THE IMPACT OF COVID-19 ON GLOBAL MIGRATION

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27 May 2020

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Introduction and Overview

COVID-19 has brought the movement of people to a halt as individual states and whole regional blocs have introduced travel restrictions. Some have been more cautious than others in accounting for international laws and conventions intended to protect human rights, specifically as they relate to refugees and asylum seekers. However, as this working paper will show, those stipulations have not stopped states from essentially shutting down asylum and refugee reception programmes. From the North America to Europe, the right to seek asylum and refuge has all but been eliminated during the COVID-19 pandemic, leaving countless migrants stranded in precarious conditions. Furthermore, though the virus has been slower in reaching humanitarian response areas, it has nevertheless arrived leaving inhabitants who were already in precarious living conditions highly vulnerable to infections. Multilateral institutions including the World Health Organization (WHO), United Nations High Commissioner for Refugees (UNHCR), and the International Organization for Migration (IOM), have provided guidance on how to ensure human rights protections for displaced migrants residing in both camp and non-camp settings.

These frameworks have slowly begun to be tested as humanitarian actors on the ground respond to outbreaks in refugee camps and displaced migrant communities around the world. However, much of this guidance hinges on indirect assumptions that these camps were already equipped with basic health and safety infrastructure such as water, sanitation, and hygiene (WASH) provision. Status reports from humanitarian areas show that access to WASH in camp settings is patchy and limited at best, medical services are limited, and living conditions cannot necessarily accommodate social distancing measures which brings into question their ability to withstand the added pressure associated COVID-19 response.

Although conditions for migrants living in non-camp settings are not as dire, COVID-19 has raised key issues for displaced and settled migrants in host countries. Most pressing during a global public health crisis is the fact that migrants, documented or not, are more likely not to have access to health care—a reality that has serious implications for broader society. In response, some states have increased access to health services to all immigrants, regardless of immigration status. However, these policies appear to be the exception, not the rule, which means migrants with precarious immigration status may not have access to health care even during a global pandemic. COVID-19 has introduced additional threats to migrants' access to consistent/safe accommodation—an issue that is inherent in displaced migration—leaving many at risk of homelessness. In response, some states have provided relief for migrants at risk of losing their accommodation by halting evictions, and others have stepped in to provide accommodation for rough sleepers.

An issue at the core of displaced migration is the legal framework that defines immigration systems. COVID-19, through the travel restrictions that it ensued, has made certain components of immigration enforcement difficult, if not impossible, to implement. Specifically, practicalities around issuing detention orders, carrying out deportations, as well as the legality of extended immigration detention have created real barriers to immigration enforcement in the interior. States have responded by halting detention orders, releasing immigration detainees, halting deportations, and extending expiration dates on residency documents. These actions, however, have not been implemented across the board which brings into question whether those who have not are still in compliance with international law.

Migrants are also overrepresented in other frontline occupations such as retail and wholesale, which means they are at a higher risk of being infected. In addition to this, immigrants have been found to be overrepresented in occupations that have been hit the hardest by global economic shut downs, such as accommodation, food, and personal services which means they are the hardest hit by the economic collateral damage of mitigation measures. Simultaneously, bureaucratic barriers such as costly and time-consuming reaccreditation processes often stand in the way which leaves highly qualified healthcare workers relegated to lower-paid non-medical occupations.

In this working paper we take a global perspective in using policy materials to detail the impact of COVID-19 for displaced migration and refugees, specifically with respect to the closure of borders, travel restrictions and the implications for asylum responsibilities therein. Presently, at least 57 CTAs (countries/territories/areas) are making no exception for refugees seeking asylum, even though WHO offers clear guidance on the use of quarantines and health screening measures at points of entry for those fleeing persecution. In formal and informal camps meanwhile, the level of provision and preparedness varies enormously and in many cases few substantive measures have been put in place.

The working paper documents country and regional developments, and includes the role of multi-level stakeholders who help make up the field of migration and refugee policy and provision. A key observation is that what is at risk is not just viral contagion, but the very basis of the international refugee conventions that have shaped our post-war landscape. This includes the principle of 'non-refoulement' which is the cornerstone of international refugee protection. Enshrined in Article 33 of the 1951 Refugee Convention, this principle insists that 'No Contracting State shall expel or return ("refouler") a refugee in any manner whatsoever to the frontiers of territories where his [or her] life or freedom would be threatened on account of his [or her] race, religion, nationality, membership of a particular social group or political opinion.' Temporary travel restrictions therefore should not apply to people with need of international protection or for other humanitarian reasons. There are ways to manage border restrictions in a manner which respects international human rights and refugee protection

standards. It is imperative that in all the uncertainty accompanying this virus these approaches and standards are upheld.

Temporarily Reintroduced Border Controls

In response to the global COVID-19 pandemic, countries around the world have implemented various border control measures on the grounds of preventing further spread of the coronavirus. Measures range from state-specific travel restrictions to complete border closures, and as this text will show, some have gone so far as to dismantle entire international asylum processes.

Travel restrictions by the numbers

As of April 9, 2020, roughly 46,000 mobility restrictions and measures have been issued by governments and authorities.[1] Nearly all international borders are closed for non-essential travel with additional measures implemented to allow for exceptional movements.

Roughly 196 countries/territories/areas (CTAs) have imposed restrictions, with the bulk of those (178 CTAs) imposing over 201 mobility restrictions per CTA. Further, 248 CTAs have had restrictions imposed on them with the bulk (244 CTAs) having between 151-200 restrictions per CTA.

Table 1. Travel Restrictions and Exceptions, by number of restrictions and CTAs, 2020

Most Common Restriction Measures	
Entry restrictions for passengers from restricted CTAs	38,293 restrictions
Medical requirements (such as quarantine)	5,738 restrictions
Visa requirements/arrangements changed	422 restrictions
Restricted nationality	299 restrictions
Other	1,208 restrictions

Key Travel Restriction Exceptions	
Nationals (including family)	97 CTAs
Residents (including family)	82 CTAs
Humanitarian workers	36 CTAs
Healthcare workers	22 CTAs
Those in need of urgent medical treatment	12 CTAs
Cross-border workers	7 CTAs
Other	56 CTAs

Additionally, the International Organisation for Migration (IOM) assessed 2,619 Points of Entry (PoEs) across 156 CTAs including border crossings, airports, sea border points, and internal transit points and found that only 9 percent remained open.

Figure 1. The Operational Status of IOM Assessed Points of Entry, 2020
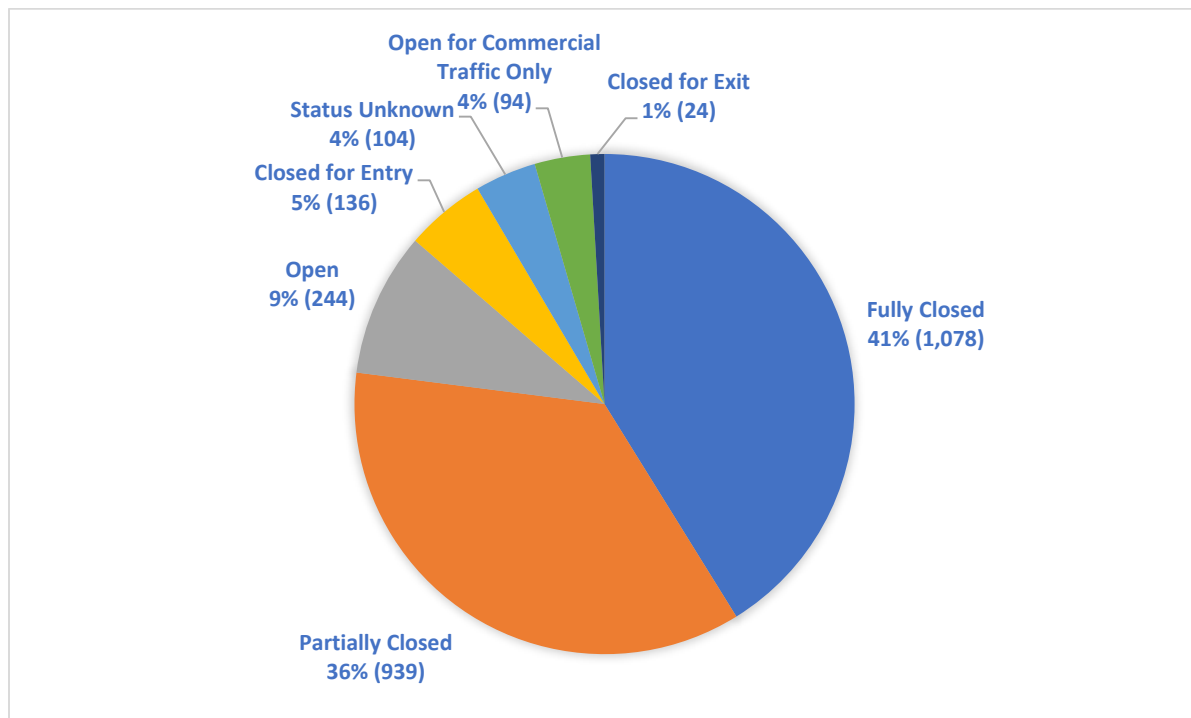
Source: Analysis of IOM's publication, 'DTM (COVID-19) GLOBAL MOBILITY RESTRICTION OVERVIEW', April 9, 2020.[2]

European Union Policy and Guidance

On March 17, 2020, the EU Commission and the European Council agreed to adopt a 30-day coordinated restriction on non-essential travel to the EU as a measure to contain the further spread of COVID-19 within the Schengen Area.[3] As a result, all Schengen Member states and the four Schengen Associated States – Iceland, Liechtenstein, Norway, and Switzerland – have applied these restrictions.[4] This restriction was subsequently extended on 8 April through 15 May 2020.[5] This travel restriction includes exemptions for specific categories of travellers and the commission provided guidance to border guards and visa authorities to facilitate the repatriation of citizens stranded abroad and to ensure the free movement of workers, especially in the health care and food sectors.[6]

According to EU Commission, temporarily reintroduced border controls do not apply to EU citizens, citizens of non-EU Schengen countries and their family members, and long-term non-EU national residents for the purpose of returning home. To limit the minimum impact on the general functioning of society, Member States were advised not to apply the restrictions on essential staff (medical practitioners and health workers, researchers, frontier workers, seasonal agricultural workers, etc.).[7] Furthermore, EU Member States and Schengen Associated Countries are allowed to refuse entry at the external borders to 'non-resident third-country nationals where they present relevant symptoms or have been particularly exposed to risk of infection and are considered to be a threat to public health. Member States must allow their own citizens and EU citizens or third country nationals legally residing on their territory to enter.

Asylum, refugee, and immigrant protections during the COVID-19 pandemic

While the EU Commission has been able to release guidance that applies to the whole bloc, other countries have acted unilaterally to institute travel restrictions and border closures. Of primary concern is whether these travel restrictions and/or subsequent state action are having an impact on international protection for asylum seekers and refugees. According to UNHCR, neither the 1951 Refugee Convention nor the EU refugee law provide any legal basis for suspending asylum applications,[8] and while irregular migrants may be detained for a limited amount of time, "arbitrary detention is prohibited under international and European human rights law" and removal must be the result of individual determinations, not blanket application of policy.[9]

In terms of the EU, member states are bound by the EU Charter of Fundamental Rights which guarantees the right to seek asylum.[10] This means that denying people access to asylum is not only illegal under EU law but may also violate the fundamental principle of nonrefoulement which is the prohibition on returning refugees or asylum seekers to a country where they are liable to face persecution or serious violations of their rights.[11] Consequently, the European Commission stated that temporary travel restrictions should not apply to travel by people with an essential need, including persons in need of international protection or for other humanitarian reasons (i.e. asylum seekers).[12] Notwithstanding these guidelines and inalienable protections, the European Court of Justice recently found several EU member states guilty of thwarting their asylum responsibilities by illegally opting out of EU treaties that require them to take their allotted share of asylum seekers from.[13] In its April 2, 2020 decision, the Court ruled that Hungary, the Czech Republic, and Poland were not allowed to argue they could not relocate asylum seekers from Greece and Italy under the guise of maintaining public safety and law and order.

Given the potential for vastly different interpretations of international protections, heightened scrutiny should be applied to state action during this time of pandemic to fully comprehend whether countries are using COVID-19 as an excuse to dwindle the rights and protections that displaced migrants are entitled to.

Evidence of Impact

To support this claim, the rest of this paper is dedicated to show how targeted states' asylum processes have been altered through their COVID-19 mitigation efforts. States represented in this include key destination and transit countries in North America, Central America, and Europe. This section will provide an overview of multilateral policy guidance on how to protect refugees and migrants across various settings in light of COVID-19. This policy overview will be contrasted with a status update on how certain humanitarian relief areas, including official and unofficial refugee camps, are responding in light of those directives. Lastly, this section will delve into how certain domestic policies in relation to health, accommodation, legal enforcement, and workforce are affecting immigrants, refugees, and asylum seekers in the interior.

Access to Asylum

In truth, the U.S. began dismantling their asylum processes at the southern border well before the COVID-19 pandemic started. Since January 2019 the Trump Administration had been operating under the "remain in Mexico" policy which requires those seeking asylum at the southern border to wait in Mexico while their application is being processed as opposed to being admitted into the US and waiting there.[14] So far under this policy, 60,000 asylum seekers have been returned Mexico while they await for their applications to be adjudicated—Mexican national or not.[15] Since COVID-19, however, the U.S., Canada, and Mexico have all instituted some type of restriction on asylum seekers.

Table 2. Status of Asylum Systems in North America, 2020

Country	Access to Asylum open or closed?	Restriction Details	Estimated Impact
U.S.	Closed	• On March 20, 2020, the U.S. Centers for Disease Control and Prevention (CDC) within Department of Health and Human Services (HHS) issued a rule formalizing their authority to "suspend the introduction of persons into the United States" to prevent	• Customs and Border Protection (CBP) has been expelling all migrants at the border in an average of 96 minutes.[19]

		the spread of a communicable disease (i.e. COVID-19).[16] Essentially, this means individuals will not be admitted into the U.S. from the southern border, even if they are seeking asylum.[17] • This rule will be in effect for one year, or until HHS determines it is no longer necessary. As a result, the US has been deporting anyone caught crossing between official ports of entry, including those hoping to turn themselves in, denying them access to asylum entirely.[18]	• In March, 6,444 migrants were expelled under this new order and in April 14,416 were expelled totalling 20,860 people that have either been sent to Mexico or to their home countries.[20] • It is estimated that close to 400 children have been expelled under this new order.[21] • Only two people have been allowed to pursue humanitarian protection at the southern U.S. border since the rule was issued.[22]
Canada	Closed	• On March 20, 2020, Canada stated they would begin turning back asylum seekers who walk in from the U.S. outside of official border crossings.[23]	• Six asylum seekers were turned back at Canada's border with the United States under recent COVID-19 restrictions, four of them irregular border crossers, from March 21 to April 2, according to data from Canada Border Services Agency (CBSA).[24]
Mexico	Open	• Mexico designated registering new asylum claims an essential service, therefore Mexico's refugee office, COMAR (Comisión Mexicana de Ayuda a Refugiados) remains open, though legally mandated processing times for asylum claims have been suspended due to COVID-19.[25] • Asylum seekers are concentrated along Mexico's northern border with the U.S. as well as the southern border with Guatemala which is the gateway for migrants coming from south and central America.	• An estimated 12,500 asylum seekers are stranded at the northern border and an additional 9,000 asylum seekers are stranded at the southern border. [26] • Border restrictions in central/south America have resulted in a 90 percent decrease in asylum applications in Mexico.[27]

			• There have been nearly 17,800 new asylum claims in 2020 principally from nationals of Honduras, Haiti, Cuba, El Salvador and Venezuela.[28]

Table 3. Status of Asylum Systems in Central America, 2020

Country	Access to Asylum open or closed?	Restriction Details	Estimated Impact
Costa Rica	Closed	• The Refugee Unit has been closed to people of concern which means no new asylum claims are being formalized.[29]	• 25,900 people are awaiting processing and

Table 4. Status of Asylum Systems in Europe, 2020

Country	Access to Asylum open or closed?	Restriction Details	Estimated Impact
Belgium	Closed	• On March 18, the first day of the government's containment measures, the authorities closed the Office for Foreigners, the place where asylum applications are lodged. It is therefore - for the time being - no longer possible to apply for asylum in Belgium.[30] • New asylum seekers can no longer receive government support under the national reception system, which	• **Unknown**

		includes housing, medical care and financial assistance.	
Greece	Closed	• Asylum services and all asylum applications were suspended for a month starting March 1st, a suspension that was subsequently extended until May 15th.[31] On March 26, the Greek parliament ratified a March 1, 2020 government decree suspending access to asylum for 30 days for people who irregularly entered the country, stating that all new arrivals should be immediately deported either to their countries of origin or transit countries, such as Turkey, without registering them. Since then, however, no deportations have occurred because Turkey has refused to accept any deportees from Greece.[32]	• As of March 31st, Greek authorities were arbitrarily detaining nearly 2,000 new arrival migrants and asylum seekers in unacceptable conditions, and denying them the right to lodge asylum claims, in two recently established detention sites on mainland Greece.[33]
Italy	Closed	• The Italian government declared its ports unsafe essentially closing its borders to sea-rescue ships.[34] • Police immigration offices and offices of Territorial Commission are closed and interviews have been suspended.[35] • People can go to Questura to manifest intent to apply for international protection.[36]	• **Unknown**
UK	Closed	• Resettlement to the UK has been temporarily suspended by	• **Unknown**

		UNHCR, the IOM and the UK government.[37]	
Germany	Closed	• Germany has suspended its humanitarian refugee admission programs. A spokesman for the Federal Ministry of the Interior confirmed that the Federal Office for Migration and Refugees had been instructed to suspend the proceedings.[38]	• **Unknown**
Netherlands	Closed	• The asylum application process has been suspended and the Immigration and Naturalisation Service stated that until 6 April 2020, the Central Agency for the Reception of Asylum Seekers "will not receive or admit foreign nationals arriving in the Netherlands to a reception centre."[39]	• **Unknown**

Refugee camps and other humanitarian response areas

Multilateral Policy Framework

The World Health Organisation (WHO) issued [Interim guidance for refugee and migrant health in relation to COVID-19 in the WHO European Region (2020)](#) which is intended for use by health authorities to guide the actions taken by health-care providers for refugees and migrants in relation to COVID-19 in all types of settings. The document stipulates that general recommendations made by WHO for COVID-19 response supersede these guidelines, but clarifies that unfounded measures regarding testing, health screening and quarantine should not be imposed on refugees and migrants.[40] The guidance includes seven recommendations which are rooted in a rights-based approach that all migrants have a human right to health, and specifies the following:

1. Healthcare initiatives should include all migrants.

2. Control measures recommended should be afforded refugees and migrants without imposing unfounded testing or quarantine.
3. Prevention/diagnostic/infection control plans should include measures to reach marginalised/hard to reach groups.
4. Information should be provided in the appropriate languages and governments should consider utilising community-based organisations or ethnic/religious media to distribute information as they may be trusted more.
   a. Involve members of refugee and migrant communities to check material for accuracy and cultural relevance
5. Governments should consider appropriate technologies that may be more effective as they may not have online access.
   a. Flyers
   b. Call centres
   c. In-person channels
   d. Texting or social media key messages
6. Make sure to address fears that may prevent migrants and refugees from seeking help.
7. Specific strategies for points of entry (to camps I assume?)
   a. Provide prevention recommendation messages and practical information on how to access health services
   b. Collect health declarations at arrival
   c. Collecting contact details to allow for a proper risk assessment and possible contact tracing should it be needed

In addition to this, on March 17, 2020 WHO, IOM, UNHCR, and IFRC co-published [Interim Guidance on Scaling-up COVID-19 Outbreak in Readiness and Response Operations in Camps and Camp-like Settings](). This guidance may apply to internally displaced persons (IDPs), host communities, asylum seekers, refugees and returnees, and migrants when in similar situations, although they might need to be tailored a bit to people living in slums. The document covers eight focus areas:

1. Coordination and planning (proactive)
2. Risk communication and community engagement (proactive)
3. Surveillance, case investigation, and outbreak rapid response team (proactive)
4. Individual health screening (proactive)
5. Laboratory system (proactive)
6. Infection prevention and control (proactive)
7. Case management and continuity of essential health services (reactive)
8. Logistics, procurement, and supply management (reactive)

Proactive recommendations revolve around developing site-specific response plans; ensuring there are reliable lines of communication to share accurate information; developing infection prevention and control measures for all households on site; and ensuring strong surveillance systems are in place to quickly identify and respond to potential cases. Reactive measures are aimed ensuring provision of services and assistance to individuals will continue throughout the site under restricted movement and access.

While these directives provide a helpful policy framework, these policies should be considered against the backdrop of real-life conditions in some of the major camps.

Table 5. Status of COVID-19 in Key Refugee Camps, 2020

Refugee Camps Placed Under Quarantine/Lock Down		COVID-19 Cases
Greek islands	There are an estimated 42,000 displaced migrants across all five Aegean isles, and holding facilities across all five isles, Ritsona Camp (north of Athens) and Moria Camp (Lesbos), are currently six times over capacity.[41] As of April 2, 2020, the Ritsona camp was housing 3,000 migrants and was placed under quarantine after 20 asylum seekers there tested positive for coronavirus.[42] Quarantine in this camp means movement in and out will be restricted for at least 14 days which will be enforced by police forces monitoring the implementation of the measures. The infections observed at Ritsona camp are now the first known cases among the thousands of asylum seekers living across Greece. On April 5, 2020 the Malakasa camp near Athens was placed in isolation for 14 days after a man tested positive.[43] On April 21, 2020 it was reported that 148 asylum seekers in a hotel managed my IOM tested positive for COVID-19.[44] The hotel is located in the southern town of Kranidi and hosts around 450 asylum seekers, most of whom are from Africa.	**Ritsona Cases**: 20 **Deaths:** 0 **Moria** **Cases:** 0 **Deaths:** 0 **Other:** 148
Hal Far, Malta	A refugee camp in Hal Far that currently houses around 1,000 migrants (mostly African) was placed under	**Cases:** 0 **Deaths:** 0

	quarantine after eight migrants tested positive for coronavirus.[45]	
Cox's Bazaar District, Bangladesh **Cases:** 232[46] **Deaths:** 0	A lockdown was imposed on the Cox's Bazaar District which is where the Kutupalong Refugee Camp that houses over one million Rohingya refugees is located. There have been 218 COVID-19 cases and 20 deaths reported in the district which spans beyond the refugee camp. Four COVID-19 cases have been identified in the camp as of May 20, 2020.	**Kutupalong Refugee Camp** **Cases**[47]**:** 4 **Deaths:** 0

Figure 2. Refugee Accommodation in Northern France

A refugee camp in Calais, France currently provides shelter for over 1,000 people without proper sanitation, water supplies or food. The number of people exhibiting symptoms of COVID-19 rose from two to nine in just three days as of April 9th.

While local authorities began moving people into formal accommodation, NGOs in the area say it will not be enough as the accommodation centres currently only have capacity for 400 people in total and there are thought to be about 1,500 people sleeping rough in informal camps in northern France.

Sources: https://www.theguardian.com/global-development/2020/apr/09/covid-19-spreading-quickly-though-refugee-camps-warn-calais-aid-groups#maincontent

Similarly, refugee camps and regions that have absorbed hundreds of thousands of displaced migrants in the middle east face unique obstacles in being able to implement multilateral guidance and directives.

Table 6. Status of COVID-19 Among Refugees in Key Middle Eastern Areas, 2020

Status Report for Camps and Regions of Special Attention in Middle East		COVID-19 Cases
Syria[48] **Cases:** 44[49] **Deaths:** 3 **Recovered:** 27	***Idlib Province-*** As of May 6, 2020 there were no confirmed cases in the north-west region of Syria, however, health officials there fear as many as 100,000 might die unless medical supplies arrive urgently.[50] This pocket of rebel-held territory is home to over three million people, half of whom have been displaced from elsewhere in the country, according to United Nations estimates. Many have been displaced repeatedly — as many as five times—and children account for half the population, according to Save the Children.[51] A cease-fire in the region started in early March, but is not expected to last long.	**Cases:** 0 **Deaths:** 0

Key obstacles in the region include:
- A health system in ruins
- Weak disease surveillance
- Population density
- Low levels of sanitation services
- Poor response capacity
- Suboptimal levels of public health preparedness
- Living conditions
- Staffing and medical equipment shortages

WHO has shipped over 5,000 tests to a lab in Idlib city and is seeking to accelerate further shipments, anticipating possible restrictions or disruptions in the cross-border flow of aid in coming weeks. However, they are in need of more protective equipment but their access to global supplied are affected by COVID-related restrictions. In meantime, a local organisation is mobilising the manufacture of facemasks (about 100/day) that it is distributing to refugees and hopes to make home-made hand sanitizer in the coming weeks.[52]

al-Hol Camp- As of May 3, 2020, there have been three COVID-19 confirmed cases in the north-east region of Syria where the al-Hol detention camp is located, although not linked to the camp itself. [53] Al-Hol is the largest of the camps on the region and most of the inhabitants are the wives and children of ISIS fighters.[54] Though the majority of these camps' inhabitants are children and women under 50, a great many may already suffer from pneumonia, chest infections and tuberculosis, which are considered co-morbidities.[55] The last WHO report on the camp (for the reporting period Oct-Dec 2019) identified that 68,080 inhabitants continued to seek shelter in a camp originally designed to house only 10,000 people and that the total number of available health services in the camp are[56]: • 15 static medical points • 8 medical mobile teams • 3 delivery clinics • 2 HIV and TB clinics • 3 field hospitals • One static point for vaccinations • One static point for leishmaniasis • One mobile medical team As of April 3rd, the field hospital run ICRC with the Syrian Arab Red Crescent remains open. Right now they have 16 health staff working in	**Cases:** 0 **Deaths:** 0

	the hospital (surgeons, nurses and physiotherapists) conducting around 200 consultations per week and around 20 surgical procedures. They are receiving around 24 patients per week and perform around 44 physiotherapy sessions.[57] Preventative measures introduced include[58]: • fencing to avoid overcrowding • additional handwashing points • extra protective equipment for triage staff • relatives are not allowed to accompany patients • screening before entry in the event of suspected cases • providing water trucking and garbage collection through contractors • delivering meals daily to tents individually, to avoid gathering and queuing In addition to this limited capacity, there are no COVID-19 testing kits in the camp, the inhabitants' have a precarious legal status, and aid has been cut off due to COVID-related restrictions.[59] Additionally, the annex (where non-Syrians and Iraqis are housed) hasn't received medical services in months and information sharing into this area itself is a challenge because neither mobile phones nor flyers are allowed.[60] It has been recommended that Iraqi authorities and the Autonomous Administration in the north east to agree to a regular, two-way humanitarian exemption to the temporary border closure at Faysh Khabour, so that aid groups working across the Iraqi border can maintain their activities and supply lines in both directions.[61] Lastly, repatriation efforts from the al-Hol camp have been halted,[62] although Finland is still trying to evacuate children from the camp as of April 20th—there are currently about 30 Finnish children and roughly a dozen Finnish women at the camp.[63] Two orphans were brought to Finland from the camp in December last year.[64]	
Jordan	***Zaatari Camp-*** There are currently no confirmed cases of COVID-19 among the refugee population in Jordan.[65] As of April 13th, it was reported that the Ministry of Health undertook 150 rapid tests of COVID-19 in Zaatari camp, and all results were 100% negative.[66] Zaatari camp currently hosts about 76,000 refugees.[67] Measures implemented to stop the spread of the virus include: • Movement restrictions – only essential and health staff are being given access	**Cases:** 0 **Deaths:** 0

	• Refugees will continue to be able to access national health services on par with Jordanian nationals, including referral of suspect cases to quarantine sites, and requisite treatment. Plans are in place to isolate any suspected cases and evacuate them by ambulance to the nearby Mafraq and Zarqa hospitals.[68] • Measures in health and WASH sectors • Community mobilization activities have been increased with focus on health awareness • Distance learning for school children (there are 32 school in the camp with lessons for the more than 18,000 enrolled students now being broadcast on a television channel used by pupils across the country)[69] The UNHCR is operating a reduced team in Zaatari and Azraq.[70] All urgent protection needs continue to be addressed. Essential services including hospitals, clinics and supermarkets remain open. Temperature screening at the entrance has begun in both camps. Electricity provision has been enhanced (from eight to more than 12 hours each day) while water and sewerage services are normal. Information is being communicated via SMS, Whats App, and social media channels. There is a crisis management team reviewing daily developments with a coordinating body at the camp level. For camp supermarkets, additional hours of opening will be enacted, as well as restriction on bread buying and crowd control measures for male/female lines and provisions for the most vulnerable. Food rations have been pre-positioned in case of diminishing informal market, although goods and materials still allowed entry to the camp.[71]	
Lebanon	***Bekaa Valley-*** 40 percent of the country's registered refugee population of nearly one million live in rural areas like the Bekaa Valley, and more than half of that group are in informal camps or "non-residential structures" like makeshift tents or unfinished building. [72] To address the issue of self-isolating in refugee camps, UNHCR colleagues in Lebanon have launched a project to build isolation units inside refugee settlements around the country.[73] On 15 March Lebanon instituted a nationwide night-time curfew, and various municipalities put in place their own restrictions on the movements of the country's estimated 1.5 million refugees. Some have also limited the ability of aid workers to enter camps even though these informal settlements have so far had no documented cases of COVID-19. Aid groups say they are having a harder time getting non-coronavirus	**Cases:**1 **Deaths:** 0

medical care to refugees, and clinics that serve Syrians say they have seen a drop-off in visitors.[74]

Médecins Sans Frontières (MSF) has been a very active partner in the country and has undertaken the following COVID-19 response activities:[75]
- Increasing the number of beds available in their facilities- they are concerned the Bekaa Valley does not have enough beds if an outbreak occurs, so they are preparing teams to receive cases in their facilities too.
- Supporting government hospitals and isolation sites - in Zahle, central Bekaa, MSF supported the Elias Hraoui Governmental hospital by setting up a COVID-19 emergency room in the outdoor area of the premises. It will be used for pre-triage and triage of adult patients, and includes a waiting area and an area for testing.
- Building community engagement and awareness - MSF teams have been engaging with local and refugee communities by conducting a series of intensive health awareness sessions about COVID-19.

Lastly, fear of deportation will be keeping some refugees from seeking treatment for COVID-19.[76] According to a camp resident, "Everyone here has outdated papers and residencies that aren't up to date," and according to Human Rights Watch, Some 73% of Syrians in Lebanon lack residency permits, and authorities forcibly deported more than 2,500 refugees last year.[77]

On April 22, 2020, news broke of the first COVID-19 case in the Bekaa Valley that originated in the al-Jalil camp.[78]

Figure 3. Asylum Seekers Stranded in Mexico, 2020

Attending to those stranded in Mexico due to the U.S.'s "remain in Mexico" policy

Cuidad Juarez, Mexico- On April 14ᵗʰ, the International Rescue Committee (IRC) launched, together with local authorities and civil society partners, a public health awareness and psychosocial support campaign for shelters at the Mexico-US border in Ciudad Juárez. The project will directly benefit 17 shelters hosting approximately 3,000 individuals and reach surrounding host communities - indirectly benefiting an additional 10,000 people.

Over the last year, the US remain in Mexico policy, "Migrant Protection Protocols" (MPP) has left 60,000 migrants stranded in Mexico to wait for the outcome of their US hearings and subjected thousands more to "metering" lists that leave them waiting months in northern Mexico to present themselves to US authorities. The IRC programming will focus on mitigating and responding to the virus in shelters across Ciudad Juárez, Mexico, supporting 13,000 asylum seekers and surrounding community members.

In February, the IRC conducted an assessment across five shelters to understand the risks that could contribute to the spread of COVID-19 which included:
- Insufficient access to running water
- Inadequate availability of insulation or heating
- Limited access to private toilets
- Poor hygiene infrastructure
- No availability of space for self-isolation
- Absence of dedicated health personnel
- Inadequate safekeeping of medicine (where available)
- Overcrowded dormitories and common areas

The new programme will, with the support of local health authorities, include:
- Sessions on the transmission of COVID-19
- Protective and preventive measures, signs and symptoms of COVID-19
- Where to access help and support, reinforcement of public health best practices
- Information about any changes in services
- Trained volunteers from the shelters will support IRC with the dissemination of information related to COVID-19, including the distribution of flyers, using loudspeakers or working with community leaders or networks of churches.

Source: https://www.rescue.org/press-release/irc-launches-coronavirus-response-serving-asylum-seekers-and-vulnerable-families

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Domestic issues affecting displaced and settled migrants in host countries

On April 17, 2020, WHO released guidance for migrants who live in non-camp settings (i.e. immigrants living in the interior). According to the publication, excluding migrants from national programmes for health promotion, disease prevention, treatment and care, as well as from financial protection schemes for health and social services makes early detection, testing,

diagnosis, contact tracing and seeking care for COVID-19 difficult for refugees and migrants thus increasing the risk of outbreaks in these populations.[79]

Guiding principles to include migrant populations in COVID-19 response measures include:
- Ensure migrant populations have access health care services such as testing/diagnostic/care/treatment/referrals.
- Limit scapegoating and discrimination of migrant populations and prevent arbitrary restrictions/detentions/deportations, etc.
- Keep things people-centered by accounting for child/gender/age sensitive response measures.
- Account for migrant-specific vulnerabilities such as: underlying conditions/disabilities; the elderly; sexual violence/abuse/exploitation; other gender-based violence; unaccompanied/separated children; and people in detention.
- Account for workplace considerations such as ensuring fair working conditions; including then in health care/social insurance programmes; and provide flexible leave/pay arrangements.
- Ensure they are involved in designing readiness/response plans.

Table 7. WHO Recommendations for Responding to Migrants in Non-camp Settings, 2020

Recommendations[80]	
Coordination and Planning	Identify barriers to health facility access to remove them in order for COVID-19 response to be effective
	Accelerate universal health coverage that covers COVID-19 related procedures as emergency care to reduce out-of-pocket expenses
	Strengthen coordination of migrant community networks including pre-hospital, hospital care, and all other chains of command
	Provide necessary assistance through bilateral and international cooperation
Surveillance, case investigation and management, and infection control	Implement inclusive public health measures and interventions to reduce mortality and human-to-human transmission
	Include migrant populations in surveillance and health information systems by rapidly detecting and reporting cases and disaggregate data by age and gender
	Encourage community-based surveillance
	Strengthen community hygiene
	Mobilise/train staff in infection control in health facilities

Points of entry screening and quarantine safeguards (some not applicable due to travel restrictions)	Safeguards should be in place to prevent stigmitisation and discrimination at the border (i.e. there are no legal grounds to refuge entry to asylum seekers who have recovered from COVID-19)
	Increase public health capacity for immigration and border/port staff
Risk communication and community engagement	Support measures to improve communication and counter xenophobia
	Provide culturally and linguistically appropriate, accurate, timely and user-friendly information in accessible formats on the health facilities available for COVID-19 care
	Identify and work with groups able to communicate well with refugees and migrants
Occupational health and safety measures	Develop, reinforce and implement occupational health and safety measures. Refugee and migrant workers should have equal access to mental health and psychosocial support and services in the workplace including personal protective equipment.
	Ensure that refugee and migrant health workers enjoy the same level of health and safety protection at work as all other workers. This includes working hours, rest and recuperation. It also includes access: to infection prevention and control measures, mental health and psychosocial support, occupational health services, health care; and protection from violence, harassment and other occupational hazards.
	Strengthen social protection systems for all concerned populations including refugees and migrants. Sickness benefits and cash transfers for families and/or workers who have lost their livelihood as a result of COVID19 need special consideration.
	Provide functional basic utilities such as water, sanitation and hand washing facility) by employers for all workers including refugee and migrant workers.

Like the other multilateral guidance, many of the actions recommended are crucial not just in times of a pandemic, but really should be in place at all times. However, the reality is that migrant groups are systematically excluded from most social and health care programmes, a reality that is only being exacerbated during the current crisis. For example, how can you reinforce occupational health and safety measures if they don't currently exist or don't apply to migrant populations? Additionally, some of the recommendations apply not just to migrant groups but would serve to strengthen society as a whole; may require more long-term planning and capacity building; and may not be applicable given current state of global travel restrictions.

Nevertheless, some states have implemented short-term interventions/relief for displaced migrants already residing in their interior. Interventions to ease some of the disproportionate impact COVID-19 has placed on migrants include issues such as health, accommodation, legal protections, and economic/workforce efforts.

Health

As stated by WHO, failure to provide immigrant and refugee communities with appropriate access to healthcare services increases the risk of outbreaks in these populations. This is alarming given that in 2018, 7.7 million non-citizens lacked healthcare insurance in the U.S., for example.[81] Public health risks extend beyond those communities and in recognition of that, some states have opted to provide relief for migrant populations. Examples include:

Table 8. State Action to Provide Health Relief for Migrant Populations, 2020

Country	Nature of Relief Offered
Saudi Arabia	• King Salman announced last month that he would cover the treatment of anyone suffering from Covid-19 in the kingdom, including foreigners.[82]
Portugal	• Certain migrants and asylum-seekers in will be provided the same full access to public services that permanent residents receive until July 1st. This means that all foreigners, including asylum-seekers, who have applied for immigration status will be treated as permanent residents. This means they can access the national health service, welfare benefits, bank accounts, and work and rental contracts. Applicants including asylum seekers need only provide evidence of an ongoing request to qualify.[83]
Turkey	• IOM has supported the Adana Governorship, where many Syrian refugees live, with basic health items such as 11 disinfecting machines, 5,000 litres of disinfection liquid, 70,000 masks, 13,000 single-use gloves, 300 manual back pumps, 5,000 litres of hand sanitizers and 2,500 thermometers. [84]
UK	• The Government has clarified that no-one in the UK, including anyone living in the UK without regular immigration status, will be charged for treatment and testing for COVID-19 if required.[85]

Accommodation

Once it became clear that containment of COVID-19 within China was not going to be possible, governments shifted gears to delaying and mitigating the effects of the coronavirus.[86] As a result, states began rolling out shelter-in-place and lockdown orders, mitigation measures

that pose an obvious obstacle for people without reliable/consistent accommodation. This issue is inherent in displaced migration and affects refugees and asylum seekers alike. Recently arrived asylum seekers may be rough sleeping while their application is being processed, and even if they are able to secure accommodation, they are at high risk of being evicted during transition periods in the application process. In recognition of these gaps, some states have provided additional relief for these vulnerable populations.

Table 9. Key Accommodation Issues Among Migrant Populations and State Action, 2020

Issue	Country Response
Rough Sleepers	***Netherlands:*** Flemish Refugee Action reported that while the asylum application process had been suspended, the country continued to provide emergency shelters for those seeking asylum, in contrast to neighbouring Belgium.[87]
	UK: Homelessness minister, Luke Hall MP, has advised that local authorities 'utilise alternative powers and funding to assist those with no recourse to public funds (NRPF) who require shelter and other forms of support due to the pandemic'.
Halting Evictions	***UK:*** The Home Office has announced it will stop evicting people seeking asylum from government accommodation for three months, while the country remains in lockdown due to the coronavirus pandemic.[88]

Legal Protections

Legal issues in relation to displaced migrants revolve around issues of detention and deportation—two processes that have been significantly affected by travel restrictions and border closures. The EU Returns Directive allows detention of certain migrants who are pending deportation for a period up to 18 months. However, the Directive stipulates that if "a reasonable prospect of removal no longer exists…detention ceases to be justified and the person concerned shall be released immediately." [89] Travel restrictions and border closures have, in essence, eliminated states' abilities to abide by the conditions of this Directive. Relatedly, this has brought into question whether migrants in immigration detention should be released, especially those in vulnerable categories and unaccompanied children.[90] The Global Detention Project has launched a COVID-19 Global Immigration Detention Platform tracking how states around the world are re-evaluating their detention practices. The following table highlights key legal issues that have arisen since the pandemic started with examples of how certain countries have responded to the issue.

Table 10. Key Legal Issues Among Displaced Migrants and State Action, 2020

Issue	Country Response

Halt new detention orders	<u>**UK:**</u> The Home Office has halted the new detention of those liable to administrative removal to 49 countries, including Jamaica, India, Pakistan, Afghanistan, Iraq, Sudan, and Albania.[91]
Release immigration detainees	<u>**Belgium:**</u> It was reported that the number of detainees fell from 603 to 304 in March 2020. Among the detainees that were released in the wake of the outbreak of the pandemic were vulnerable individuals, including people with diabetes or bronchitis, as well as people slated for removal under the Dublin Agreements because of the inability to return them to European countries that no longer accept transfers.[92] Detainees released, however, were left homeless.
	<u>**Spain:**</u> On 16 March 2020, the Spanish police released eight people from the Centros de Internamiento de Extranjeros (CIE) in Valencia, recognizing that operating returns is not possible due to the movement restrictions put in place across the globe due to the COVID-19 emergency.[93] It is expected that unreturnable people will continue to be released from immigration detention centres without awaiting the expiration of the detention period (60 days).[94]
	<u>**UK:**</u> The Home Office released 350 people held under immigration powers. The number of people held in immigration detention has reduced dramatically, by nearly 500 people, from 1,225 on 1 January to 736 on 24 March.[95]
	<u>**Germany:**</u> There have been cases of asylum seekers in detention being released since migrants are not being repatriated under the Dublin regulations at the moment (see section on deportations).[96] The deadlines for the transfer of refugees to other EU countries are usually six, in exceptional cases 18 months. After the deadline, returns under the Dublin Regulation are no longer possible. For some refugees in Germany, the move by the Italian government means that they are allowed to complete their asylum procedure in Germany.[97]
	<u>**Netherlands:**</u> Release from detention is considered on a case-by-case basis and is influenced by whether individuals have criminal convictions. On 30 March, NOS mentioned that at least 10 Dublin cases were released, and consequently directed to the temporary emergency shelter in Zoutkamp.[98]
Halt deportations	<u>**Belgium:**</u> Closed centres, essentially detention centres, are invariably occupied by migrants pending deportation. The population in these centres is 50% foreigners who have been released from prison while

	the others have been released but with an order to leave the country within 30 days. Given border closure, leaving is impossible even if they wanted to leave.[99]
	Germany: There are less deportations due to the Corona crisis because refugees who are in Germany, but would otherwise have to carry out their asylum procedure in Italy according to the Dublin regulation, will not be transferred there for the time being.[100]
	France: Repatriations or deportations planned for March will be delayed for a later date but the Offices responsible still expect to respect the quotas laid out for the period 2020-21.[101]
	Netherlands: The Repatriation and Departure Service (DT&V), the organization responsible for organizing expulsions from the Netherlands, does not engage in any face-to-face contact with migrants. The government argues that, as travel possibilities are severely limited, that the expected results of the return interviews DT&V caseworkers initiate will be limited, and cannot outweigh risk for public health.[102]
	U.S.: On March 18, 2020, U.S. Immigration and Customs Enforcement (ICE) announced that it would temporarily adjust its enforcement posture its Enforcement Removal Operations (ERO) to focus on public safety risks and individuals subject to mandatory detention based on criminal grounds. For those individuals who do not fall into those categories, ERO will exercise discretion to delay enforcement actions until after the crisis or utilize alternatives to detention, as appropriate.[103]
Extend residency documents that may have expired	*Greece:* The asylum service confirmed that applicants' cards and residence permits due to expire while the asylum system is suspended will remain valid.[104]
	France: All residence permits will be extended by three months from Monday, March 16, to cover any expirations during the lockdown which is expected to last at least for the next two weeks.[105]
Expedite reunification procedures	*UK:* The Government has announced its intention to seek an arrangement with the EU to preserve the right to family reunion for unaccompanied children seeking international protection in the EU or the UK, and has signalled that it will continue with Dublin III transfers of asylum seekers from Europe as well as processing in-country

	applications, where possible, despite COVID-19. The closing of airports, reduction of flights and reduced capacity across the board mean that few if any transfers are possible at this time.[106]

Economic and workforce considerations

The coronavirus pandemic has brought countless economic and workforce issues to the forefront of society—several of which are directly related to immigrant integration in the labour force. Issues related to immigrant workers can be categorized into two buckets: 1) untapped potential of immigrant professionals; and 2) the overrepresentation of immigrants in front-line occupations.

Untapped Potential of Immigrant Professionals in Medical Fields

Prior to the pandemic, the U.S. was experiencing a shortage across medical professions. According to a 2019 report by the Association of American Medical Colleges (AAMC), the shortfall is projected to be between 40,000 to 122,000 physicians over the next decade, with a shortage of 29,000 to 42,900 doctors in 2020, depending on several factors.[107] This issue is not unique to the U.S. as the world was experiencing a shortage of 7.2 million healthcare workers in 2013 —a shortage that is expected to grow to 12.9 million by 2035.[108] Additionally, in the midst the of COVID-19 outbreak WHO identified a global shortage of 5.9 million nurses—a shortage that is primarily experienced in Africa, Southeast Asia, the Eastern Mediterranean, and parts of Latin America.[109]

Although both high and low income countries are experiencing shortages in healthcare professions, the impact is felt differently. For example, it is estimated that the death of one doctor in Africa is bound to affect 10,000 people.[110] On the other side of the spectrum, the pandemic is already exacerbating the U.S. shortage as nearly 9,300 U.S. healthcare workers have contracted COVID-19 and 27 have died as of April 9, 2020.[111]

In response to the shortage of medical professionals, France, Germany, Spain, Argentina, Chile, Peru, and several U.S. states (New York State, New Jersey, Massachusetts, and Colorado) have relaxed their licence and certification requirements for medical professionals to allow them to respond to COVID-19.[112] Similarly, other countries including China and Italy were forced to pull healthcare professionals out of retirement and graduate medical students early to fill the gap.[113]

These issues have inadvertently highlighted the untapped potential of immigrants and refugees who have been trained in medical professions in their home country but are not able to practice in those fields because of reaccreditation issues. For example, across the U.S. it is estimated that there are 263,000 immigrants and refugees with undergraduate degrees in health-related fields that are either relegated to low-paying jobs that require significantly less education, or are out of work.[114] Furthermore, although visas for medical professionals have been classified as emergency services in the U.S., embassy and consulate closures in conjunction with travel bans have created practical barriers for foreign nationals wishing to apply.[115] As with shortage issues, other countries also began to realise the untapped potential across their foreign nationals.

According to the Facebook group 'Syrian Doctors in Germany' there are 14,000 Syrian doctors waiting for their qualifications to be approved.[116] In response, individual states such as Bavaria and Saxony have announced easier access to exam procedures and a relaxation on qualification rules. Bavaria recently announced that doctors without medical licences would be given immediate permission to work there for a year,[117] and the eastern state of Saxony issued a call for unlicensed foreign doctors on Facebook.[118] About 400 people expressed interest to this call—many of whom were simply unlicensed because of the labour-intensive accreditation process which requires translations of previous work records and verification of proficiency in German.[119] To get qualified doctors out on the frontlines, Saxony is now waiving licensing requirements and fast-tracking the training of hundreds of refugee medics.[120]

In the UK, migrants make up 12 percent of the 1.9 million-strong health workforce,[121] and according to a migrant advocacy group, they currently know of 230 doctors who are fully qualified in their own countries—most of whom have many years of experience as doctors.[122] On April 9th, the UK General Medical Council (GMC) announced that it used its emergency powers to add over 30,000 doctors to the register to support the government's response to the pandemic. With the agreement of the chief medical officers in all four countries, they have focused initially on doctors who were previously registered or licensed to practise but have also welcomed a number of refugee doctors who passed their English language tests and Plab exams with over 25 doctors with refugee status registered since the start of the year.[123]

In addition to this, unregistered refugee and migrant doctors can play a part in the pandemic response as Medical Support Workers with NHS England. This will allow doctors who've passed an English test (OET/IELTS) to do some clinical tasks under supervision. As of April 9th, 100 refugee doctors have already signed up for the scheme, and 48 refugee doctors have opted to take intensive English language courses so they can apply for the NHS role within three months.[124] Many of the untapped healthcare professionals are surgeons from Syria, Sudan, Iran, Iraq, and Turkey, and on average, they have 7.5 years of medical experience.[125]

This issue existed before COVID-19 and will continue to plague immigrant and refugee health professionals after the current crisis subsides. Bureaucratic and cumbersome reaccreditation processes are at the core of this issue. Figure 4 below, for example, provides a snapshot of the reaccreditation process for foreign-trained medical professionals residing in the UK.

Figure 4. Reaccreditation of Foreign-trained Medical Professionals in the UK, 2020

<u>***Cost:***</u> Migrants who have been trained in medical professions in their home country often find reaccreditation cost-restrictive and time consuming.

- The Professional and Linguistic Assessment Board (Plab 1 and 2) cost £230 and £840 respectively
- Pre-courses professionals are required to enrol in prior to sitting for Plab 1 and 2 cost £2,000+
- Refugees and asylum seekers may be able to receive the following assistance with GMC registration fees if they have settled status and those who have applied for asylum may be eligible if they meet certain criteria.
    - Two attempts of the Plab 1: free of charge
    - Two attempts of Plab 2: half price
    - The registration fee can be paid in 4 quarterly payments of 10 monthly payments

<u>***Time:***</u> It can take doctors 12 to 18 months to get their language qualifications and their Plab 1 and Plab 2 qualifications.

<u>***Additional verification of international medical graduates:***</u> International medical graduates applying for provisional or full registration with a licence to practise need to have their primary medical qualification independently verified before we grant registration. submit a request through the Educational Commission for Foreign Medical Graduates (ECFMG). While, most schools respond within 90 days, this depends on whether the awarding institution accepts these requests electronically. Fees for this are roughly $230.

- The GMC will pay the verification fees to ECFMG on the behalf of refugees who have settled status in the UK.

Sources: (a) https://www.theguardian.com/world/2020/mar/25/covid-19-call-for-fast-track-registration-of-refugee-doctors-in-uk (b) https://www.ecfmgepic.org/fees.html (c) https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/fees-and-funding/help-for-refugees (d) https://www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/primary-source-verification-for-international-medical-graduates

Immigrants in "frontline" Occupations

The pandemic has postulated certain industries as frontline which includes industries responding to needs created by COVID-10 (i.e. healthcare, retail, wholesale, etc.) as well as those hardest hit by economic shut-downs (i.e. accommodation, food and personal services, etc.).[126] Migrants are overrepresented on both fronts. As the coronavirus brought the global economy to a halt, data began rolling in depicting the essential—though often invisible—role immigrants play in local economies. COVID-19 has flipped the narrative around "low-skilled"

jobs such as grocery store workers, construction, sanitation services, and food supply chain occupations such as agriculture and processing—occupations that are more likely to be filled by immigrants than native-born populations.[127]

In the U.S. for example, six million immigrant workers are in frontline occupations keeping U.S. residents healthy and fed, representing roughly 19 percent of frontline workers.[128] Furthermore, an additional six million immigrants are in industries hardest hit by the pandemic which means that collectively, 12 million immigrant are on the frontlines in terms of COVID-19 response and impact.[129] Similarly in the EU, 13% of key workers are immigrants, on average.[130]

Table 11. Immigrants in Frontline Occupations by Share in Key States, 2020

Share of Immigrants in Frontline Occupations	
U.S.	**19 percent**
EU	**13 percent**
Italy	20 percent
Belgium	20 percent
Germany	20 percent
Sweden	20 percent
Austria	20 percent
Ireland	26 percent
Cyprus	29 percent
Luxembourg	53 percent

Sources: (a) Immigrant key workers in Europe: The COVID-19 response that comes from abroad, https://voxeu.org/article/covid-19-immigrant-workers-europe, (b) Immigrant Workers: Vital to the U.S. COVID-19 Response, Disproportionately Vulnerable, https://www.migrationpolicy.org/research/immigrant-workers-us-covid-19-response.

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[4] The 26 Schengen countries are: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland. The Schengen Area covers most of the EU countries, except Ireland, and the countries that are soon to be part of: Romania, Bulgaria, Croatia and Cyprus. Although not members of the EU, countries like: Norway, Iceland, Switzerland and Lichtenstein are also part of the Schengen zone. Although most of the Schengen countries are in the European Union, you should not confuse the Schengen Area with the EU.

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[17] The rule hinges on differentiating between Section 212(f) of the Immigration and Nationality Act ("INA") which applies to the "entry" of aliens, and Section 362 which instead provides the authority to prohibit the "introduction" of persons into the United States.

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