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Locked down and left out?

Why access to basic services for migrants is critical to our COVID-19 response and recovery

A report by the Red Cross Red Crescent Global Migration Lab

Cruz Roja Colombiana

Swedish Red Cross

British RedCross

Credit: Philippine Red Cross (2020)

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Cover photo caption: Abdul Karim Adamou (Niger Red Cross animator and volunteer) and Ali, a 32-year-old migrant originally from Guinea Conakry, sew masks during a psychosocial activity in Niamey in March 2020. Photo credit: Noemi Monu, Danish Red Cross.

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Executive summary

This report was prepared by the newly established Red Cross Red Crescent (RCRC) Global Migration Lab and draws on research conducted by eight National RCRC Societies (National Societies) from Australia, Colombia, Egypt, Ethiopia, the Philippines, Sudan, Sweden and the United Kingdom. It provides evidence of the direct and indirect impacts of the COVID-19 pandemic and related policy measures on migrants' access to basic services, including vaccines.[i]

As a global humanitarian network with a presence in 192 countries, the International RCRC Movement (the Movement) approaches migration from a purely humanitarian perspective. The Movement uses a deliberately broad description of migrants to include all people who leave or flee their home to seek safety or better prospects, usually abroad, and who may be in need of protection or humanitarian assistance. RCRC actors seek to respond to humanitarian needs and address risks and vulnerabilities, without seeking to encourage, discourage or prevent migration. As auxiliaries to states in the humanitarian field, National Societies work to address the protection and assistance needs of migrants all along their journeys, regardless of their legal or migratory status, in accordance with the Fundamental Principles of the Movement.

This report builds on existing research on the impacts of COVID-19 on migrants by providing further insights into common barriers to accessing basic services across a range of migration contexts – including for undocumented or irregular migrants, people seeking asylum and refugees, indigenous migrants, migrants in transit, migrants on temporary visas or residency permits, returning migrants and those left stranded due to the pandemic. It also explores the extent to which migrants are being included in COVID-19 vaccination policies and plans globally.

Country-level data collection and analysis took place between July and December 2020, with additional desk research conducted until early February 2021. In total, more than 3,250 migrants were surveyed and/or interviewed and discussions held with over 150 key stakeholders, representing community leaders, local authorities, government representatives, local, national and international humanitarian and development organizations, and RCRC staff and volunteers.[ii]

The findings confirm migrants continue to face significant humanitarian consequences due to the exacerbation of existing barriers to basic services and the evolution of new challenges during the COVID-19 pandemic. Although not all findings apply uniformly across the countries examined, and likely not to all countries outside the scope of the research, key barriers identified during the pandemic include: exclusion based on legal status; inaccessible information - both in language and channels of dissemination; insufficient or unavailable services; financial barriers; inconsistent application of relevant laws and policy; fear, health and safety concerns; lack of relevant documentation; and digital exclusion.

COVID-19-related policy measures, including lockdowns and movement restrictions, while aimed at improving public health outcomes, have contributed to migrants' inability to meet their basic needs and live in safety and dignity. The most significant impacts identified in the report include: risks to physical health; worsening mental health conditions; severe economic effects – namely, an overwhelming level of loss of employment or livelihoods; food insecurity; and challenges in accessing adequate shelter to remain safe and healthy. While pandemic-related policy measures have also affected broader communities, the evidence confirms migrants have experienced disproportionate impacts due to vulnerabilities associated with barriers to support and the circumstances of their journeys. Migrants are also at risk of heightened stigma and discrimination and being left behind in the roll out of COVID-19 vaccines, generating individual and public health concerns.

The report welcomes the measures taken by some governments to mitigate the impacts of the virus and facilitate access to basic services for migrants - such as relaxations in visa compliance or flexibility in residency permit renewals and inclusion of migrants in free COVID-19 testing and treatment. However, emergency responses for migrants, particularly undocumented migrants and those with temporary status, have tended to be inconsistent with pandemic support measures put in place for nationals or permanent residents. Migrants have frequently been excluded from socio-economic support policies, despite playing key roles in response and recovery efforts, being over-represented in employment sectors hard-hit by the pandemic and being impacted by the same prevention and control measures as host communities. Indeed, COVID-19 has further exposed systemic barriers and underlying inequalities in access to basic services for migrants and has widened support gaps, with increasing concerns as to whether countries will include all migrants, irrespective of legal status, in COVID-19 vaccination policies and roll-out strategies.

Addressing barriers to basic services for migrants is in everyone's interest. Drawing on the evidence presented, in the context of the current pandemic and in preparation for future health emergencies, governments, donors, and development and humanitarian actors should listen to and be guided by the voices, expertise and experience of migrants.

It is the primary responsibility of states to respect, protect and fulfil the human rights of migrants, including their economic and social rights. The report recommends that states work together with other stakeholders to:

1. Ensure all migrants, irrespective of legal status, are included in local and national COVID-19 responses that guarantee access to basic services, including healthcare, housing, food, water, sanitation and hygiene services, psychosocial support, education, emergency support and protection services.
2. Ensure all migrants, irrespective of legal status, have effective access to timely, accurate and reliable information on COVID-19 (and any future pandemics) in a language they understand and through accessible dissemination channels. This information should include prevention measures and when, where and how to access testing, treatment, vaccines and other relevant supports.
3. Ensure all migrants, irrespective of legal status, are included in COVID-19 testing, treatment and vaccination policies and roll-out strategies and have equal access to testing, treatment and vaccines.
4. Ensure all migrants, irrespective of legal status, who have lost their livelihoods and are unable to meet their basic needs are included in pandemic-related socio-economic support (now and in the future).
5. Continue to adapt existing laws and policies to ensure inclusive access to basic services and complement any policy changes with operational guidelines and awareness training for frontline responders to ensure entitlements in law are realized in practice. This includes addressing formal barriers preventing migrants from accessing services, such as amending restrictive rules and/or working to limit the loss of temporary visa status and regularise status for people without visas, but also informal barriers, such as information gaps, language issues and prohibitive costs. Furthermore, migrants must have safe access to humanitarian assistance without fear of arrest, detention or deportation. In all circumstances, the primary consideration should be to treat migrants humanely, taking into account their specific vulnerabilities and protection needs, and to respect their rights under international law.

i. For the purpose of the research, basic services include those considered as essential for the well-being and the dignity of migrants such as, but not limited to: access to healthcare, including COVID-19 testing, tracing, treatment and vaccine; access to timely, reliable and culturally appropriate information; shelter; food; water, sanitation and hygiene services; livelihoods and income support; and protection services.

ii. ICRC did not provide any information obtained as part of its bilateral and confidential dialogue with authorities.

Introduction

British Red Cross volunteer, Anisa, prepares food packages at the Hackney Destitution Centre in London. The Centre provides food parcels, toiletries and practical support to vulnerable refugees and people seeking asylum. Staff and volunteers are keeping the centre open at a reduced capacity to continue helping those in need during the COVID-19 pandemic.

This report was prepared by the newly established Red Cross Red Crescent (RCRC) Global Migration Lab. It draws on research conducted by eight National RCRC Societies (National Societies), representing programme operations in all regions. National Societies from Australia, Colombia, Egypt, Ethiopia, the Philippines, Sudan, Sweden and the United Kingdom undertook primary and/or secondary data collection with migrants[1] and key stakeholders, in coordination with the International Federation of Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC), providing evidence of the direct and indirect impacts of the COVID-19 pandemic and related policy measures on migrants' access to basic services, including vaccines.[2]

Direct impacts relate to individual and public health concerns, such as risks of contracting and spreading COVID-19, including due to difficulties in accessing testing or treatment. Indirect impacts are those beyond physical health outcomes, such as vulnerabilities linked to socio-economic consequences of government measures to prevent transmission, including loss of livelihoods and psychosocial impacts.

This report considers access to basic services in various migration contexts, including for undocumented or irregular migrants, people seeking asylum and refugees, indigenous migrants, migrants in transit, migrants on temporary visas or residency permits, returning migrants and those left stranded due to the pandemic. In doing so, it seeks to identify common impacts and vulnerabilities across migrants' journeys and to illustrate gaps in accessing basic services and subsequent humanitarian consequences. The report acknowledges that COVID-19 has also affected and exacerbated vulnerabilities for migrants in immigration detention,[3] migrants in camps and camp-like settings,[4] and migrant children (particularly those who are separated or unaccompanied);[5] however, the research conducted did not directly focus on these groups. The possible impact of COVID-19-related policy measures on migrants' access to international protection and other protection impacts not related to access to basic services are also outside the scope of this research.

Research findings build on those of the IFRC report - *Least protected, most affected: Migrants and refugees facing extraordinary risks during the COVID-19 pandemic*[6] - by further exploring the impact of COVID-19-related policy measures on access to basic services through direct conversations and engagement with migrants and local communities. Their experience, expertise and insights are central to the findings and conclusions presented and to formulating policy and operational responses now and in future global health crises.

Data collection and analysis took place between July and December 2020, with each National Society utilizing specific methods and tools depending on local context and status of COVID-19 restrictions. Some surveys, interviews or focus groups were conducted in person; others were online or over the phone. In total, more than 3,250 migrants were surveyed and/or interviewed, in addition to discussions with over 150 stakeholders representing community leaders, local authorities, government representatives, local and international humanitarian and development organizations, and RCRC staff and volunteers.[7] The table below presents an overview of the national research samples, with more detailed information on the specific methodology and demographics available in Appendix 1.

Table 1: Overview of National Society COVID-19 research samples

Country	Migrant focus	Geographic focus	Number/type of consultation
Australia	Migrants on temporary visas and undocumented migrants	Nationwide	- 1,925 migrants surveyed online - 24 migrants interviewed - 22 key sector informant interviews - 6 focus group discussions
Colombia	Indigenous migrant communities and undocumented migrants, including seasonal migrants, along the border with Venezuela	Guajira and Vichada Departments	- 203 migrants surveyed - 2 focus groups discussions
Egypt	Migrants of African origin and Syrian refugees	Greater Cairo	- 10 focus group discussions (with 60 migrants, including refugees) - 5 key informant interviews
Ethiopia	Ethiopian migrants returning mainly from Sudan and the Middle East	Arsi zone in Shirka Woreda; North Gonder Zone in Debark Woreda; and Addis Ababa	- 93 migrants surveyed - 13 key informant interviews
Philippines	Locally stranded individuals[8] and returned migrants from Sabah, Malaysia	Visayas (Ilo-Ilo and Bacolod); Mindanao (Cagayan De Oro and Zambonga)	- 405 migrants surveyed - 24 key informant interviews - 5 focus group discussions
Sudan	Undocumented migrants (including those in transit) and returned migrants	Northern State	- 385 migrants surveyed - 5 focus group discussions
Sweden	People seeking asylum, undocumented migrants and migrants with temporary permits	Nationwide	- 23 migrants interviewed - 11 Swedish Red Cross interviews - 6 focus group discussions
Sahel region	Migrants in transit countries	Niger, Burkina Faso, Guinea, Mali	Insights from the AMiRA programme[9], IFRC-UNHCR research[10] and IFRC research[11], including 59 key informant interviews and, in Guinea and Niger, 23 focus group discussions with migrants, 16 interviews with Red Cross personnel and partners and 20 interviews with local authorities and community leaders.
United Kingdom	People seeking asylum and refugees	Nationwide	Direct reporting from operations, first-hand experiences shared by the VOICES network[12] in 2020 and ongoing policy analysis by British Red Cross.

Global context: Migration and COVID-19

In 2020, the number of people living outside of their country of origin was estimated at 281 million, largely due to labour or family migration, but also due to humanitarian crises. The number of persons forcibly displaced across national borders worldwide was 34 million, double that of 2000.[13]

Migrants, including refugees, have been critical to COVID-19 pandemic responses, often playing a large role in essential response sectors.[14] They constitute a significant share of key workers in healthcare, scientific research, formal and informal care economy, food supply chains, transportation and personal protective equipment (PPE) production and are also overrepresented in sectors most affected by the pandemic, including food, hospitality, accommodation, retail, administration and manufacturing.[15]

COVID-19 has also shocked the global economy and impacted remittance flows, perhaps worse than the 2008 financial crisis.[16] The Organization for Economic Cooperation and Development (OECD) has predicted a 4.5% decline in world gross domestic product (GDP).[17]

While migrants account for just 3.5% of the global population,[18] they contribute to approximately 9% of global GDP.[19] The International Labour Organization estimates that nearly half of all workers worldwide are at risk of losing their livelihood due to the pandemic[20] and nearly two-thirds of migrants are labour migrants.[21] The World Bank has predicted a 14% drop in remittances globally in 2020,[22] and estimates that COVID-19 could push up to 88-115 million people into extreme poverty.[23]

Migrants are not immune to the pandemic and its impacts; indeed, they have been disproportionately affected. The limited data available on COVID-19 cases by country of origin commonly show a significant over-representation of migrants.[24] Since the publication of the aforementioned IFRC *Least Protected, Most Affected* report, it is clear that the heightened risks and vulnerabilities faced by migrants during the pandemic remain. As the focus on COVID-19 vaccination plans advances, there is a real risk that migrants may be left behind.

Volunteers from the Philippine Red Cross ensure water and sanitization stations are available to returning migrants.

Key COVID-19-related laws and policies

COVID-19 has generated considerable uncertainty for governments and people alike – necessitating a dynamic and flexible response in the face of rapidly changing and complex circumstances. Prior to March 2020, 'lockdowns' and 'physical or social distancing' were uncommon, yet these are now normal practices. Between March and October 2020, the total number of movement restrictions around the world increased to more than 96,000.[25] At one point, 168 countries fully or partly closed their borders, with 90 making no exception for people seeking asylum.[26]

Government policies, alongside the virus itself, have had substantial impacts on the health, well-being and livelihoods of all people, including - and disproportionately impacting - migrants. Policy measures have evolved as governments have faced enormous challenges in rapidly responding to the virus. By analysing the extent to which migrants have been included and/or impacted by these policies, the research aims to inform future responses to public health emergencies to better ensure the safety and dignity of everyone.

Common measures to control the spread of the virus in the countries of study included: limiting the movement of and contact between people; enacting social or physical distancing regulations; closing public spaces, schools and non-essential businesses and restricting international and inter-state travel. In some countries, mandatory 14-day quarantine measures were enacted for anyone entering the territory. Lockdowns resulted in risks of migrants becoming undocumented or irregular, for example due to an inability to renew visas, comply with visa conditions or depart the country. Countries such as Australia, Egypt and the UK enacted measures to prevent this, including flexibility in visa conditions or extended renewal timeframes.

Measures to tackle the spread of COVID-19 must be lawful, necessary and proportionate to the objective of protecting public health, and non-discriminatory. The extent to which migrants have been able to comply with and/or benefit from those measures and have had access to COVID-19-specific support has varied across the countries studied, with the exception of COVID-19 testing. Nearly all countries have introduced policies on free testing for anyone with symptoms, apart from Sudan and Ethiopia, where, due to resources, testing policies focused on groups of people with similar characteristics presenting symptoms (frontline healthcare workers, people returning from overseas, those in contact with a known case).[27]

Global spotlight on vaccines: An opportunity to be better

At the time of finalizing this report in early February 2021, the extent to which migrants, irrespective of legal status, will be included in COVID-19 vaccination policies remains uncertain, with plans continuing to evolve across countries. While some states have demonstrated commitment to ensure all people within their borders have free access, there are also indications that, in addition to ongoing systemic barriers in accessing basic services and increased vulnerabilities to COVID-19 impacts, all migrants, irrespective of legal status, may not be covered in vaccination policies and roll-out strategies, presenting both individual and public health concerns.

Some states have expressed that certain groups of migrants will not be included. In the Dominican Republic, for example, the government has said anyone without residency papers will not be immunized.[28] The situation is similar in Costa Rica, where the government has noted refugees and people seeking asylum (with an active refugee application) will be included, but migrants in an irregular situation will not.[29] In Poland, only foreigners with the right to stay will have access to the vaccine on the same terms as citizens.[30]

Other states have not explicitly excluded migrants but have also not provided clarity on who will be included. In Turkey, there has been no official declaration as to whether refugees, registered or unregistered, will be immunized.[31] In South Africa, it is unclear whether undocumented migrants will be covered.[32] In Australia, it was first announced the vaccine would be free for some visa holders;[33] however, the government has since confirmed all visa holders living in Australia will be eligible.[34] Access for undocumented migrants is unclear. In Sweden, according to the government and the public health authority, all people over 18 will have access within the first six months of 2021,[35] but the degree to which people seeking asylum and undocumented migrants will be included is uncertain due to existing

barriers to access. In Egypt, citizens must register online to access the vaccine,[36] but a specific plan for migrants is yet to be shared. In Singapore[37] and Bahrain[38] migrant workers will have free access to the vaccine, but it is not clear if all migrants will be covered. Of the 133 countries which the United Nations High Commissioner for Refugees (UNHCR) had information on, 81 had finalized their vaccination strategies and only 54 included explicit provisions to cover populations of concern such as people seeking asylum and refugees; though, some countries do not list specific categories of people, leaving it unclear whether refugees are included by default.[39]

Promising practices continue to emerge, however. Colombia initially indicated undocumented migrants would not be included;[40] yet, a plan to regularize Venezuelan refugees and migrants who entered the country before 31 January 2021 by granting temporary protection status, facilitating vaccine access.[41] In the Netherlands, undocumented migrants and people seeking asylum in the country for more than one month are eligible.[42] In Jordan, all migrants, regardless of status, are eligible.[43] In Lebanon, the government announced everyone, regardless of nationality will be eligible.[44] In Canada, the vaccine is provided regardless of citizenship, with some provinces offering it to anyone regardless of immigration status.[45] In Sudan, the government indicated people seeking asylum and displaced people are at high risk and will have access to the vaccine.[46] The Philippines called for greater cooperation to safeguard migrants.[47] Malaysia announced it will extend its free COVID-19 vaccination programme to all foreigners residing in the country, including refugees and undocumented migrants.[48]

Nonetheless, historic barriers to accessing basic services for migrants, exacerbated by the pandemic and highlighted in this report, are likely to affect access to COVID-19 vaccinations, even if eligibility exists in law. For example, in Greece, more than 50,000 people are unable to access to the public health system, including people seeking asylum whose claims have been rejected, as they have no social security number; without this, they will be unable to access the vaccine.[49] Vaccination is free to anyone living in the UK without permission and no immigration checks are needed for overseas visitors when being vaccinated,[50] but existing barriers to accessing healthcare including problems registering with a doctor and fears due to data sharing between health services and immigration enforcement are yet to be addressed. And, although the United States announced the direct inclusion of migrants regardless of immigration status in its vaccine roll-out,[51] reports of undocumented migrants not being vaccinated due to fears of deportation or being reported to immigration authorities are emerging.[52] This is consistent with findings around accessing broader services during the COVID-19 pandemic.

Greater efforts must be made to ensure migrants experiencing vulnerabilities are included in vaccination plans and to design strategies that complement inclusive polices with measures to address ongoing barriers to basic services (both formal and informal), particularly for undocumented migrants. If existing barriers are not addressed, the gap between policy and practice will remain, with detrimental outcomes for migrants and the communities in which they live and work. COVID-19 vaccination plans present an opportunity for states to do better and to ensure that vaccine access is affordable, non-discriminatory and available to all people, irrespective of status. This is in everyone's best interest.

Credit: Philippine Red Cross Society

Country-specific policy measures

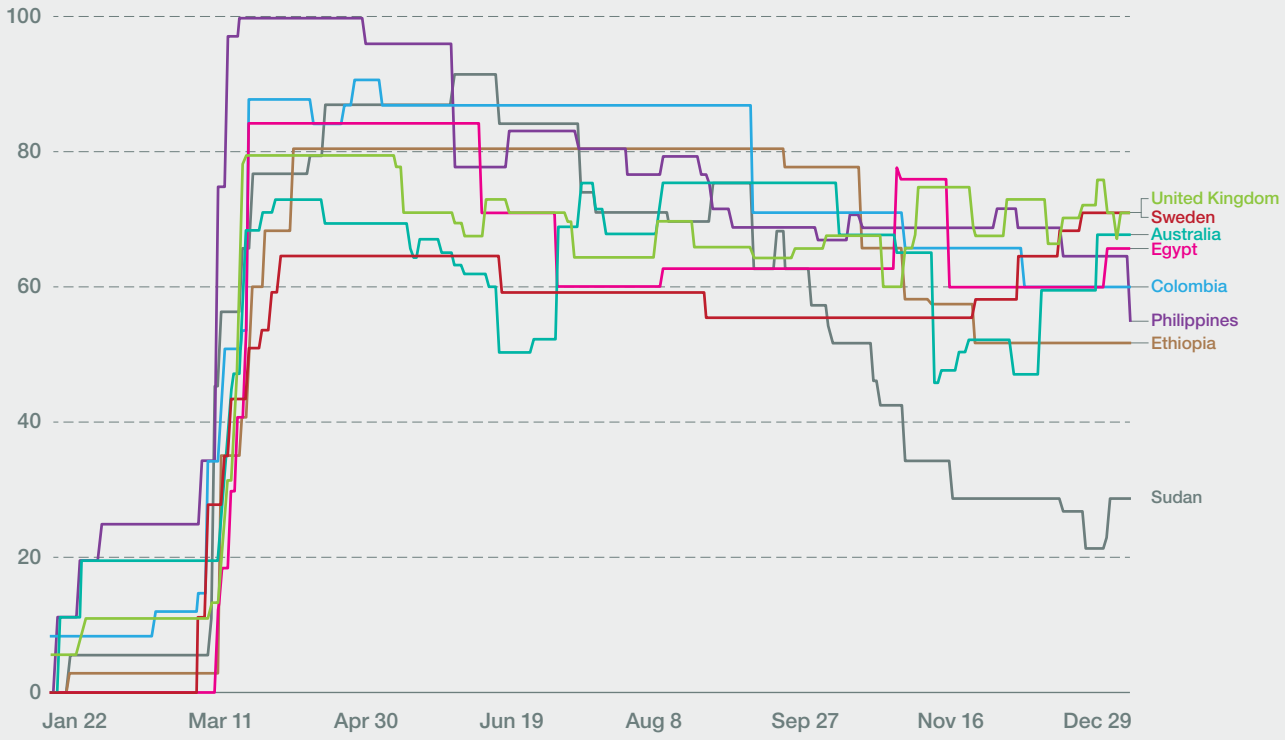
Figure 1 outlines the level of severity of policy measures in the countries of study from January to December 2020, providing context to the research findings and responses from migrants and stakeholders surveyed or interviewed. The figure does not assess the appropriateness of these policies.

An overview of select country-specific policy measures and the extent to which the migrants groups studied have been included is summarized below, with a more detailed breakdown in Appendix 2.

Figure 1: Severity of country response measures[53]

COVID-19: Government Response Stringency Index

This is a composite measure based on nine response indicators including school closures, workplace closures, and travel bans, rescaled to a value from 0 to 100 (100 = strictest). If policies vary at the subnational level, the index is shown as the response level of the strictest sub-region.



Source: Hale, Webster, Petherick, Phillips, and Kira (2020). Oxford COVID-19 Government Response Tracker - Last updated 13 January, 12:01 (London time)
Note: This index simply records the number and strictness of government policies, and should not be interpreted as 'scoring' the appropriateness or effectiveness of a country's response.
OurWorldInData.org/coronavirus • CC BY

AUSTRALIA

When the first COVID-19 case was confirmed in January 2020, national and local governments took increasingly strict measures including, by March 2020, banning international and inter-state travel, imposing lockdowns, enacting physical distancing regulations, temporarily closing non-essential businesses, mandatory hotel quarantine for international and inter-state arrivals, eventual mandating of face-masks in certain locations and providing free testing and treatment. Permanent residents and Australian citizens experiencing financial hardship had access to COVID-19-specific income support from the national government, but the majority of people on temporary visas and all undocumented migrants were ineligible and many were also unable to access the public healthcare system. Federal and State governments provided limited crisis or emergency payments to migrants meeting specific hardship criteria.

COLOMBIA

Colombia reported its first COVID-19 case in March 2020 and subsequently declared a state of emergency until September 2020, announcing quarantine and lockdown measures, closing its borders and placing limits on public gatherings.[54] A 2018 Supreme Court decision requires all migrants, regardless of status or situation, be provided access to health services in case of emergencies; however, there are gaps in access and significant waiting times, due to the saturation of health services, increasing demand, as well as particular barriers faced by indigenous undocumented migrants, outlined in this report. COVID-19 testing and treatment is available to anyone with symptoms.

EGYPT

The first case was reported in Egypt in February 2020 and a state of emergency declared, including a partial curfew, closure of places of worship and public transport, limits on international travel and encouraging people to work from home.[55] Registered migrants and refugees have access to public health services for primary and secondary healthcare - including COVID-19 testing. The government issued the exceptional extension of expired visas and residency permits. A government fund to support Egyptians who lost their jobs was established, but migrants were not covered.

ETHIOPIA

In March 2020, with the first confirmed case, Ethiopian authorities closed land borders, schools and entertainment outlets, and announced social distancing measures. Mandatory 14-day quarantine at designated hotels was enacted for all people entering the country and a state of emergency declared, including restricting international travel, banning public transport between states and public gatherings. Layoffs by private employers were forbidden.[56] The country has been impacted by large numbers of returning migrants due to COVID-19, particularly from the Middle East, and is working to strengthen reintegration support.[57]

PHILIPPINES

The Philippines reported its first cases in late January 2020 and closed all non-essential businesses and public transport from March to July 2020. International and domestic travel restrictions were put in place and schools closed.[58] Given the large number of people stranded within the country due to movement restrictions and flight/transport availability, the government created a national task force to support 'locally stranded individuals', designating government departments to provide basic support such as food, healthcare, temporary shelter and transport.

SWEDEN

Following the first case in late January 2020, Sweden implemented travel restrictions, social distancing measures and many secondary schools and universities switched to distance learning.[59] Sweden chose a strategy relying mainly on voluntary public health measures. People seeking asylum and undocumented migrants are entitled to healthcare that cannot be deferred or postponed under the Swedish Communicable Diseases Act, which covers testing and treatment for COVID-19.

SUDAN

After the first case in March 2020, the Sudanese government implemented a partial lockdown, contact monitoring, closure of schools and borders, social distancing and quarantine and isolation measures for six months.[60] When the second wave hit in November 2020,[61] the government reduced its workforce and encouraged people to take precautions.[62] In Northern State, where the research took place, the government established three quarantine shelters for returning migrants and provided access to basic services, such as food, psychosocial support and healthcare, in cooperation with other stakeholders, for 14 days.

Colombian Red Cross Society (July 2020)

Colombian Red Cross carries out COVID-19 health promotion activities, including delivery of hygiene kits, to migrants in the border area of La Guajira, Colombia.

SAHEL REGION

At the end of September 2020, West Africa accounted for just 0.3% of the confirmed COVID-19 death toll worldwide.[63] Many West African governments declared states of emergency or public health emergencies and put in place strict preventative measures. Governments in Burkina Faso, Guinea, Mali and Niger implemented a similar range of restrictions. Land and air borders were closed, and curfews imposed. Movements were restricted, with transport between cities halted in Burkina Faso, and assemblies of people limited. Public spaces were closed across all four countries, including places of worship, educational institutions and entertainment and hospitality sectors. In many countries such as Guinea and Niger, masks were mandatory in public spaces.

THE UNITED KINGDOM

In March 2020, following the first cases of COVID-19 in late January, the UK government implemented travel restrictions, social distancing measures, closures of entertainment, hospitality, non-essential shops and indoor premises, and increased testing, with a phased reopening in September 2020. The second wave led to a further country-wide lockdown in November.[64] Socio-economic measures included banning evictions from privately rented housing, temporary shelter for the homeless, in some cases including migrants, and a weekly increase in welfare payments for UK residents and for people seeking asylum accessing Asylum Support; though, the increase was over 90% lower for people seeking asylum.

Barriers to accessing basic services during the pandemic

COVID-19 and related policies to control the pandemic exacerbated existing barriers in accessing basic services for migrants and generated new challenges. The most significant barriers identified in the research include ineligibility or exclusion based on legal status; inaccessible information – including on where and how to access services and prevent COVID-19; financial barriers; insufficient or unavailable services; inconsistent application or interpretation of relevant laws and policies; fear, health and safety concerns; lack of relevant documentation; and digital exclusion.

Exclusion based on legal status

The research found that despite migrants often being disproportionately affected by pandemic control measures, they were initially excluded from policy measures designed to mitigate socio-economic impacts and have not been entitled to equitable access to basic services based on their legal status.

> *"Because we're not Australian citizens… there isn't much for us to apply for, or to get assistance and stuff, which just made it worse for me and my kids around that time..."* - Migrant on a temporary visa in Australia

In Australia, migrants on temporary visas, for the most part, were ineligible for COVID-19-related income support from the national government; however, limited emergency relief supports, including emergency relief payments and food assistance, were subsequently provided by national and state governments following advocacy from humanitarian actors. During interviews, 67% of undocumented migrants and 42% of migrants on temporary visas explicitly cited ineligibility due to visa status as the key barrier to accessing support. In total, 92% of migrants on temporary visas and 100% of undocumented migrants interviewed faced some degree of difficulty in accessing basic services including medical care, food, accommodation or financial assistance. People on temporary visas and undocumented migrants are also largely ineligible for public housing or emergency accommodation; 60% of migrants on temporary visas interviewed reported having difficulty accessing accommodation due to the pandemic, as did 50% of undocumented migrants.

In Sweden, relevant laws do not outline clear expectations around what housing or shelter should be provided under the Social Services Act. Further, the Supreme Administrative Court jurisprudence on the municipalities' responsibility for providing 'acute' social assistance to all persons who reside within the municipality, has been interpreted in different ways. As a result, eligibility for social services and housing assistance or shelter for undocumented migrants remains unclear, resulting in support to migrants being denied in some instances. This situation has been exacerbated during the COVID-19 pandemic.

Undocumented migrants excluded from housing support in Sweden

In the early stage of the COVID-19 outbreak, a social department within a well-populated municipality in Sweden initially announced no homeless person would lack a roof over their head, and no one would be denied a place in a shelter, regardless of symptoms. When raising the need to refer migrants to shelters, the municipality suggested undocumented migrants be referred to a special shelter, operated by a voluntary organization based on an agreement with the municipality. However, undocumented migrants were not eligible for support, as the agreement with the municipality only included EU citizens. The social department later confirmed there were no shelters accessible to undocumented migrants and that, prior to the pandemic, the municipality had adopted guidelines not to provide any emergency assistance to undocumented migrants and that this policy would be upheld despite the ongoing pandemic. This policy decision exacerbates the challenges undocumented migrants already face in complying with public health recommendations and increases risk of infection and transmission.

In the UK, many COVID-19 welfare support measures excluded migrants with 'no recourse to public funds',[65] including people seeking and refused asylum and undocumented migrants. People seeking asylum are also not allowed to work and do not have access to mainstream welfare benefits and housing. The government provides accommodation and support to people seeking asylum facing destitution; however, people receiving this support struggled to meet essential living needs before the

Credit: Swedish Red Cross

Swedish Red Cross provides key COVID-19 information to migrants, including how to prevent transmission and where to access support.

pandemic and, in recent months, faced impossible choices between buying food and accessing phone credit to keep in touch with families and service providers.

In Egypt, COVID-19 employment support measures did not include migrant workers. In addition, registered migrants and refugees have access to primary care at the same level as Egyptian nationals, but eligibility for secondary and tertiary healthcare access varies.

In Colombia, 88% of migrants surveyed reported their migration status was not a key barrier to support during the pandemic. In the Philippines and Ethiopia, an inability to access basic services due to legal status was also not widely reported; however, the majority of migrants surveyed in these locations included nationals of the country (i.e. returned migrants and those stranded internally).

Inaccessible information

The absence of accurate and up-to-date information on COVID-19 prevention, testing, treatment and pandemic support services was a key barrier for migrants. Lack of information available in languages spoken by migrants and shortcomings in disseminating messages via channels and formats utilized by migrants prevented access and affected the ability to stay safe and healthy.

In the Philippines, 21% of people surveyed who were stranded noted lack of information on support services available and where and how to access services as a barrier; language barriers were also noted, particularly among returned migrants from Malaysia. In Ethiopia, returned migrants highlighted limited access to information on the virus and on where and how to access basic services and support during the pandemic, in addition to the inaccessibility of information (in person or online) for people with limited literacy. In Egypt, COVID-19 messages by the government were only provided in Arabic; however, Egyptian Red Crescent supported translation into languages of migrant communities to increase and ensure outreach. In Sweden, the lack of information available in languages spoken by migrants and delays in dissemination hindered access to support, including to testing and treatment. Information shortcomings regarding healthcare for undocumented migrants prior to COVID-19 were exacerbated at the beginning of the pandemic.[66] In the UK, much information was provided through digital channels, leading to exclusion for migrants without internet access, and barriers were presented by lack of multi-lingual public health advice and information. In Australia, stakeholders noted there was confusion among migrants as to who was eligible for what support given the complexities of the visa system and conflicting information from national and local governments; however, only 7% of migrants surveyed online stated they had no access to information in their language.

> *"I was not able to get the financial assistance because I was not aware of it, I learned about it later from a friend who had received it."* – Returned migrant in the Philippines

> *"The information in the beginning, was not in all languages, and we found that many came to us for information, it hadn't reached all people in society."* – Nurse, Swedish Red Cross Health Referral Clinic for Undocumented Migrants.

> *"People are very confused… they are not getting the right information, and most of them can't read English. They do not know what to do or even where to go to get information… There are also concerns about access to healthcare. What to do with prescription pick up, other health issues… [doctor] appointments."* – Refugee in the UK

By contrast, 80% of migrants surveyed in Colombia, including seasonal migrants and indigenous migrant communities, reported the information provided by humanitarian actors and institutions on how to access assistance and support during the pandemic was useful and helped to meet basic needs. However, it was frequently reported that prevention and support messages did not consider the social and cultural practices and channels used by indigenous migrants, limiting outreach. It is important to note that the language of the government is also the language of the majority of migrants in the country, rendering information more accessible.

Financial barriers

Unsurprisingly, costs associated with accessing basic services, particularly healthcare, housing and food were identified as a key barrier in nearly all countries – a barrier exacerbated by the negative impacts of policies to control the virus on migrants' employment and livelihoods and compounded by the exclusion of migrants from income support measures in most contexts.

"The main determinant in getting services is money and you get money through work which was affected by lockdown" – Migrant in Egypt

"What medical assistance? In this village you have to buy everything. We cannot buy pharmaceuticals prescribed by the health centre. Everything is expensive." – Migrant in Niger

"Clients… disengage [from] access to support (such as GP consultations on phone)... they cannot afford food, cannot have basic needs met and cannot get basic support and [are like] 'You want me to go have data on my phone to call you or send documents or do a video consultation?' This was a barrier." – Service provider in Australia

In Egypt, though registered migrants, refugees and people seeking asylum have access to public healthcare services, challenges remain in terms of costly secondary and tertiary healthcare. Migrants surveyed confirmed private healthcare facilities were unaffordable and public ones were too far from where they lived. In the Sahel, migrants' access to healthcare was already limited prior to the onset of COVID-19 due to costs.[67] In Sudan, 76.9% of migrants surveyed reported lack of funds to obtain health and mental health services. In Sweden, limited financial resources was also cited as a barrier.

In the UK, primary healthcare is free of charge; however, for secondary care services, the healthcare system is residence-based, which means migrants with insecure legal status can be charged, including to access hospital treatment such as maternity services. In Australia, the most significant barrier to accessing basic services during the pandemic was lack of sustainable financial support, reported by 74% of migrants surveyed.

In Australia and the UK, research specifically indicated that lack of funds prevented migrants from accessing communication services, due to an inability to top-up or maintain mobile phone credit or data. This contributed to an inability to communicate with family, friends and service providers as well as to receive up-to-date information on the virus and restrictions in place by governments.

In the Philippines, only 4% of respondents noted that costs of services, like swab testing, presented a barrier; however, it should be noted that the majority of those interviewed (99%) were stranded within their own country upon return or en route to heading overseas for work and had greater access to and inclusion in pandemic support measures.

Insufficient or unavailable services

Due to the pandemic, there was a need to scale up basic services quickly, including for people who may not have previously needed access to support (such as those who were able to work prior to the pandemic and had access to funds, or those who became stranded within countries). The research found the limited services traditionally available to migrants were now even more restricted and under greater strain due to COVID-19 control measures and increased demand.

"After a long process, the aid of [one organization] came just to 100 EGP [~6.4 USD] for a 6-month period. It cost me 50 EGP to get to [the organization's] office to receive the aid." - Refugee in Egypt

"Many [of us] walk from far away to here, but there is no easy access to shelters. They must be created for women, children and the elderly" – Migrant in Colombia

"I believe if we could secure some form of economic support to our families, most of us would get immediate relief and emotional freedom"
– Returned migrant in Ethiopia

In Egypt, the reduction in the number of government staff by 50% and the closing of offices providing housing, official documentation and travel services prevented access to critical support, affecting migrants, including refugees, from receiving or submitting paperwork necessary to access basic services. Hospitals were also affected by the lockdown and health services were more limited. People also avoided non-emergency medical visits, hampering access to preventative care.

In the Northern State of Sudan, routine health services were affected, alongside medication supplies, resulting in a severe shortage of essential and life-saving medicines and healthcare. The closure of rural health clinics and hospitals led migrants to travel long distances for medical treatment. In the research, 76.9% of migrants surveyed outlined the limited availability of health and mental health services; 62.4% noted they did not have any access to COVID-19 testing; and just over 70% did not have access to basic services such as food or psychosocial support.

Colombian Red Cross Society provides critical medial care during the pandemic to indigenous migrant communities living along the border with Venezuela.

‘Bi-national’ migrant communities face multiple health and safety risks in Colombia

Along the Colombian-Venezuelan border live several indigenous communities relying on regular and often circular cross-border migration for food security and livelihoods. These ‘bi-national’ ethnic communities have extended stay permissions in both countries and have traditionally experienced social marginalisation and faced limited access to healthcare, employment and education. Living along the border areas, they are also exposed to threats from armed groups. Many remain undocumented. COVID-19 has increased concerns about lack of access to healthcare for these migrants, in particular.

In La Guajira and Vichada Departments, which share a 249km and 529km border with Venezuela, respectively, the pandemic and subsequent state of emergency intensified a chronic humanitarian crisis already underway due to existing barriers for indigenous migrants to access basic services. Border restrictions halted free transit and cut off many from family and support networks, livelihoods and humanitarian assistance. Movement restrictions also led to more risky and irregular migration, heightening safety concerns and fears of un-checked COVID-19 transmission. In La Guajira, vulnerabilities were compounded by climate-related impacts (including hurricanes, drought and flooding). In Vichada, limited access to safe drinking water - due to intense rains, flooding and water-borne diseases - and intense over-crowding has had both critical individual and public health implications in the context of COVID-19.

In Colombia, due to pandemic restrictions and movement constraints, some indigenous migrants were cut off from basic services across the border and faced limited service provision in their communities – with distance and lack of transport cited as key barriers. In addition, though access is granted in law, increased demand hindered access to already limited health services in border areas. A lack of PPE for indigenous healthcare institutions was also cited as was insufficient temporary shelter given the high number of migrants returning from Venezuela. In terms of education and protection services, 11% of migrants expressed these did not take into account their socio-cultural needs.

In Ethiopia, returned migrants identified the distance to services and transportation requirements as barriers and the need for greater psychosocial support. Gaps in availability of PPE, hand sanitizer and soap and mental health staff were reported in quarantine centres. The AMiRA programme teams across the Sahel also reported lack of quality protection and mental health services for migrants.

In Sweden, many health services were temporarily suspended for physical visits. The settings where specific services were normally provided, such as scheduling appointments on site at healthcare centres or hospitals, were modified to digital services. In the UK, issues with accommodation supply and quality for people seeking asylum were reported - for example, sharing bedrooms and using hotels during the pandemic. Voluntary services supporting undocumented migrants, including night shelters, were unable to operate at the same capacity or provide support in line with local public health restrictions. In Australia, reduced capacity and the inability of providers to take on additional people at refuges due to COVID-19 restrictions were reported. In the Philippines, 11% of people surveyed who were stranded noted services were not available when needed; though only 3% stated services were inaccessible due to distance.

Inconsistent application of relevant laws and policy

A common theme throughout the research was a lack of consistency in the interpretation and application of relevant laws concerning migrants’ access to basic services, as well as of specific COVID-19-related policy changes. This presented a barrier to accessing basic services during the pandemic in Australia, Egypt, the Philippines, Sweden and the UK.

"[There is] little awareness and confusion around free COVID-19 testing…among clients and service providers. One client went to a private clinic because he was directed by a public health [official] to go there. This affected access not just for him but also possibly his community. He had to pay for the test... this gave the impression the testing is not free. People from public healthcare should not be referring to private clinics. This creates a barrier [and] future reluctance to get tested." – Service provider in Australia

"We observe everyday people who try to get the healthcare they are entitled to, but they don't get it because the healthcare personnel don't know they should be getting treatment. This is the most common telephone call we receive from migrants."
– Nurse at the Swedish Red Cross Health Referral Clinic for Undocumented Migrants

In Egypt, migrants, including refugees, welcomed the government's decision not to charge fines for expired residency permits and to extend the period for renewal and allow expired permits to be used to register for some services - such as education or healthcare. But, many noted authorities in different locations were not aware of the policy change. The flexible approach by the national government was not always mirrored by frontline officials delivering services. In some cases, financial aid was transferred via post due to the closure of service providers, but the post office did not accept expired permits as identification. Migrants, including refugees, also faced barriers to communication services as telecom companies did not renew phone lines or allow migrants to pay bills with expired permits. This led to isolation and delays in receiving information and updates on the COVID-19 situation.

In Australia, concerns were raised by service providers and government stakeholders around access to basic services in law versus practice, with some interviewed highlighting how COVID-19 testing and treatment policies as well as emergency relief support might be clear at the central level, but not necessarily at the local level among frontline responders, resulting in migrants being turned away or told they are ineligible.

In Colombia, though the state guarantees universal access to healthcare in emergencies for all migrants – including in the context of COVID-19 - there is little dissemination on the regulatory scope of this policy, leading to gaps in local enforcement and access.

The proportion of unmet healthcare needs for refugees and people seeking asylum was already high in Sweden before the pandemic.[68] Healthcare staff have limited knowledge and awareness of the law and regulations on access to healthcare for refugees and persons with temporary residence permits and what is meant by the concept "healthcare that cannot be postponed or deferred"[69], leading to discretionary interpretations and exclusion from services.

In the UK, mixed practices across different local authorities were evident in terms of access to shelter for migrants at risk of homelessness and traditionally ineligible for public welfare support.[70]

In the Philippines, 21% of people surveyed reported that inconsistent interpretation and implementation of national guidelines prevented access to basic services and led to confusion over where and how to secure travel documents; 27% reported having travel delayed and prolonged stays in holding areas due to confusion in securing travel documents and permits.

Fear, health and safety concerns

A range of health and safety concerns were shared by migrants, reflecting a level of fear due to real or perceived consequences in accessing basic services.

"Being among so many people [to get help] we can easily catch the COVID-19." – Migrant in Colombia

"People will not present to hospital even though they are violently unwell because they are fearful of reporting/deportation or detention."
– Service provider in Australia

In Egypt, several migrants surveyed did not attend medical treatment and appointments due to fears of COVID-19 transmission. In the UK, immigration checks are carried out and charges applied for people with insecure immigration status seeking secondary healthcare. This causes barriers, including fear of immigration enforcement, for people from migrant backgrounds. In Ethiopia, a lack of trust between and among service providers, frontline responders and returned migrants was cited as a key barrier to basic services. In Sweden, the research suggested migrants may also avoid accessing basic services because of fear of being infected.

In Colombia, indigenous migrants expressed concerns about contracting the virus due to the nature of having to seek support in crowded locations. In Australia, despite policies ensuring free COVID-19 testing and related treatment, 11% of migrants surveyed feared accessing basic services and support because they were worried about getting sick; 30% were afraid to access support due to their visa status (including fear that accessing support would impact their current or future visa or would lead to being reported to authorities). Fear as a barrier was echoed by nearly 50% of stakeholders interviewed. In the Sahel, a number of migrants - including undocumented migrants - are likely to remain 'invisible' and avoid seeking help during the pandemic, out of fear of stigma, violence or apprehension by the authorities.

Lack of relevant documentation

Migrants at various stages of their journey reported absence of, or inability to obtain, relevant documentation (such as identification documents or residency permits) as a barrier to accessing basic services during the pandemic.

In Egypt, registration and refugee status determination processes provide identity documents necessary for people seeking asylum to access basic services. Policy measures leading to the physical closure of key offices as well as the limitations on number of government staff contributed to exacerbating delays to receive and renew these documents which existed prior to the pandemic. In Sudan, undocumented migrants and people seeking asylum transiting through Northern State lacked registration documents from the government, preventing access to employment and other basic services. Though the immigration police issue labour permits to access work, these must be renewed at cost every six months. During the pandemic, ongoing registration processes were halted and migrants who had lost work could no longer afford to pay the fees for permit renewal, hindering access and placing migrants at risk of arrest. In the Philippines, returned migrants expressed lack of personal identity documents as a key factor limiting access to services and securing travel passes to find work. In Colombia, undocumented indigenous migrants faced difficulties in accessing health care, due to difficulties in obtaining special stay permits.

Digital exclusion

As many basic services moved online due to COVID-19 restrictions, migrants with limited digital literacy or digital access encountered new barriers. In Egypt, the online issue and renewal processes for residency permits were not accessible to everyone, preventing those with expired or no documents from recharging phone credit, paying rent and utilities and receiving other forms of assistance (such as cash or food relief). In the UK, migrants faced challenges in accessing medical appointments due to online services and lack of smart phones or data to access telehealth or other support services. In Sweden, digital healthcare presented barriers for migrants without the necessary Swedish bank ID and personal social security numbers. The process to access to testing among people seeking asylum and undocumented migrants also presented barriers due to the need to have a social security number. In Colombia, access to education for indigenous migrant children was reported as at risk due to lack of internet and digital tools to engage in online studies. In Australia, stakeholders cited challenges due to the transition of health and mental health support services online, meaning migrants who had lost jobs due to the pandemic and were without income to purchase phone data or credit were at risk of exclusion.

Digital service provision – challenges and opportunities

Forced to adapt programs and move online due to government policies and restrictions, National Societies contributing to the research highlighted positive and negative aspects of digital service provision (such as remote casework and telehealth). A growing reliance on digital technology allowed National Societies to reach migrants who could otherwise not have accessed services due to COVID-19. Emergency relief support from Australian Red Cross reached migrants across 99% of geographic areas in the country through an online portal. Digital solutions allowed staff and volunteers in Sweden in at risk groups to deliver services remotely. Across several National Societies, it unlocked opportunities for introducing new technologies and alternative ways of working.

For some migrants, the digital interface provided a preferred and more dignified way to receive support.

Abdi is a case worker with Australian Red Cross. The Emergency Relief program offering casework and financial assistance to migrants was ramped-up and remote support also provided during the pandemic.

In an internal survey, British Red Cross found most people interviewed reported remote working as positive and preferred having a phone or video call rather than waiting for a face-to-face appointment. In Australia, 74% of migrants surveyed online who received emergency relief support found the online application easy to access and apply. The process also meant migrants did not have to spend money to travel to offices to receive support.

However, digitalisation comes with challenges. The rapid uptake of digital tools increases the potential for harm related to digital exclusion, privacy and data protection and challenges in identifying safety concerns. Many data protection authorities have issued guidelines or statements on the application of their respective national data protection laws in the context of COVID-19. Taking mitigating actions has been paramount for National Societies, including through the development of new internal vulnerability screening tools, guidelines on remote casework and data protection procedures.

RCRC staff and volunteers, as well as partners and community service providers in Australia, Sweden and the UK highlighted that digital technologies delineate social inequalities in service delivery. The research confirmed there is a need for digital approaches to be complemented with face-to-face or telephone support and for continued efforts to bridge the digital divide, including by engaging migrants in the design and delivery of digital-based services and working with governments to help tackle digital exclusion.

Coping with COVID-19: Migrants demonstrate ingenuity and resilience despite barriers to basic services

In the face of heightened risks and exclusion from mainstream supports, migrants have demonstrated resilience and innovation, stepping up to keep themselves and their communities healthy and safe.

- In Australia, women on temporary visas started a community kitchen, cooking for others in need of food; people seeking asylum without work rights have been critical volunteers in preparing and distributing food parcels and relief packages; one person set up a dog-walking business to support his community and his own mental health; another successfully advocated for PPE for migrant workers.
- A refugee in the UK explained: “I am trying to create online groups, due to the social distancing rules, where once or twice a week over Zoom, social media like WhatsApp groups we can have an exchange of ideas, talk about the advocacy we are doing and how we can continue that virtually... We can also have improv comedies, jokes or storytelling to lift morale. People can come up with uplifting videos for us and the wider British public.”
- People stranded in the Philippines reported keeping healthy by eating well (26%), exercising (25%), spending time with family (9%) and gardening (7%). Others joined webinars or online courses, baking or cooking classes and setting-up business online, among others.
- In Sudan, migrants highlighted solidarity within their community, with some landlords postponing rent payments until the situation improved.
- In Egypt, community solidarity was also highlighted, particularly among Somali, Yemeni and Sudanese migrant communities who self-organized to provide food vouchers from restaurants or to collect and distribute financial aid and food parcels.

Impacts on migrants' health, safety and well-being

COVID-19 and related policy measures: The continuum of barriers and impacts

Physical health risks amplified

- Higher risk of prevalence due to working and living conditions
- Risk of severity of virus due to underlying/chronic health conditions
- Barriers to healthcare, information and adequate shelter increase risks

Prevalence of insecure and unsafe housing

- Loss of job means no income to pay rent and contributes to overcrowding and rough-sleeping
- Barriers to access public housing and/or emergency accommodation

Mental health worsened

- Stress, anxiety, depression, uncertainty and fear
- Inability to meet basic needs increases distress
- Barriers to accessing health/mental health services and financial support exacerbates impacts

Food insecurity increased

- Choices between eating, paying rent or topping up phone credit to keep in touch with families, services and information
- Increased costs of food, with loss of income and carriers to basic services mean not enough food to eat.

Economic hardship and financial insecurity

- Loss of employment, livelihoods and income
- Inability to meet basic needs
- Barriers to accessing socio-economic support measures magnify impacts and contribute to exploitation risks

The exacerbation of existing barriers and new challenges presented by COVID-19, such as restrictions on movement and quarantine measures, have led to significant humanitarian consequences for migrants. The impacts of the pandemic and barriers faced in accessing services are not stand-alone but are part of a continuum of risks and challenges to keeping safe and healthy.

The most significant impacts of the virus and related policy measures in the countries of study concern physical health risks, poor mental health outcomes and negative economic impacts.

Though there is limited public data on the incidence of COVID-19 among migrants in the countries of study, the findings indicate migrants may be more at risk of contracting and experiencing severe cases of the virus – particularly where there is limited accessible information on prevention and limited knowledge of, or access to, COVID-19 testing and treatment and access to healthcare for underlying health conditions. There is also the potential for increased prevalence given challenges in following public health recommendations due to living conditions and socio-economic circumstances.

Increased stress, anxiety and worsening mental health due to the pandemic and lockdown measures was reported by both stakeholders and migrants, alike. Migrants have been particularly vulnerable to loss of income, employment and livelihoods and have not been consistently included in government socio-economic support measures, leaving them in precarious situations. Impacts on migrants' ability to meet basic needs have been severe. Food insecurity is evident, while access to safe and adequate shelter is restricted. Stigma and discrimination was evident, reflecting global reports of COVID-19 amplifying pre-existing social and economic disparities and prejudices.[75]

The evolving and dynamic nature of the pandemic has also meant both people and governments have been faced with unplanned and unanticipated situations requiring rapid responses. The research underscores the multifaceted impacts of the pandemic on migrants' mobility. Though country-level research did not explicitly focus on sexual and gender-based violence, exploitation or trafficking, some key insights are presented in Tables 2-9. Further humanitarian impacts documented relate to family separation, education, mobility and the inability to contribute to the response due to visa restrictions (i.e. lack of work rights).

The tables below highlight the key findings across the countries of study and the impacts of the pandemic and related policies on the health, well-being and safety of migrants.

Table 2: Physical health impacts

PHYSICAL HEALTH

Key findings and evidence	Listening to migrants: Voices of lived experience
• **Australia** - 6% of migrants on temporary visas surveyed noted physical health impacts as the most significant impact and 13% stated they had unmet health needs; 14% reported having to continue to work even though they might have symptoms or be exposed to COVID-19 due to lack of access to financial support. Stakeholders noted access to medicine as a key challenge. • **Colombia** - Chronic non-communicable diseases (such as diabetes and high blood pressure) are contributing to premature mortality among migrant and refugee populations. Migrants with pre-existing medical conditions are at higher-risk of experiencing severe impacts of COVID-19 and face barriers in accessing treatment for chronic illnesses due to current strains on healthcare facilities. • **Egypt** - Only 3% of migrants, including refugees, surveyed noted they or a household member had contracted COVID-19; 7% chose not to disclose. Migrants with chronic health conditions (such as diabetes) reported challenges in accessing medication due to closure of clinics and hospitals. • **Ethiopia** - The discontinuation of referrals for health and mental health support due to the state of emergency and closure of services negatively impacted returned migrants with chronic health and mental health conditions. • **Philippines** - Returned migrants in holding centres at airports, stadiums and border points awaiting onward travel faced increased risk of COVID-19 due to overcrowding and inability to physically distance. • **Sahel region** - Migrants were at increased risk of infection due to inability to comply with prevention measures given living conditions (overcrowding, rough-sleeping and poor water and sanitation facilities). • **Sudan** - 25% of returned migrants surveyed were suspected to have COVID-19 and were subsequently quarantined in line with government protocols; 63% were satisfied with services in quarantine. • **Sweden** - 32% of COVID-19 cases from March to May 2020 were among migrants (who only account for 19% in the population).[76] This is mainly linked to socio-economic factors such as often being overrepresented in labour sectors most affected by the pandemic, not being able to work remotely, using public transport, less stable employment and overcrowded or sub-standard housing.	*"In the beginning I received very little information. I became infected [with COVID-19]... Since then I wear a mask, keep distance, and wash hands... I have nothing to do which leads to a lot of stress... I can't leave Sweden and have difficulty sleeping at night. I'm very anxious and feel like I am in a prison..."* – Migrant in Sweden *"PPE is not available. Migrants are expected to find and pay for it themselves… One employer provided a single use disposable mask and told workers to wear it for 3-4 days."* – Undocumented migrant in Australia *"You are afraid - what if it is the coronavirus and you are affecting more people. It really affected me mentally and also physically."* – Refugee in the UK

Table 3: Mental health impacts

MENTAL HEALTH

Key findings and evidence	Listening to migrants: Voices of lived experience
• **Australia** - 42% of migrants surveyed said the pandemic negatively impacted their mental health; 17% noted isolation and lack of social life as particularly difficult to cope with; 12% had unmet mental health needs; 33% stated feeling isolated and alone was a barrier to keeping safe and healthy and seeking support. Service providers reported spikes in acute mental health concerns such as suicidal ideation. • **Colombia** - Loss of employment and/or income due to quarantine caused high levels of stress for Venezuelan migrants; particularly for women with fewer support networks. This was evidenced by significant increases in depression and anxiety disorders. Migrants surveyed also requested more information related to self-care during COVID-19 given mental health impacts. • **Egypt** - Migrants, including refugees, surveyed cited physical distancing regulations as the biggest factor affecting their mental health. Fear of contracting COVID-19 increased anxiety and stress. The loss of employment and associated stress led some to experience suicidal ideation. • **Ethiopia** - Returned migrants confirmed the pandemic and state of emergency measures – including the return process and quarantine protocols - had significant impacts on their mental health and psychosocial well-being. 46.7% of returned migrants surveyed reported experiencing mental distress due to the pandemic (including anxiety, depression or other psychological pressures); 16.3% at a severe level and 30.4% at a moderately high level. • **Philippines** - 8% of migrants stranded reported increased anxiety (including 10% of internal migrant workers, 4% of returned overseas Filipino workers and 10% of returned migrants to Mindanao). • **Sahel region** - There is a high prevalence among migrants supported by the AMiRA programme of poor mental well-being indicators, including persistent fatigue, difficulty sleeping, and feelings of guilt, sadness, anxiety, panic and fear. The strain of forced immobility and loss of livelihoods created further mental health and well-being problems. • **Sudan** - 84% of migrants surveyed reported a decline in mental health. Migrants expressed fear of contracting COVID-19 and dying, isolation and uncertainty about their fate (including in relation to deportation and dealing with local authorities) as creating enormous psychological pressure. • **Sweden** - People seeking asylum and refugees were identified as being at risk of mental ill-health, even prior to the pandemic. Evidence suggests the pandemic may result in additional traumatising life events, as well as introduce or aggravate pre-existing depressive symptoms.[77] • **UK** - People seeking asylum and refugees have been identified as five times more likely to suffer from complex mental health problems, such as PTSD.[78] The pandemic and conditions in the asylum system have exacerbated existing and created new mental health issues. Migrants reported mental health impacts, lack of social interaction and loneliness due to lockdown measures and restrictions.	*"Being at home for more than seven months has been very depressing, also having various stress and financial pressures. I feared the financial crisis more than COVID-19."* – Migrant on temporary visa in Australia *"[COVID-19] turned our lives upside down …we already have trauma."* – Refugee in Egypt *"[COVID-19] is keeping us all at home and that's difficult because we're social beings. Families are separated, social media is where we connect now and, the more isolated people are, it has an impact on what activities they can do and on their mental health..."* – Refugee in the UK *"No sleep, no nothing. No routine, strange fear... I've never experienced or seen anything like that. But of course, no one's seen anything like it though, have they?"* – Undocumented migrant in Australia

Table 4: Economic Impacts

ECONOMIC IMPACTS (LIVELIHOODS AND EMPLOYMENT)

Key findings and evidence	Listening to migrants: Voices of lived experience
• **Australia** - 58% of migrants surveyed online cited either job loss or financial impact as the most significant impact of pandemic; 62% of migrants interviewed cited job loss as a key impact; 87.5% of migrants interviewed noted worsened financial circumstances. • **Colombia** – Migrants experienced partial or total loss of livelihoods – particularly those in the informal economy – due to the state of emergency and isolation and quarantine measures. • **Ethiopia** - Returned migrants outlined that state of emergency measures prevented employment and economic support. Migrants whose livelihoods depended on cross-border mobility with Sudan were particularly impacted. • **Egypt** - The state of emergency and related curfew and business closures impacted migrants employed irregularly in the hospitality and cleaning sectors. Nearly 80% surveyed said their jobs were badly affected by COVID-19 measures (defined as 70-100% decrease in income). Reduced work hours and challenges in purchasing facemasks and hygiene products due to loss of income were reported. • **Philippines** - 33% of people surveyed lost jobs or businesses due to the pandemic. Returned migrants from Malaysia were among the most affected (70% lost jobs or business), followed by internal migrant workers (60%) and overseas Filipino workers stranded in the country (30%); 16% of those surveyed had to borrow money or take out loans. • **Sahel region** - A rapid assessment carried out in Niamey in July 2020 by the AMiRA Programme found migrants working as manual labourers before the pandemic no longer had jobs. Those without work prior to the pandemic turned to begging as a coping strategy; the majority were not able to make enough money to support their basic needs. • **Sudan** - General lockdowns and curfew policies affected migrants' access to money to offset daily expenses; 92.2% of those surveyed noted their income was negatively affected by the pandemic. • **Sweden** - Migrants are overrepresented in sectors most affected by the pandemic such as hospitality (migrants account for at least 40% of employment in this sector).[79] Residence permit conditions enhance vulnerability in terms of a job loss. 75% of migrants accessing one food programme run by the National Society stated their income was negatively affected by the pandemic.	*"The jobs have vanished…now, I am not working. Before I worked with cleaning jobs, receptions. It´s so difficult, things are shutting down…"* – Migrant in Sweden *"For street vendors, many of us lost investment capital due to the pandemic."* – Migrant in Colombia *"Even Sudanese suffer from the lockdown, curfew, job insecurity and loss of livelihood, but so do we and we are left alone."* – Migrant in Sudan *"[COVID-19] has had a huge impact… After I graduated, I did not get the job I was supposed to, what I have studied for. But I had to take a job. But they wanted to take advantage of me... Then I got another job in the restaurant business, but due to the restrictions they had to close. Now I have a part-time job at another restaurant…they say every day that it is not certain that I will be able to continue working."* – Migrant on temporary permit in Sweden

Table 5: Impacts on food and shelter

FOOD AND SHELTER

Key findings and evidence	Listening to migrants: Voices of lived experience
• **Australia** - 80% of people receiving emergency relief payments from Red Cross indicated they will use them to meet food needs;[80] 50% of migrants surveyed online had trouble accessing enough food to sustain themselves; 44% reported unmet housing needs; and 50% of those interviewed noted the pandemic has led to difficulty with maintaining accommodation. • **Colombia** - Border closures, movement restrictions and loss of livelihoods led to limited access to shelter and food, with many migrants eating only once per day; 18% surveyed cited food security and malnutrition as the biggest risks for children during the pandemic. Homelessness is increasing. • **Egypt** - Access to food is a key issue with many migrant families moving to share houses to save money and feed their children. Many surveyed were totally dependent on food parcels from humanitarian organizations; 95% reported facing housing insecurity. Some were already homeless. • **Philippines** - 50% of returned migrants, 12% of internal migrant workers and 11% of overseas Filipino workers all stranded internally due to travel restrictions and lack of flights were not able to put enough food on the table; 9% reported eating only once per day. • **Sahel** - The pandemic has exacerbated migrants' already precarious access to safe shelter, leaving many homeless or living in overcrowded shelters (including transit centres).[81] • **Sudan** - 71.2% of undocumented migrants surveyed faced challenges in meeting daily food needs and paying rent and utilities; 84% noted degradation in water, sanitation and hygiene conditions at home due to the pandemic; 71.2% noted negative impacts on their housing situation. 52.2% of returned migrants noted sufficient food was available during mandatory quarantine centres. • **Sweden** - National Society experience shows undocumented and homeless migrants often suffer from food insecurity. Over 50% of migrants accessing a National Society food program during the pandemic were living in unstable housing conditions without contract, crowded with many people in one apartment or moving around between different places. • **UK** - People seeking asylum report struggling to afford food and being forced to choose whether to spend the small amount of money they have on food, or other essential items.[82] In March 2020, all evictions from asylum support accommodation were suspended,[83] safeguarding nearly 50,000 people seeking asylum from risks of homelessness and destitution. The 'Everyone In' homelessness scheme provided accommodation to people rough-sleeping. Some local authorities provided emergency accommodation to migrants; around 50% of the 5,400-people taken into emergency accommodation in London were migrants who had no recourse to public funds or were European nationals not eligible for support under normal circumstances.[84]	*"The support we have been missing [is]…housing, paying rent and bills, and clothes."* - Migrant in Sweden *"We were evicted once because we didn't have any money for rent."* – Migrant in Colombia *"[It is] hard to meet the rent. The choice is between paying rent and eating food"* – Undocumented migrant in Australia *"I am in urgent need of food aid. I have three children and they are starving. I lost my job because I had COVID-19. I have no resources."* – Migrant in Colombia *"The thing we need most as families was food because stores were closed."* – Migrant in Egypt *"We have to travel to the bigger shops with lower prices but now with lockdown we can't travel and the small shops hiked their prices. Things like soap and hand sanitiser are very expensive and leave only a few pence for food and other essentials."* – Refugee in the UK

Table 6: Stigma and discrimination

STIGMA AND DISCRIMINATION

Key findings and evidence

- **Australia** - Despite a national increase in racism incidents[85] during the pandemic, data collected did not reflect this as a key impact; only 1% of migrants surveyed experienced racism.
- **Colombia** - The National Society reported stigmatization as a result of the pandemic, with one migrant noting "…lately we are blamed for everything that is bad." There is evidence of regression in integration and social inclusion and significant increase in negative attitudes towards migrants, associated with the poor economic conditions and competition for livelihoods.
- **Egypt** - Reflections on stigma varied, with some migrants, including refugees, facing physical and verbal discrimination and others being accused of bringing the virus to the country at the start of the pandemic.
- **Ethiopia** - Families were hesitant to accept returned migrants due to fear of contracting COVID-19 and associated stigma.
- **Philippines** - 80% of locally stranded individuals did not experience stigma or discrimination. The majority surveyed were Filipino migrants recently returned from overseas or stranded internally which may contribute to this result.
- **Sahel region** - COVID-19 amplified existing stigma. Returned women in Niger shared how being returned by the state during the pandemic increased stigma; people avoided them out of fear of contamination. Some returned migrants in Guinea did not receive a warm welcome from their families, who were wary of taking them back in due to the pandemic.[86]

Table 7: Mobility impacts

MOBILITY IMPACTS

Key findings and evidence

- **Australia** - For some migrants, return home is not an option for safety reasons, including people seeking asylum; for others, there are barriers to immediate return, including border closures or caps on arrival numbers, few flights and high ticket prices, and the costs of quarantine on-arrival.[87] Other impacts include the effective cessation of the resettlement programme and the inability of migrants and refugees to sponsor immediate family members.
- **Colombia** - Due to border closures, isolation and quarantine measures, indigenous communities regularly migrating across the border to/from Venezuela were unable to do so. Migrants also resorted to risky migration routes. The reappearance of caravans of migrants in transit, travelling by bus and on foot, through unsafe routes and experiencing protection, environmental and COVID-19 risks has been observed.
- **Egypt** - Refugees awaiting resettlement had plans put on hold. Seasonal migrant workers were prevented from returning home and had no option but to remain in Egypt, where they were without support or employment and spent all seasonal earnings.
- **Ethiopia** - Due to job loss, migrants surveyed were compelled to return from overseas; 95% were reported to be in vulnerable situations upon return according to a key stakeholder.
- **Philippines** - Migrants returned home in mass due to the pandemic and fears of being stranded abroad, only to be stranded internally in larger cities due to travel restrictions.
- **Sahel region** - Restrictions on movement made it difficult for migrants to continue journeys, either between or within countries, resulting in many stranded for months, particularly in major transit cities such as Bamako, Gao, Niamey, Agadez and Ouagadougou.

Table 8: Sexual and gender-based violence

SEXUAL AND GENDER-BASED VIOLENCE (SGBV)

Key findings and evidence
• **Australia** - 30% of key stakeholders, including government and non-governmental organisations, reported increased domestic violence among migrants accessing their services. • **Colombia** - Violence towards migrant and refugee women and girls increased, particularly when preventive isolation measures were put in place. New forms of violence were identified, such as threats of being infected with COVID-19. • **Egypt** - Some migrants, including refugees, reported an increase in domestic violence due to being at home more often and having limited access to support. Some left home due to violence and slept on the streets. • **Sweden** - The National Society recorded an increase in SGBV in some of its services and developed guidelines for local branches to make safe referrals when SGBV was identified.[88] The threat of being infected with COVID-19 was reported as a new form of abuse. • **UK** - The National Society reported an overall increase in gender-based violence, particularly domestic abuse, and increasingly complex safeguarding concerns for migrant women. During the first three months of national lock-down, the UK's 24-hour domestic abuse helpline saw a 65% increase in calls and 700% increase in visits to their website.[89]

Table 9: Risks of labour exploitation and trafficking

RISKS OF LABOUR EXPLOITATION AND TRAFFICKING

Key findings and evidence
• **Australia** - Stakeholders shared accounts of migrants at risk of exploitation due to lack of income support and desperation to take any job available to survive. Reports of migrants being paid below the official hourly rate, working without pay and false advertisements directed to migrants for exploitative work purposes were reported. • **Colombia** - Indigenous migrants reported being paid very little and taken advantage of due to the pandemic, needing to work despite exploitative conditions. The increased use of irregular routes due to border closures heightened risks of trafficking (especially for women and girls) and recruitment of migrants by armed groups (also as a means to access some form of livelihood). • **Egypt** - Migrants and refugees highlighted exploitative work conditions, including working extra hours with no pay. • **Sahel region** - The risk of trafficking and other exploitative work has increased with the loss of livelihoods with the pandemic.[90] • **Sweden** - National Society experience indicates several factors such as changes in legislation and lack of access to basic services has led to increased labour exploitation, due to the migrants' need to secure shelter and livelihood without access to assistance and social services.

Global COVID-19-related protection concerns

Credit: Andrés Lemus, Guatemalan Red Cross

Protection concerns, not related to access to basic services, that migrants may face due to the pandemic itself and the response measures adopted by states, are beyond the scope of this research.

This textbox highlights key general trends on the protection concerns observed across the globe. As outlined in this report, barriers limiting migrants' access to prevention measures, healthcare and other basic services make it more difficult for migrants to keep safe or seek treatment. What has been observed more globally - outside of this report's research - is that the requirement to report migrants in an irregular situation to law enforcement or migration authorities - as placed by certain states on healthcare and other service providers and humanitarian organisations - may deter migrants from seeking much needed help. Furthermore, camps, formal and informal settlements, including urban slums, as well as immigration detention facilities pose specific challenges in terms of physical distancing and hygiene measures, which causes further health concerns for migrants in those sites. Migrants in camps and camp-like settings have also been disproportionately affected by the application of lockdown, quarantine or isolation measures when these were not accompanied by adequate prevention measures and appropriate medical preparedness and response.

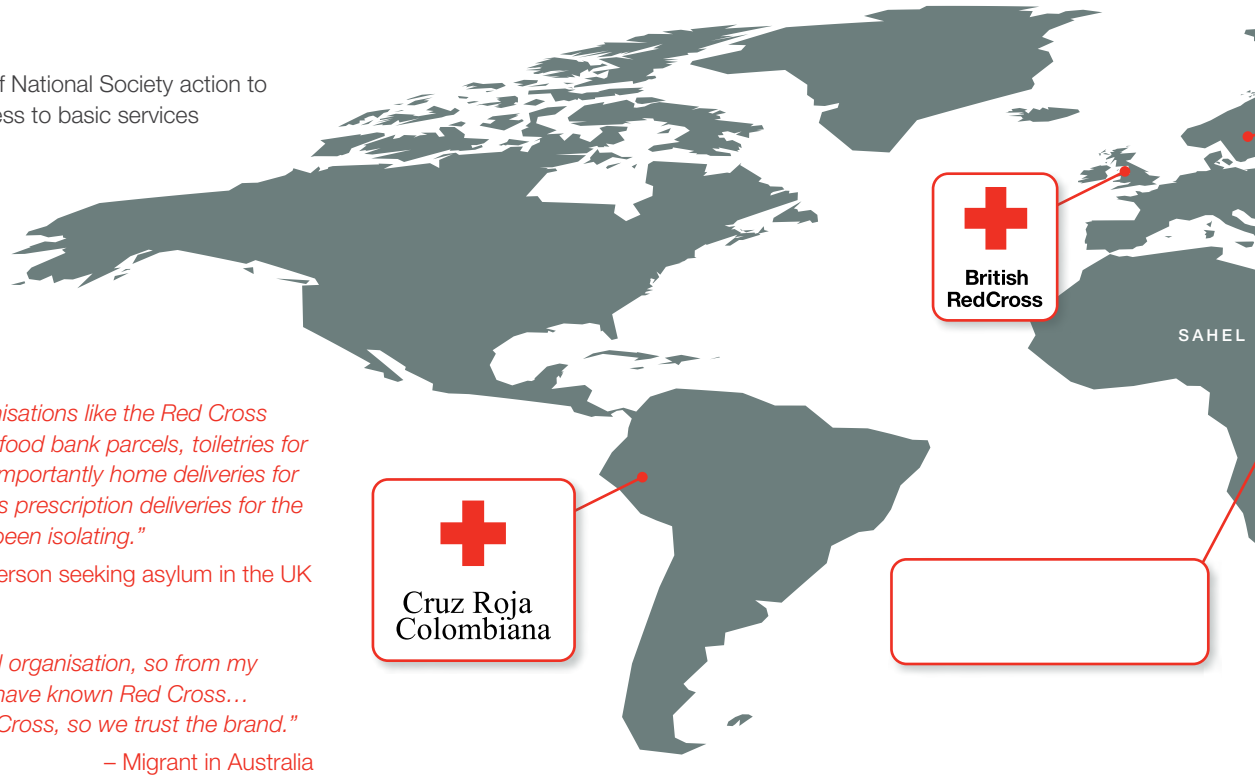
The disruption in assistance, loss of livelihoods - due to migrants' heavy reliance on the informal sector for income - and increasing isolation caused by the pandemic have affected the ability of migrants to meet their basic needs. This exposes them to increased risk of food insecurity as well as to neglect, abuse, exploitation and violence, including sexual violence. It may compel them to adopt harmful survival strategies such as child labour, child marriage, transactional sex or returning home to unsafe or untenable circumstances.

Migrants have also been exposed to increased risks of returns, potentially in violation of the principle of non-refoulement, due to blanket border closures, push-backs and/or expedited returns procedures implemented by some states without safeguards in place to protect migrants against refoulement and to ensure access to international protection for those in need. Failure to maintain humanitarian exceptions to travel restrictions, such as resettlement procedures for refugees and exemptions to allow access to critical or life-saving medical care or to family reunification for individuals who are highly dependent on care from their relatives, has also been a concern. Furthermore, tensions and fears created by the pandemic have compounded pre-existing discrimination against migrants, leading to stigmatization, scapegoating and exacerbating the risk of violence from communities and xenophobic groups. Homeless migrants have sometimes faced harassment by the police due to not being able to implement lockdowns and other preventive measures.

Migrant children, like other children across the world, have been affected by school closures and a reduced access to education. For children in immigration detention, transit sites or camps, all of these places may have suffered from reduced staff presence and a reduced offer of humanitarian services, including health, mental health and education. The restrictions of movement within countries or across borders have led to new family separation, particularly linked to enforced quarantine or isolation measures or hospitalization of family members, or prolonged existing family separation, as border closures, restrictions on movement and/or access to COVID-19 testing have slowed or prevented family reunification.

Red Cross and Red Crescent in action during COVID-19

Figure 2: Snapshot of National Society action to ensure migrants' access to basic services



"I thank God for organisations like the Red Cross who can help us with food bank parcels, toiletries for everybody and most importantly home deliveries for food parcels as well as prescription deliveries for the vulnerable who have been isolating."

– Person seeking asylum in the UK

"Red Cross is a global organisation, so from my childhood until now I have known Red Cross… We have trust in Red Cross, so we trust the brand."

– Migrant in Australia

National Societies around the globe have stepped in and scaled up support to mitigate and address impacts of the pandemic and facilitate access to basic services and humanitarian assistance to migrants, irrespective of legal status. National Societies found innovative ways to adapt to challenges presented by movement restrictions and other public health measures and, in many contexts, were recognised as providing an essential humanitarian service and so had specific exemptions.

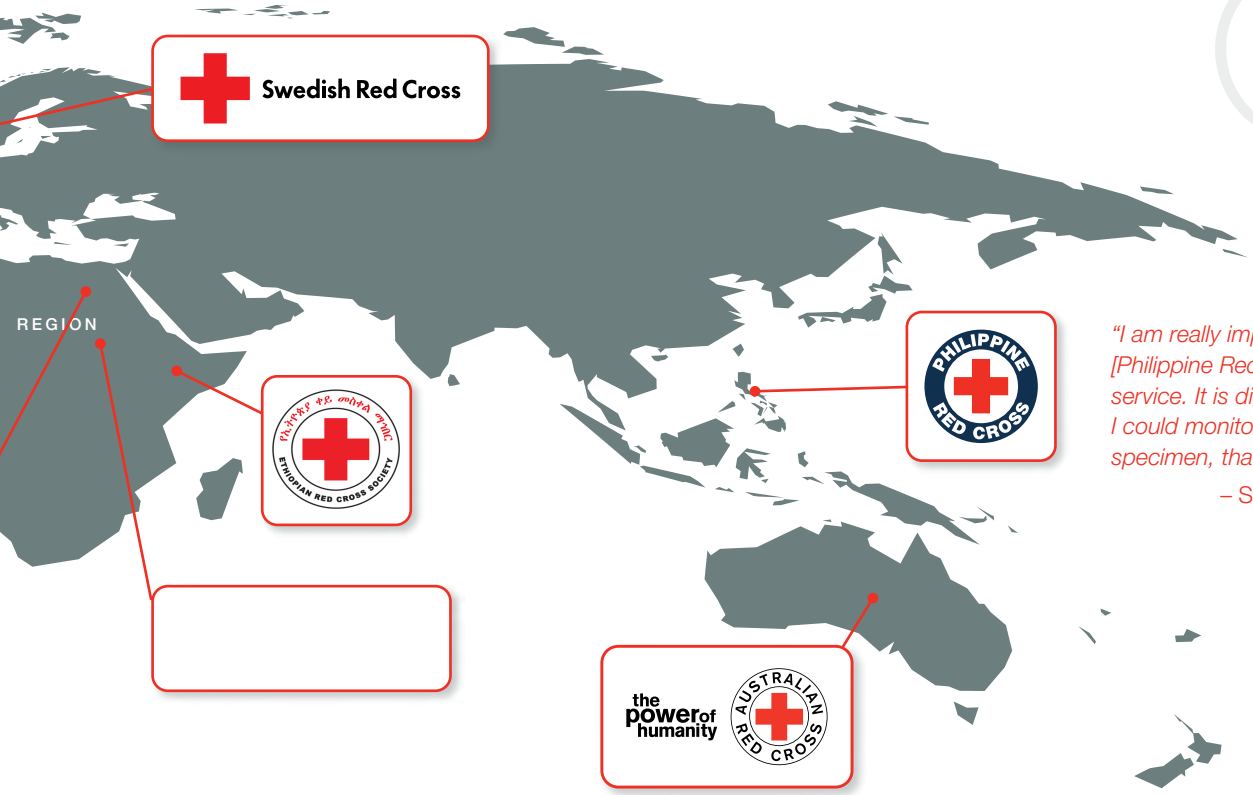
Figure 2 highlights key actions to ensure access to basic services for migrants by the National Societies contributing to this research since the start of the pandemic.

AUSTRALIAN RED CROSS: Established a nationwide online portal to provide emergency relief support to migrants, including cash assistance, casework for people with significant vulnerabilities and key referral information. From April to November 2020, over 95,000 people were impacted, including 20,000 through food relief and over 65,000 payments issued.

BRITISH RED CROSS: From March to end of November 2020, refugee support teams assisted 21,748 people seeking asylum, refugees and migrants with 159,262 casework interventions; provided direct cash assistance to 1,237 people; distributed 9,503 food parcels; provided emergency accommodation to 217 individuals; supported 3,806 individuals with accommodation-related interventions; established a new female-only young refugee peer support group; and translated government health guidance into 60 languages, with partners. In addition, the Hardship Fund was created by the National Society with Aviva and the Aviva Foundation to provide short-term financial help to those affected by the pandemic who cannot afford essentials. As of November 2020, 60% of the 7,226 people supported were people seeking asylum, refugees and people with no access to public funds due to their immigration status.

COLOMBIAN RED CROSS: Assisted more than 525,000 migrants and host communities from March to December 2020, providing more than 1,320,000 critical medical services; delivered COVID-19 prevention and awareness information and dignity and hygiene kits to indigenous migrant communities through mobile health units; undertook protection monitoring; delivered safe drinking water, direct cash transfers, rent assistance and psychosocial support (include through telecare); established child and youth-friendly spaces; and injected capital into individual and collective initiatives of migrants affected by COVID-19.

ETHIOPIAN RED CROSS SOCIETY: Provided direct cash assistance; psychological first aid; livelihood support; reintegration assistance; protection/hygiene kits; access to information; restoring family links services; access to mental health and psychosocial support; and key referral and linkage services. Approximately 300 returned migrants per week were supported from April to September 2020. More than 500 returned migrants were provided with in-kind and cash support.



"I am really impressed by the [Philippine Red Cross] swab testing service. It is digital and real time. I could monitor the status of my specimen, that lessens my anxiety."

– Stranded migrant in the Philippines

EGYPTIAN RED CRESCENT: Provided direct cash assistance to migrants and refugees; shifted livelihood and health education activities online; translated and disseminated government COVID-19 information in five languages; provided e-vouchers via mobile phone for food and hygiene materials; produced four different videos in eight languages and 10 COVID-19 myth-busting awareness messages in five languages.

PHILIPPINE RED CROSS: Provided COVID-19 testing, food relief and hygiene/dignity kits in hotels and quarantine facilities and at ports of arrival; delivered psychological first aid; established child friendly spaces; offered free SIM cards to maintain communication; provided referrals to quarantine centres and offered temporary shelter in metro Manila. The National Society also updated its 'Virtual Volunteer' web-based application which puts vital information directly into the hands of those who need it – prospective migrants, those away from home, and the family members of migrants. It was updated with the most current information about COVID-19, including the location of quarantine facilities, government advisories and contact details of relevant organisations and agencies, to support migrant workers while abroad and upon return to the Philippines.

SAHEL REGION: The AMiRA programme in the Sahel region of West Africa - Burkina Faso, Guinea, Mali and Niger – as well as in Egypt and Sudan provides psychosocial support, healthcare and referrals, access to information and livelihood assistance. National Societies in nine Sahel countries reached over 13 million people with risk communication and community engagement activities, mobilising a network of over 20,000 volunteers from March to September 2020.

SUDANESE RED CRESCENT SOCIETY: In Northern State, provided psychosocial support, first aid and food relief to returned migrants in quarantine isolation centres; developed and disseminated COVID-19 awareness messages in local dialects, reaching 149,129 migrants and host community members; equipped shelters for returned migrants with water and sanitation items; distributed face masks, sanitizers and food baskets to 569 migrants; and provided direct cash support to 311 migrant families, as well as access to medicines and referrals for mental health support.

SWEDISH RED CROSS: Scaled up and adapted its migration counselling service to become digital; offered online and in person support through six treatment centres for persons affected by war and torture; facilitated access to healthcare through its health referral clinic for undocumented migrants; established a national hotline to prevent isolation and loneliness and provide psychosocial support and accurate information; provided food relief and other in-kind support; distributed information in different languages and engaged with people in immigration detention remotely. Local branches adapted to restrictions and recommendations, keeping social activities and meeting places open.

Recommendations

Drawing on the evidence presented, in the context of the COVID-19 pandemic and in preparation for future health emergencies, governments, donors and development and humanitarian actors should listen to and be guided by the voices, expertise and experience of migrants.

It is the primary responsibility of states to respect, protect and fulfil the human rights of migrants, including their economic and social rights. The report recommends that states work together with other stakeholders to:

1. Ensure all migrants, irrespective of legal status, are included in local and national COVID-19 responses that guarantee access to basic services, including healthcare, housing, food, water, sanitation and hygiene services, psychosocial support, education, emergency support and protection services.
2. Ensure all migrants, irrespective of legal status, have effective access to timely, accurate and reliable information on COVID-19 (and any future pandemics) in a language they understand and through accessible dissemination channels. This information should include prevention measures, when and where to access testing, treatment, vaccines and other relevant supports.
3. Ensure all migrants, irrespective of legal status, are included in COVID-19 testing, treatment and vaccination policies and roll-out strategies and have equal access to testing, treatment and vaccines.
4. Ensure all migrants, irrespective of legal status, who have lost their livelihoods and are unable to meet their basic needs are included in pandemic-related socio-economic support (now and in the future).
5. Continue to adapt existing laws and policies to ensure inclusive access to basic services and complement any policy changes with operational guidelines and awareness training for frontline responders to ensure entitlements in law are realized in practice. This includes addressing formal barriers preventing migrants from accessing services, such as amending restrictive rules and/or working to limit the loss of temporary visa status and regularise status for people without visas, but also informal barriers, such as information gaps, language issues and prohibitive costs. Furthermore, migrants must have safe access to humanitarian assistance without fear of arrest, detention or deportation. In all circumstances, the primary consideration should be to treat migrants humanely, taking into account their specific vulnerabilities and protection needs, and to respect their rights under international law.

Conclusion

Credit: Noemi Monu, Danish Red Cross

Amina, from Niger Red Cross, speaks to a migrant who just arrived at a support center in Niamey.

The research confirms that migrants face significant humanitarian consequences due to the exacerbation of existing barriers - and the evolution of new challenges - in accessing basic services during the COVID-19 pandemic. COVID-19-related policy measures, while aimed at improving public health outcomes, have contributed to migrants' inability to meet their basic needs and to live in safety and dignity. Barriers to basic services risk compromising public health efforts. Emergency responses to assist migrants have tended to be inconsistent with support measures for nationals or permanent residents, with migrants frequently excluded from socio-economic policies, despite playing key roles in response and recovery efforts, being over-represented in sectors hard-hit by the pandemic and being impacted by the same prevention and control measures as host communities. Indeed, COVID-19 has further exposed systemic barriers and underlying inequalities in access to basic services for migrants and has often widened support gaps, with increasing concerns as to whether countries will include all migrants, irrespective of legal status, in COVID-19 vaccination campaigns. In recognizing that policy environments differ across countries, the research has revealed migrants throughout their journeys and across various contexts are at heightened risks of direct and indirect impacts of the virus and face common barriers to accessing basic services, to varying degrees, due to pre-existing and COVID-19- specific policies. Longstanding and systemic barriers have not disappeared but have instead been amplified in this global public health crisis, with new challenges emerging, all of which place migrants at heightened risk of COVID-19 infection and transmission. Policies to support migrants have been largely reactive and ad hoc rather than inclusive from the outset. While these measures are welcomed, they are not sufficient to meet the needs of migrants and have led to discriminatory levels of support, generating risks to individual and public health and safety. There is a need to come together in policy and practice to ensure equitable and effective access to basic services - including COVID-19 testing, treatment and vaccines - for all migrants, irrespective of legal status. This is in everyone's interest.

Appendix 1 - Methodology and demographics

Country	Additional details of methodology and sample demographics
AUSTRALIA	Methodology: • Online survey: 1,925 valid responses collected over two weeks (9-27 October 2020) via SurveyMonkey in six languages. An email with links to the survey in language was sent to 21,904 migrants who had accessed at least one emergency relief payment from Australian Red Cross between April and September 2020 (the survey response rate was 8%). People were given the option to take the survey over the phone instead of online; 11 surveys were completed over the phone. • Semi-structured interviews: 24 migrants accessing Australian Red Cross services (12 on temporary visas and 12 undocumented migrants were interviewed). 22 external stakeholder across all states and territories were interviewed, including service providers, humanitarian actors, migrant networks, community organizations and governments. • Focus group discussions (FGD): 1 FGD with people on temporary visas and undocumented migrants (30 participants in total). 5 internal FGD with Australian Red Cross staff and volunteers (including caseworkers, support officers and senior management). Demographics of online survey respondents: • Gender: Female (61%); Male (39%). • Household composition: Single adult (72%); Couple (18%); Couple with children (8%); Single adult with children (2%). • Country of origin: China (excluding SARS and Taiwan) (24%); Nepal (21%); Philippines (12%): India (10%); Thailand (7%); Malaysia (4%); Vietnam (4%); Colombia (3%); Sri Lanka (2%); South Korea (1%); other (13%). • Type of visa: International Student (69%); Bridging Visa (11%); Temporary Graduate (8%); Working Holiday (3%); Other Temporary (4%); Temporary Resident (skilled employed) (3%); Visitor (1%); Temporary Resident (other employed) (1%). • Number of years in Australia: Less than 1 year (18%); 1-3 years (51%); 3-5 Years (19%); 5-7 years (7%); more than 7 years (5%). • Household member with a disability: No (93%); Yes (3%); Not sure (4%).
COLOMBIA	Methodology: • A survey questionnaire was developed to better understand the impact of the pandemic on migrants and to validate assumptions based on secondary sources and data provided by Red Cross operations through a community engagement and accountability approach from June to December 2020. • The purpose of the survey was to assess the situation of access to services for migrants in the Guajira/ Maicao and Vichada, with a particular focus on protection services for young people, access to information and perceptions of stigmatization. • 203 migrants were surveyed (with a focus on indigenous migrants, including migrants in transit, seasonal migrants and undocumented migrants). • 2 FGD were also held with migrants accessing Red Cross services. Demographics of survey respondents: • Gender: Female (56%), Male (44%). • Migration status: seasonal migrants (97%); permanent migrants (2%); transitory migrants (1%). • Period of residence: 1 week or less (3%); 1 month or less (2%); 6 months or less (12%); more than 6 months (83%).

Country	Additional details of methodology and sample demographics
EGYPT	Methodology: • FGD with members from migrant and refugee communities and in-depth interviews with community leaders held in 5 locations. All sessions took place in Egyptian Red Crescent hubs, except for one, which took place in a hub operated by a partner organization. All hubs lie in Greater Cairo, Egypt. • Members of migrant and refugee communities were invited through Egyptian Red Crescent hub coordinators and community leaders in 5 different locations. • A total of 10 FGD and 5 in-depth interviews were conducted. Participants did not have to have accessed Egyptian Red Crescent services to participate. • Each FGD included 6 participants, to guarantee application of COVID-19 social distancing recommendations. • FGD sessions were separated by gender and age group was considered. • The total number of people who participated in FGD was 60, in addition to the 5 community leaders who joined the in-depth interviews. Demographic information: • Gender: FGD: Male (50%); Female (50%). Community Leaders: 2 Male, 3 Female. • Age: 18-25 (17%); 26-40 (49%); 41-60 (32%). • Country of Origin: Sudan (30%); Syria (19%); Somalia (19%); Yemen (14%); South Sudanese (7%); Ethiopia (5%); Eritrea (5%); Djibouti (2%). • Migration status: Registered refugee (69%), Person seeking asylum, awaiting outcome of application (24%); Migrant (3%); Unregistered (3%). • Education: Tertiary education (41%), Secondary (24%); Postgraduate (5%), Primary (8%); Prep (8%); Vocational (3%) Online (3%); Illiterate (7%).
ETHIOPIA	Methodology: • Both primary and secondary data sources were used to conduct the study. • Primary sources included a quantitative survey, key informant interviews, case study and observation. • Key informants interviews were conducted with 13 program staff, including Ethiopian Red Cross Society, Danish Red Cross Society, and ICRC. • Two in-depth critical case analyses from migrants accessing Red Cross support were included. • Quantitative primary data was collected from 93 returned migrants receiving economic and psychosocial support from Ethiopian Red Cross Society field offices in Debark and Shirka. Demographics of survey respondents: • Gender: Female (80.6%); Male (19.4%). • Age: Under 30 (83.9%); Over 30 (16.1%) • Marital status: Married (50.5%); Single (26.9%); Divorced (17.2%); Separated (3.2%); Widowed (2.2%). • Country/city of destination: Sudan (55.9%); Saudi Arabia (11.8%); Beirut (17.2%); Dubai (9.7%); Eritrea (1.1%); Kuwait (2.2%); Yemen (1.1%).

Country	Additional details of methodology and sample demographics
PHILIPPINES	Methodology: • The researcher reviewed policies and relevant documents, conducted a survey, FGD and key informant interviews in Ilo-Ilo Province, Negros Occidental, Misamis Oriental and Zamboanga del Sur. • A virtual modality was used for the FGD and key informant interviews. • The survey included a mix of face-to-face and virtual consultation. • Locally stranded individuals, returned migrants, Philippine Red Cross Society COVID-19 Responders and Administrators, local government and line agency officials were interviewed. Demographics of survey respondents: • Nationality: Filipino (99%); Other (1%). • Gender: Male (58%); Female (41.5%), Prefer not to say (0.5%). • Age: Mean age was 33.9 years. • Migration status: Internal migrant (74%); Overseas Filipino workers (23%); returned migrants from Malaysia (3%). • Main source of income: Private employer (47%); None (32%); Self-employed (11%); Government (7%); Other (2%). • Majority of the respondents travelled from Luzon (77%), including overseas Filipino workers stranded during the lockdown. The sample also included locally stranded individuals in Visayas (17%) and some parts of Mindanao (6%).
SAHEL REGION	The data in this report for the Sahel region is largely based on the AMiRA programme and the IFRC (2020) report: Risks and Resilience: Exploring migrants' and host communities' experiences during the COVID-19 pandemic in West Africa. Data collection for the IFRC report was from August to October 2020 under three main pillars: • Desk review of existing research. • Remote Key Informant Interviews with 59 persons, targeting two groups: - Humanitarian actors in the region, including 35 Red Cross staff at global and regional levels, as well as those at management levels in National Societies in Gambia, Guinea, Niger, Chad, and Senegal; 22 representatives from national and international NGOs and United Nations agencies implementing migration projects in the five countries of focus, in addition to some select respondents with a broader regional remit - Two other key informants from a West African university and a religious actor providing services to migrants. • In-field qualitative data collection in Guinea and Niger reaching 180 persons, including interviews with 20 key informants such as local authorities and community leaders; interviews with 16 field-level Red Cross personnel and partners; and 23 FGD with current migrants, returnees, and members of the host community. Secondary data for this report was also gathered from: Bluet, K. and Davy, D. (2020) *Access to essential services for people on the move in the ECOWAS Region A report on legal frameworks and barriers to freedom of movement, residence and establishment, and access to healthcare, education, employment, housing and legal assistance*, UNHCR and IFRC Sahel Cluster.

continued on following page

Country	Additional details of methodology and sample demographics
SAHEL REGION CONTINUED	For the draft British Red Cross (BRC) case study on Understanding *Trafficking In persons along the Migratory route: An analysis of the Sahel Context with a focus on Burkina Faso* (December 2020), information was gathered through a desk-based review of relevant literature, articles, laws and policies. This analysis was complemented with remote interviews with colleagues from the Spanish Red Cross, Burkinabe Red Cross Society and other international organizations, namely IOM and UNICEF, for a total of 9 interviews. The research was conducted from mid-September until the end of October 2020. Burkina Faso was selected as a country of focus after representatives of the BRC expressed interest in and willingness to take part in this assessment. Key informants were identified in cooperation with BRC's Psychosocial Support and Protection focal pointn namely: 2 Social Assistants, BRC AMiRA Programme, Dori; 1 Field Coordinator, BRCS AMiRA Programme, Ouagadougou; 1 PSS/Protection Focal Point, BRC AMiRA Programme; 1 Protection of vulnerable groups Focal Point BRC; 1 Health Coordinator BRC; 1 AMiRA Programme Coordinator, Spanish Red Cross; 1 Protection Officer IOM Ouagadougou; 1 Child Protection Specialist, UNICEF Ouagadougou.
SUDAN	Methodology • A descriptive study of migrant communities in the Northern State of Sudan was conducted, including irregular migrants crossing the border with Egypt and Libya; seasonal workers; and displaced persons from the Nuba Mountains. • Dongola locality was selected for the focus due to the presence of the main COVID-19 isolation centre and reception centres for migrants stranded from Egypt and returnees from Libya. • The sample size for the questionnaire survey was 385. The questionnaire/survey addressed health and treatment services for migrants, the role of the Red Crescent, impacts of COVID-19 on migrants' livelihoods and access to basic services. • Key informant interviews were conducted with government departments, Red Crescent actors, local authorities and migrants (from Ethiopia, South Sudan and those displaced from the Nuba Mountains). • The Statistical Analysis Program (SPSS) was used to analyse data collected. • Secondary sources were also consulted, including migration laws and measures adopted by the country and the Northern State government, reports of the Sudan Red Crescent Society and reports of the Ministry of Health on COVID-19. Demographics of survey respondents: • Gender: Female (67.3%); Male (32.7%). • Age: Under 30 (27.8%); 30-40 (27%); 40-50 (18.6%); over 50 (26.6%). • Household: Married (83.4%); Single (16.6%).

Country	Additional details of methodology and sample demographics
SWEDEN	Methodology: • Primary qualitative data collection, consisting of 33 interviews and 6 focus groups. • The questions used in interviews and focus groups were semi-structured and data collected was used inductively to assess the impact of Covid-19 on migrants and the operations of Swedish Red Cross. • Due to the pandemic and consequential travel restrictions, interviews and focus groups took place on the digital platform Microsoft Teams. • There was a total of 19 participants across the digital focus groups, including volunteers at local branches, staff within specific areas of operations, as well as managers of treatment centres. • 11 interviews were with Swedish Red Cross colleagues from various departments. • 23 interviews were with migrants - 12 took place in coordination with a Swedish Red Cross care service facility; 4 were conducted in person at a Swedish Red Cross local branch office; 4 were conducted at a housing accommodation with asylum seekers; and 3 interviews via telephone. • Relevant and on-going academic research in the field of public health and insights from previously published reports by the Swedish Red Cross were considered.
UNITED KINGDOM	The information in this report draws on findings from the following collection of primary research, publicly available data, operational insights and evaluations gathered by the British Red Cross (BRC). This includes: • First-hand testimony shared by six members of the VOICES network – a network of people with direct experience of seeking asylum in the UK who speak out to change policy and practice. • Primary qualitative fieldwork, including 2 FGD and 5 in-depth interviews conducted over Zoom with participants from a spread of areas under additional local restrictions during July-December 2020. • Qualitative and quantitative insights from BRC frontline services including Refugee Support and Restoring Family Links services in all four nations of the UK. • Public data sources including immigration statistics from the UK Home Office, domestic abuse statistics from the Office for National Statistics and homeless data published by the Local Government Association. • Relevant insights and research from statutory and voluntary sector partners in the UK.

Appendix 2 - Key COVID-19 policies and migration statistics in research countries

AUSTRALIA	
Migration Statistics	7.7 million migrants (30.1% of population)[91]
COVID-19 Context (as of 24 January 2021)	First COVID-19 case confirmed on 25 January 2020 28,761 cases 909 deaths[92]
General COVID-19 public health and policy measures (applicable to everyone in country)	- International travel ban - Internal travel restrictions - Lockdown measures, including closure of certain commercial venues, public spaces and businesses, movement restrictions, limits on gatherings - Physical distancing in place - Mandatory hotel quarantine for overseas arrivals for 14 days, with the exception that travellers from New Zealand[93] - Mask-mandates in certain locations - Regional COVID-19 resurgence triggered a renewed lockdown in Melbourne in July until September 2020 - In November 2020, South Australia implemented an immediate, strict lockdown for three days following the spread of a community cluster - In December 2020, an outbreak in Sydney led to tightened restrictions
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- Migrants on temporary visas largely excluded from mainstream COVID-19 income support packages (including related to JobKeeper[94] and JobSeeker[95]). - Policy changes at the state and territory level for free COVID-19 testing and treatment;[96] for everyone, irrespective of status. - Limited emergency relief payments available to some migrants on temporary visas and undocumented migrants (supported by Federal and state and territory governments). - Migrants on temporary visas and undocumented migrants largely ineligible for public health scheme (Medicare). - Amendments to some visa conditions to prevent migrants from irregular status and to support people to continue to work in key sectors;[97] and extending total permitted work hours for students in key industries including health care.[98] - COVID-19 concessions for certain temporary visa classes.[99] - Flexibility in determining visa compliance for international students.[100] - Temporary moratoriums on evictions (depending on state/territory) and inclusion of migrants in eligibility for some crisis housing support or rent relief schemes (depending on state of residence). - Including some migrants on temporary visas in the Pandemic Leave Disaster Payments.[101] - Free COVID-19 vaccine for all visa holders.[102]

COLOMBIA	
Migration Statistics	1.9 million migrants (3.7% of population)[103]
COVID-19 Context (as of 24 January 2021)	First COVID-19 case on 6 March 2020 1,987,418 cases 56,586 deaths[104]
General COVID-19 public health and policy measures (applicable to everyone in country)	- State of Emergency declared on 17 March 2020 - Quarantine began on 25 March to 1 September 2020 - International travel ban - Internal travel restrictions - Lockdown measures, including closure of certain commercial venues, public spaces and businesses, movement restrictions, limits on gatherings and physical distancing in place
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- Decree 330 (2001) by the Ministry of Health and Social Protection permits and grants legal status for the establishment of indigenous health promotion entities. - Law 992 (2005) 'Agreement for the Integral Development and Basic Assistance of the Wayuu Indigenous Peoples of the Republic of Colombia and Republic of Venezuela' establishes collaboration on joint development plans to improve the living conditions of the Wayuu Indigenous Peoples located in areas adjacent to and on both sides of the Colombia-Venezuela border. - Resolution 1272 (2017) by the Special Administrative Unit for Migration in Colombia implemented the Special Permit to Stay (PEP) for Venezuelan migrants. - Joint Circular No. 16 (2018) allows migrant children to enrol in the national education system whether or not they have required documentation. - Judgement T210 (2018) by the Circular Court upheld right to health, regardless of status. - Decree 117 (28 January 2020) relates to regularization of migrants in Colombia (Special Permit to Say for Promotion of Formulation – PEPFF) and grants special permission to stay for Venezuelan migrants supported by an employer. - Resolution 285 (12 March 2020) by the Ministry of Health and Social Protection declared a health emergency throughout the country and encouraged local governments to undertake prevention and control measures to minimizes risks of contagion among migrants. - Circular 015 (13 March 2020) by the Ministry of Health and Social Protection included specific recommendations to address COVID-19 risks among indigenous groups, including mandatory preventative isolation. - COVID-19 vaccine access – The government has announced plan to regularize migrants and refugees from Venezuela by granted temporary protection status for 10 years, which will contribute to facilitating vaccine access, including for undocumented migrants.

EGYPT	
Migration Statistics	543,900 migrants (0.5% of population)[105]
COVID-19 Context (as of 24 January 2021)	First case of COVID-19 on 14 February 2020 161,143 cases 8,902 deaths[106]
General COVID-19 public health and policy measures (applicable to everyone in country)	- International travel ban - Partial curfew put in place - Public transport closed - Lockdown measures, movement restrictions and physical distancing in place - Mask-mandates in certain locations
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- Expansion of health services to ensure inclusion of registered migrants and refugees in COVID-19 testing and treatment. - Returns temporarily halted (no deportations). - Exceptional extension of expired visas and residency permits issued by government; migrants permitted to use expired documents to access some services; people allowed to renew visas without penalty or fines (including people on tourist visas or with expired residency permits). - Government-supported temporary accommodation to refugee women experiencing domestic violence. - Government fund for workers affected by job loss due to the pandemic established, but migrant workers not included. - COVID-19 vaccine free for all Egyptian citizens.

ETHIOPIA	
Migration Statistics	1.1 million migrants (0.9% of population)[107]
COVID-19 Context (as of 24 January 2021)	First COVID-19 case on 14 March 2020 133,298 cases 2,063 deaths[108]
General COVID-19 public health and policy measures (applicable to everyone in country)	- State of Emergency declared on 8 April until early September 2020 - International travel bans with mandatory quarantine on arrival - Internal travel restrictions - Public transport closed - Closure of certain commercial businesses, schools, bans on public gatherings, and social distancing measures
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- Ban on layoffs by private employers. - The Administration for Refugee and Returnee Affairs and National Disaster Risk Management Agency provide support to returned migrants.

PHILIPPINES	
Migration Statistics	225,500 migrants (.5% of population)[109]
COVID-19 Context (as of 24 January 2021)	First COVID-19 case on 30 January 2020 511,679 cases 10,190 deaths[110]
General COVID-19 public health and policy measures (applicable to everyone in country)	- Declaration of Enhanced Community Quarantine from March to July 2020 - International and internal travel restrictions - Lockdown measures, including closures of businesses, schools - Compliance to health protocols (wearing of mask, mandatory quarantine, etc.)
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- National Task Force Against COVID-19 created and operational guidelines on the Management of Locally Stranded Individuals (LSIs) developed. - Support provided to LSIs - including internal migrant workers, returned overseas Filipino workers and foreign migrants - including food, healthcare, temporary shelter and transport. - Republic Act 8042 or the "Migrant Workers and Overseas Filipino Act of 1995" emphasizes that the state, at all times, shall uphold the dignity of its citizens whether in country or abroad.

SAHEL REGION	
Migration Statistics	7.6 million migrants in West Africa[111]
COVID-19 Context (as of 24 January 2021)	First COVID-19 case in February 2020 in Nigeria. 209,912 cases[112] 3,434 deaths[113]
General COVID-19 public health and policy measures (applicable to everyone in country)	- Governments in Burkina Faso, Guinea, Mali and Niger closed borders and imposed curfews and closed public spaces (including places of worship, educational institutions, hospitality sector) - Movement restrictions and transport between cities halted in Burkina Faso - Assemblies of people limited, from 20 people in Guinea to a maximum of 50 people in Mali - Mask mandates in many countries, such as Guinea and Niger, in public spaces - Official working hours restricted in Mali
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- Internal movement, within the Sahel region, is regulated by the ECOWAS 1979 *Protocol Relating to Free Movement of Persons, Residence and Establishment*, which allows citizens of the 15 ECOWAS member states to move within the bloc's territory[114] but in reality many experience difficulties such as extortion, bribing, and verbal and physical abuse. - In Niger the enforcement of law 036/20157[115] has been a barrier for undocumented migrants. - Irregular migrants are often dependant on smugglers as they are legally vulnerable and (outside of ECOWAS) may have limited rights to access services.

SUDAN	
Migration Statistics	1.4 million migrants (3.19% of population)[116]
COVID-19 Context (as of 24 January 2021)	First COVID-19 case on 23 March 2020 28,233 cases 1,707 deaths[117]
General COVID-19 public health and policy measures (applicable to everyone in country)	- Partial lockdown, physical distancing measures, contact-tracing, quarantine and isolation for six months. - Second wave in November 2020 led to restrictions on working days of government staff, allowing vulnerable workers not to go to work - Some universities closed down - Health hygiene measures encouraged, including mask wearing
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- COVID-19 vaccine to be accessible to high-risk groups, including displaced people and people seeking asylum.

SWEDEN	
Migration Statistics	2 million migrants (19.8% of population)[118]
COVID-19 Context (as of 24 January 2021)	First COVID-19 case on 31 January 2020 547,166 cases 11,005 deaths[119]
General COVID-19 public health and policy measures (applicable to everyone in country)	- Travel restrictions - Physical distancing measures relating to a range of situations such as public and private gatherings, public transport, businesses, - Closures of secondary schools and universities (moved online) - General recommendations for the Swedish Migration Agency, Swedish Probation Agency and the Swedish National Board of Institutional Care (dealing with people deprived of liberty)[120]
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- Communicable Diseases Act (2004:168) regulates the response to outbreaks and threats of outbreaks of contagious diseases and covers COVID-19 testing and treatment. - Aliens Act (2005:716). - Law on temporary limitations to the possibility of being granted a residence permit in Sweden, 2016:752 (prolonged on 20 July 2019 [2019:481]). - Law on Reception of Asylum Seekers and Others (1994:137). - Swedish Social Services Act (SFS, 2001). - Act on Health Care for Asylum Seekers et al. (SFS 2008:344) – People seeking asylum are entitled to emergency health and dental care and healthcare "that cannot be deferred or postponed"; also entitled to childbirth care, abortion care, advice on contraception, maternity care. - Children and young people under 18 seeking asylum are entitled to the same healthcare and dental care as children resident in Sweden. - Act on Health Care for Certain Aliens in Sweden Without Necessary Papers (SFS 2013:407) - Undocumented migrants over 18 are entitled to health and medical and dental care that cannot be deferred. Undocumented migrants under 18 should be mentioned. - Prolonged financial support to newly started businesses, among which businesses operated by immigrants are overrepresented. - Free COVID-19 vaccine to all Swedish residents. The Swedish Association of Local Authorities and Regions (SALAR) recommends the inclusion of everyone who lives or permanently resides in Sweden.[121]

UNITED KINGDOM	
Migration Statistics	9.4 million migrants (18.8% of population)[122]
COVID-19 Context (as of 24 January 2021)	First case of COVID-19 on 31 January 2020 3,617,463 cases 97,329 deaths[123]
General COVID-19 public health and policy measures (applicable to everyone in country)	- Lockdown measures including, closures of entertainment, hospitality, non-essential businesses, schools - Physical distancing measures - On 10 May, Government set out a roadmap to ease the lockdown in England (Scotland, Wales and Northern Ireland have separate rules). - Second wave led to second country-wide lockdown on 5 November.[124]
Select policy measures specific to migrants' access (or lack thereof) to basic services and support (including COVID-19-specific measures)	- Basic Universal Credit welfare payments increased by £20 per week; but Asylum Support increased by £1.75/week initially. - Coronavirus Job Retention Scheme and Self-Employed Income Support Scheme (not inclusive of all migrants and people seeking asylum). - Home Office announced 3-month suspension on evictions from asylum-support accommodation, recognizing risks of homelessness and destitution. - Funding for 'Everyone In' scheme to house all rough-sleepers during the pandemic – which included migrants. - Ban on evictions from private rented accommodation. - Funding for local authorities to provide Local Welfare Cash Assistance, emergency food provision and other essential needs. - Free COVID-19 vaccine being rolled-out to all residents including migrants, but existing barriers to registering a doctor, and fears of data-sharing between health services and immigration enforcement present have not been addressed.

Endnotes

1. The IFRC uses a deliberately broad description of 'migrants' as: "*Persons who leave or flee their habitual residence to go to new places - usually abroad - to seek opportunities or safer and better prospects. Migration can be voluntary or involuntary, but most of the time a combination of choices and constraints is involved. It therefore includes, among others, labour migrants, stateless migrants and migrants deemed irregular by public authorities. It also concerns refugees and people seeking asylum, notwithstanding the fact that they constitute a special category under international law and that international refugee law sets out specific protections and entitlements to those falling within its scope.*" IFRC Policy on Migration (2009)
2. For the purpose of the research, basic services include those considered as essential for the well-being and the dignity of migrants such as, but not limited to, access to health care, including covid-19 testing, tracing, treatment and vaccine; access to timely, reliable and culturally appropriate information; shelter; food; water, sanitation and hygiene services; livelihoods and income support; protection services.
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7. ICRC did not provide any information obtained as part of its bilateral and confidential dialogue with authorities.
8. Locally stranded individuals are defined as: anyone either foreign nationals or Filipino citizens in a specific locality within the Philippines who have expressed intention to return to their place of residence / home origin. They could be categorized as (i) Filipino local workers; (ii) students; (iii) local or foreign tourists; (iv) individual stranded in various localities while in transit; and (v) other stranded individuals (Government of the Philippines, National Task Force Against COVID-19 2020-02, p. 2).
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The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

None of us is safe until all of us are safe.