministry of Manpower 2020).

Singapore responded quickly and effectively to the virus: creating a task force, establishing a quarantine of the dormitories and extensive testing and segregation of healthy and ill residents with daily monitoring, and providing on-site healthcare facilities. The local community created websites to provide educational messages in migrants' languages and to recruit volunteer interpreters. Massive efforts were put in place for migrant housing facilities that

allowed for proper social distancing, monitoring and enforcement of quarantine and services including food, hygiene maintenance (reusable masks, hand sanitizer and thermometers), and Wi-Fi to communicate with family abroad (KOH 2020). While Singapore's response to the surge in cases was swift and effective, proper inclusion and consideration of migrant health in pandemic preparedness planning and response could have prevented such herculean efforts. Migrant workers in Singapore are not just at higher risk for COVID-19; cases of enteric fevers and tuberculosis have been on the rise while half of all diagnosed hepatitis E cases were associated with migrants. Those who work outdoors without proper protections are at higher risk of vector-borne diseases like dengue, Zika and chikungunya (Sadarangani et al 2017). In order to prevent further epidemics, Singapore, and other countries that rely on migrant workers, should implement policies and programs including education on hygiene, sanitation and nutrition alongside vaccine campaigns (when possible) for at-risk diseases and access to healthcare.

As noted above, COVID-19 and the US government's response disrupted virtually every aspect of the immigration system, including border closings, suspension of immigrant processing and limiting social services to immigrants. In addition, tens of thousands of people remain in immigration detention despite the high risk of COVID-19 transmission in crowded jails, prisons, and detention centers that U.S. Immigration and Customs Enforcement (ICE) uses to hold noncitizens. Not only were asylum-seekers prohibited from seeking protection in the US, the pandemic led to the suspension of almost all immigration court hearings and limited the functioning of those few courts which remain open (American Immigration Council 2020).

While immigrants are a large and ever-growing part of American society, they are also disproportionately low-income and uninsured. A number of those unemployed as a result of the pandemic have had to rely on publicly-funded health care for screening and/or treatment of COVID-19 however, due to eligibility restrictions, those who have not yet become US citizens do not qualify for Medicaid. Having populations of individuals without access to care or information on how to protect themselves creates an opportunity for virus transmission spreading across communities and the country. Unemployment places additional stress on migrants' access to health care. A recent study by the Migration Policy Institute provided scenarios for the impacts of unemployment on access to healthcare services. They estimate that before the pandemic about 4 percent (or 7.7 million) of those unemployed did not have public or private health insurance coverage. Using medium and high-unemployment scenarios they concluded that 17.5 percent and 25 percent (respectively) would be uninsured (Capps & Gelatt 2020).

5. What we learn about migration and global governance from the pandemic?

While it is likely that both internal and international migration will change in response to the pandemic, migration will continue to play a major economic and social role in the post-pandemic world. “Indeed, the immediate response of states across the globe to the spread of COVID-19 has been to close borders; however, the fundamental factors that led to an interconnected world will remain relevant. Information technology, social media, electronic payment systems, sophisticated shipping systems, multinational companies and complex international business structures are part and parcel of life in the twenty-first century and are unlikely to disappear” (Hafuel-Radoshitzkey & Heistei 2020) The fact is that the global economy depends on free movement of capital, services and migrant workers and that hundreds of millions of families live in different countries. As long as there are disparities in standards of living, people will move to where they can support themselves and their families. And unless there is a sharp reduction in conflict and human rights abuses, and the many on population movements, it is unlikely that either internal or international displacement will diminish. However, the pandemic will impact both national policies toward migrants and international governance of international migration and forced displacement.

On the national level, COVID-19 and migration restrictions are a boon to nativist nationalists – a trend apparent in democratic states over the past decade and characterized by the rise of right-wing, anti-immigrant political parties. The end of the Cold War and the 9/11 attacks changed the public discourse on migration to focus on international security in addition to the economic, social, cultural and humanitarian contexts. Now the COVID-19 pandemic is adding a public health dimension to traditional security concerns where migrants are seen as carriers of disease. The ‘fear of the other’ now includes a health dimension. Stigmatization, misinformation and discrimination are already leading to a rise in xenophobia (United Nations 2020)

As Sandvik and Garnier (2020) note, we are likely to see even more herding and lockdown of migrants and the exacerbation of marginalization of migrants. Given the dependence of modern developed economies on migrant labor, governments are faced with a choice. In some cases, such as Singapore where migrants make up over 40 percent of the population (Statista 2020), curtailing migration would mean either a drastic economic decline or a fundamental change in its economic model. In these cases, governments would be well-advised to ensure inclusion of migrants into their national public health systems. Thus,

countries such as Portugal, Canada and the United Kingdom have expanded access to health services to migrants. Other governments may try to expel migrants as a way of dealing with the potential public health threat; the US government expelled some 14,000 migrants in April 2020 (Montoya-Galvez 2020) while Saudi Arabia has expelled large numbers of undocumented Ethiopian migrant workers (Endeshaw & Paravicini 2020). And in yet other cases, governments may try to impose more restrictions on migrants while recognizing the need for their labor; Germany brought in 40,000 migrants in April 2020 to harvest asparagus while imposing strict limits on their movements and interactions with the local population. This ‘quasi-quarantine’ model is likely to become a more frequently-used mechanism for securing needed migrant labor (Hurst 2020). In another model, some governments are setting up migration ‘bubbles’ which allow travel between countries regarded as relatively safe while excluding others (Chugh 2020).

While some governments may expand health coverage to migrants in recognition of the fact that public health depends on the health of migrants, others will further marginalize migrants, particularly undocumented migrants, limiting access to social services, including public health. If migrants continue to work in essential industries and services, but do not have access to health services, they are likely to be disproportionately at risk of disease and of spreading the disease.

One of the striking characteristics of response to the pandemic has been the turning inward and moving away from multilateral cooperation. Most striking is the case of US president Trump’s criticism and then withdrawal from the WHO in mid-2020. Rather than exercising leadership within multilateral bodies, the US rejected an expanded role for international cooperation, focusing instead on curtailing migration. The US withdrawal may lead to increasing Chinese influence in multilateral bodies such as the WHO.

In 2000, United Nations Security Council resolution (UNSCR) 1308 on HIV/AIDS and later UNSCR 2177 in 2014 on Ebola both underscored that the control of infectious disease required urgent action and a coordinated international response to the pandemic. In the case of COVID-19 – a much greater threat to international peace and security than either HIV/AIDS or Ebola -- the Security Council was painfully slow to react, largely because of US insistence on calling the disease the ‘Wuhan’ or ‘Chinese’ virus for months. It was not until early July 2020 that the Security Council adopted a resolution (UNSCR 2532) on COVID-19 (UN Security Council 2020). The resolution endorsed the UN Secretary-General’s call for a global humanitarian ceasefire and asked for UN agencies and peacekeeping operations to assist with response to COVID-19. But there was only passing mention of the need to work

together and no mention of a commitment to strengthening global institutions to the pandemic or the central role of the WHO.

The lack of a strong multilateral response to the pandemic emphasizes the trend of declining commitment to international institutions and global governance and the growth of what some characterize as the ‘illiberal world order.’ And yet the impact of the pandemic on the global economy and on migration trends – notably the sharp decline in remittances – are global problems that require a strong collective response. The World Food Program, for example, is sounding the alarm of a dramatic increase in world hunger, pointing to an increase in the number of food-insecure persons from 149 billion to 270 million by the end of 2020 without a massive increase in international support (UN WFP 2020). The fact that it took the international community such a painfully long time to adopt a simple Security Council resolution on the pandemic does not inspire optimism in the potential for an effective response to the long-term global problems which will result from COVID-19.

And on the issue of migration governance, the 2018 adoption of the Global Compact on Safe, Orderly and Regular Migration seemed to herald a new phase of global cooperation on migration and underscored the need for countries to work together to address shared concerns, including global health. While governments have always resisted cooperating on migration issues – seeing it as fundamental to their national sovereignty – current trends suggest that implementing the Global Compact on Migration will become even more difficult in the future.

6. What we learn about pandemics from migration?

We must use our evolving understanding of emerging disease threats, the environment, and human behavior (including migration) to inform policies and procedures for disease prevention, containment and response. It is clear that the volume and frequency of global travel and migration will remain a key way of life post-COVID-19. Up until now, research has shown little evidence that travel restrictions and border closings alone can prevent disease spread. This is echoed in the IHR, focusing on detection and response at source, strengthening surveillance and response at Points of Entry, and on enabling global communication channels rather than border closures. In addition, it is now more important than ever for nations to consider social determinants of health frameworks in designing and providing health care. As we outline above, migration will continue to increase as people move to where they can support themselves and their families. Migrants contribute to basic infrastructure, culture and economy and have become, for many global cities, the backbone of a number of essential functions.

Migrant health often remains sidelined in broader discussions on migration. Available data is insufficient to inform and support robust health systems for migrant care, placing migrants in a forgotten demographic in national health strategies. To date action from the international community is lagging behind the commitments made in international compacts and agreements including the Global Compact on Migration (UN 2018), the New York Declaration (UN 2016), the Global Human Rights Framework (International Justice Resource Center), WHO Constitution (WHO 2006) and the 2030 Agenda for Sustainable Development (UN 2015) which directly and indirectly promote migrant health. The responsibility rests with States to respond to the health needs of migrants. It is our hope that with the acceptance by States of their responsibility to ensure adequate standards of care for health and human rights, coupled with the on-going threat of emerging infectious diseases in our interconnected world that coordination will/can occur between government and organizations to consider and plan for the inclusion of migrant health in national health programs and pandemic preparedness and response plans. This is not a short-term problem brought to light by the COVID-19 pandemic; we must ensure access to health care for migrants not only as human right but a critical component of health systems strengthening and global health security.

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