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International Migration, Immigrant Health, and Social Policies during the COVID-19 Pandemic

A Case Study of Six Countries

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INTRODUCTION

Humans have migrated since the beginning of history. Recently, though, technological, political, economic, and, increasingly, climate factors have stoked an increase in international migration (Czaika & de Haas, 2014). The International Organization for Migration's 2019 *World Migration Report* identified 272 million migrants worldwide—a 57% increase since 2000 (McAuliffe & Khadria, 2019; Menozzi & Mishra, 2020). Although drivers of international migration persist, in March 2020, the global COVID-19 pandemic brought the world to an abrupt stop; the resultant wide-reaching containment and travel restriction policies dramatically affected net migration (McAuliffe & Khadria, 2019). Many countries closed international borders to tourism, students, and nonessential travel, and slowed or halted visa processes (Benton et al., 2021). In April and May 2020, air travel was down by 92% compared to the same time period the year before (Benton et al., 2021). The Office of the United Nations High Commissioner for Refugees (UNHCR) resettlement program halted refugee departures between March and June 2020 (Moetaz, 2020). Overall, the United Nations estimated a 27% suppression in the expected global migration growth between July 2019 and June 2020 (Menozzi & Mishra, 2020, p. 5). This slowdown, and the resulting decline in remittances, produced major impacts on the economic well-being of immigrants and their families in their countries of origin; it also provoked labor shortages in receiving countries (Newland, 2020). Additionally, immigrants were overrepresented in groups at high risk for job loss and among essential workers (increasing their risk of illness), while also being afforded the least protections offered by the host country's safety-net and other social policies (Newland, 2020; Papademetriou & Hooper, 2020).

In this chapter, we explore the effects of the global COVID-19 pandemic on migration patterns to upper-middle- and high-income countries, as well as its impact on immigrant health. We spotlight the United States, Australia, Canada, United Arab Emirates, United Kingdom, and Mexico. In 2019, the first five of these countries were among the top 10 receiving countries in the world, and Mexico was the second leading sending country (McAuliffe & Khadria, 2019, p. 26). The United States (U.S.) and Mexico were selected due to the drastic impact the COVID-19 pandemic had on migration in the largest international corridor in the world, with over 6 million more migrants annually than any other corridor in North America and outpacing corridors elsewhere by even wider margins (McAuliffe & Khadria, 2019, pp. 58–109). Any discussion of migration in the United States is inextricably linked to a discussion of migration in Mexico. The United Arab Emirates is notable in that not only is it a top receiving country outside of the Global North, but its immigrant workforce makes up 90% of employees in the private sector and 80% of the region's population overall (Karasapan, 2020; McQue, 2020).

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First, we discuss changes to international migration patterns that emerged from 2019 to 2021, focusing on comparing containment and travel restriction measures taken across the case-study countries. Second, we provide an overview of the social distribution of risk factors in immigrant populations before the COVID-19 pandemic, as well as the prevalence of COVID-19 morbidity and mortality in the immigrant population by country. We also explore the mental health impacts of the COVID-19 pandemic in the immigrant population by case country. Finally, we consider countries' economic and social policies (e.g., employment, family, economic, housing, healthcare, and legal system domains), which varied widely during this time; we review major pandemic-related changes to these policies in the case-study countries and the extent to which these social policies included or excluded immigrants. Overall, we contribute toward a greater understanding of the global impact of the COVID-19 pandemic on immigrant populations worldwide.

THE EFFECT OF THE COVID-19 PANDEMIC ON INTERNATIONAL MIGRATION PATTERNS

Sociological theory on migration posits that people may leave their countries of origin due to "push" and "pull" factors (Castelli, 2018). Push factors are forces that make individuals' current place of residence inhospitable. Pull factors motivate individuals to leave for novel opportunities in the destination country. Both factors lead migrants to leave their homes for "greener pastures." Most migrants today move to geographically adjacent countries or from lower- to higher-income countries (Van Hear et al., 2018). Indeed, high-income countries received 75% of the new international migrants from 2000 to 2020; this migration was driven primarily by labor, family reunification, and education, according to the United Nations' 2020 *International Migration, Highlights* report (Menozzi & Mishra, 2020). By 2020, 65% of all international migrants lived in high-income countries (Menozzi & Mishra, 2020). Before 2020, there was little reason to imagine that the migration patterns established in the preceding 20 years would not continue.

Prior to the COVID-19 pandemic, the case countries showed several of these marked patterns of migration. The Supplemental Table shows the top five nationalities of immigrants and destination countries of emigrants from the case countries in 2019, based on United Nations (UN) mid-year estimates of international migrant stock (see Appendix to this chapter). The aforementioned importance of the United States–Mexico border is clear in this table, in that the United States and Mexico represent each other's top sending and receiving countries. Similarly, the table shows that Canada represents the United States' second most common destination, while the United States represents Canadians' most common destination. Immigrants from India fall within the top five immigrant nationalities in all the case-study countries except for Mexico. In the United Arab Emirates (UAE), the large number of immigrants from India is part of a regional trend, and much of the UAE's low-income labor population consists of Southeast Asian migrants (De Bel-Air, 2018, pp. 7–34). In the United Kingdom, India remains the top immigrant nationality, reflecting colonial ties between the two nations.

Migrant Stock Pre-COVID-19 Compared to Migrant Stock during the COVID-19 Pandemic

To assess the impact of the pandemic on migration patterns, Tables 6.1–6.3 show UN international migrant stock mid-year estimates (July 1, 2017–July 1, 2020) for 2017 (*International migrant stock 2017*, 2017), 2019 (*International migrant stock 2019*, 2019), and 2020 (*International migrant stock 2020*, 2020). Table 6.1 presents data for female and male migrants combined; Tables 6.2 and 6.3 represent data separately for female and male migrants, respectively. From 2017 to 2019, there was an increase in the migrant stock population in all case-study countries except Mexico (Table 6.1). From 2019 to 2020, however, although the number of immigrants continued to increase for most case-study countries, there was a decline in the rate of change of the migrant stock population in the United Kingdom and the United States. In contrast, although the number of migrants in Mexico declined during 2017–2019, it rebounded during 2019–2020. In data collected by the Mexican government, the increase was explained by an increase in humanitarian and family migration not experienced by any other case country (OECD, 2021). Most of the case country's trends hold for both male and female migrants (Tables 6.2 and 6.3).

TABLE 6.1 UNITED NATIONS (UN) INTERNATIONAL MIGRANT STOCK MID-YEAR ESTIMATES (JULY 1, 2017–JULY 1, 2020), BOTH SEXES

	UN Estimates 2017	UN Estimates 2019	UN Estimates 2020[a]	2017–2019 Rate of Change of Migrant Stock[b]	2019–2020 Rate of Change of Migrant Stock[b]
United States	49,776,970	50,661,149	50,632,836	0.009	−0.001
United Kingdom	8,841,717	9,552,110	9,359,587	0.039	−0.020
United Arab Emirates	8,312,524	8,587,256	8,716,332	0.016	0.015
Canada	7,861,226	7,960,657	8,049,323	0.006	0.011
Australia	7,035,560	7,549,270	7,685,860	0.035	0.018
Mexico	1,224,169	1,060,707	1,197,624	−0.072	0.121

Note. According to the UN Department of Economic and Social Affairs, estimates were calculated based on the following equation $\bar{r} = \ln\left(\frac{M1}{M0}\right) / (t1 - t0)$, where M0 refers to migrant stock in year 0 and M1 refers to the migrant stock the following year. International migrants for the United States, Canada, United Kingdom, and Australia referred to the foreign-born population in the country. Estimates for Mexico included a combination of foreign-born population and refugees or people in refugee-like situations based on reports by the Office of the United Nations High Commissioner for Refugees. Estimates for United Arab Emirates included refugee data as well, in addition to foreign citizens rather than foreign-born population. This means they would exclude naturalized citizens from the migrant population count and include those born in the UAE whose father was not a citizen (citizenship is conferred on the basis of jus sanguinis).

[a] United Nations estimated the COVID-19 impact on migration by assuming "no increase or decrease in the number of international migrants between 1 March and 1 July, 2020, namely the last four months of the estimation period."

[b] Rate of change of the migrant stock population was calculated as a mean annualized rate using the UN Department of Economic and Social Affairs equation $\bar{r} = \ln\left(\frac{M1}{M0}\right) / (t1 - t0)$.

TABLE 6.2 UNITED NATIONS (UN) INTERNATIONAL MIGRANT STOCK MID-YEAR ESTIMATES (JULY 1, 2017–JULY 1, 2020), FEMALE MIGRANTS ONLY

	UN Estimates 2017	UN Estimates 2019	UN Estimates 2020[a]	2017–2019 Rate of Change of Migrant Stock[b]	2019–2020 Rate of Change of Migrant Stock[b]
United States	25,585,361	26,172,767	26,153,840	0.011	−0.001
United Kingdom	4,636,299	4,970,114	4,895,164	0.035	−0.015
United Arab Emirates	2,105,200	2,261,236	2,296,540	0.036	0.015
Canada	4,098,126	4,174,467	4,220,962	0.009	0.011
Australia	3,594,030	3,804,832	3,873,673	0.028	0.018
Mexico	603,782	528,795	596,115	−0.066	0.120

Note. According to the UN Department of Economic and Social Affairs, estimates were calculated based on the following equation: $\bar{r} = \ln\left(\frac{M1}{M0}\right) / (t1 - t0)$, where M0 refers to migrant stock in year 0 and M1 refers to the migrant stock the following year. International migrants for the United States, Canada, United Kingdom, and Australia referred to the foreign-born population in the country. Estimates for Mexico included a combination of foreign-born population and refugees or people in refugee-like situations based on reports by the Office of the United Nations High Commissioner for Refugees. Estimates for United Arab Emirates included refugee data as well, in addition to foreign citizens rather than foreign-born population. This means they would exclude naturalized citizens from the migrant population count and include those born in the UAE whose father was not a citizen (citizenship is conferred on the basis of jus sanguinis).

[a] United Nations estimated COVID-19 impact on migration by assuming "there was no increase or decrease in the number of international migrants between 1 March and 1 July, 2020, namely the last four months of the estimation period."

[b] Rate of change of the migrant stock population was calculated as a mean annualized rate using the UN Department of Economic and Social Affairs equation $\bar{r} = \ln\left(\frac{M1}{M0}\right) / (t1 - t0)$.

TABLE 6.3 UNITED NATIONS (UN) INTERNATIONAL MIGRANT STOCK MID-YEAR ESTIMATES (JULY 1, 2017–JULY 1, 2020), MALE MIGRANTS ONLY

	UN Estimates 2017	UN Estimates 2019	UN Estimates 2020 [a]	2017–2019 Rate of Change of Migrant Stock[b]	2019–2020 Rate of Change of Migrant Stock[b]
United States	24,191,609	24,488,382	24,478,996	0.006	0.000
United Kingdom	4,205,418	4,581,996	4,464,423	0.043	–0.026
United Arab Emirates	6,207,324	6,326,020	6,419,792	0.009	0.015
Canada	3,763,100	3,786,190	3,828,361	0.003	0.011
Australia	3,441,530	3,744,438	3,812,187	0.042	0.018
Mexico	620,387	531,912	601,509	–0.077	0.123

Note. According to the UN Department of Economic and Social Affairs, estimates were calculated based on the following equation: $\bar{r} = \ln\left(\frac{M1}{M0}\right) / (t1 - t0)$, where M0 refers to migrant stock in year 0 and M1 refers to the migrant stock the following year. International migrants for the United States of America, Canada, United Kingdom, and Australia referred to the foreign-born population in the country. Estimates for Mexico included a combination of foreign-born population and refugees or people in refugee-like situations based on reports by the Office of the United Nations High Commissioner for Refugees. Estimates for United Arab Emirates included refugee data as well, in addition to foreign citizens rather than foreign-born population. This means they would exclude naturalized citizens from the migrant population count and include those born in the UAE whose father was not a citizen (citizenship is conferred on the basis of jus sanguinis).

[a] United Nations estimated COVID-19 impact on migration by assuming "there was no increase or decrease in the number of international migrants between 1 March and 1 July, 2020, namely the last four months of the estimation period."

[b] Rate of change of the migrant stock population was calculated as a mean annualized rate using the UN Department of Economic and Social Affairs equation $\bar{r} = \ln\left(\frac{M1}{M0}\right) / (t1 - t0)$.

CONTAINMENT MEASURES AND TRAVEL RESTRICTIONS

On December 31, 2019, the government in Wuhan, China, confirmed that an unknown respiratory illness had emerged, later determined to result from infection with the novel pathogen SARS-CoV-2 (D. B. Taylor, 2021). Within one month, the first confirmed cases outside of China were detected in Japan, South Korea, and Thailand (D. B. Taylor, 2021). The World Health Organization declared the event a "Public Health Emergency of International Concern," signaling the highest level of alarm to the global community (Maxmen, 2021; World Health Organization, 2020). In February 2020, pressure built as outbreaks occurred in Europe, the Middle East, North America, and Latin America, and the disease was officially named COVID-19 (D. B. Taylor, 2021). The European Union coordinated as a block to close its 27-member countries to non-essential travel in mid-March 2020 (Goodman et al., 2020). Spain and Italy went into national lockdowns, closing schools and non-essential businesses (e.g., bars and restaurants) and limiting public gatherings; several more countries followed suit in April 2020 (Neuman & Romo, 2020; Paun et al., 2020; Reuters, 2020). The patterning of the travel restrictions (Figure 6.1) imposed immediately and in the subsequent outbreaks of COVID-19 variants underscored the complexities of the social and economic integration of a globalized world (Bickley et al., 2021), highlighted by the swift spread of SARS-CoV-2.

Travel Bans

Even before governments required it, airlines globally began suspending flights to China, in part due to low passenger volume and safety concerns as travel advisories were implemented around the world (Liao, 2020; Mansoor & Carlisle, 2020). For example, British Airways first canceled flights to Beijing and Shanghai in January 2020, and then canceled all flights to mainland China in February (Reuters Staff, 2020a). By January 31, 2020, the United States had banned entry of non-U.S., nationals who had visited China in the preceding 14 days (Trump, 2020a), and in early February, Australia did the same (Ziebell, 2020).

Most national travel bans included exceptions for citizens, permanent residents, and some visa holders. In early February 2020, though the United Arab Emirates banned the entry of all foreign nationals who had visited China, they also included

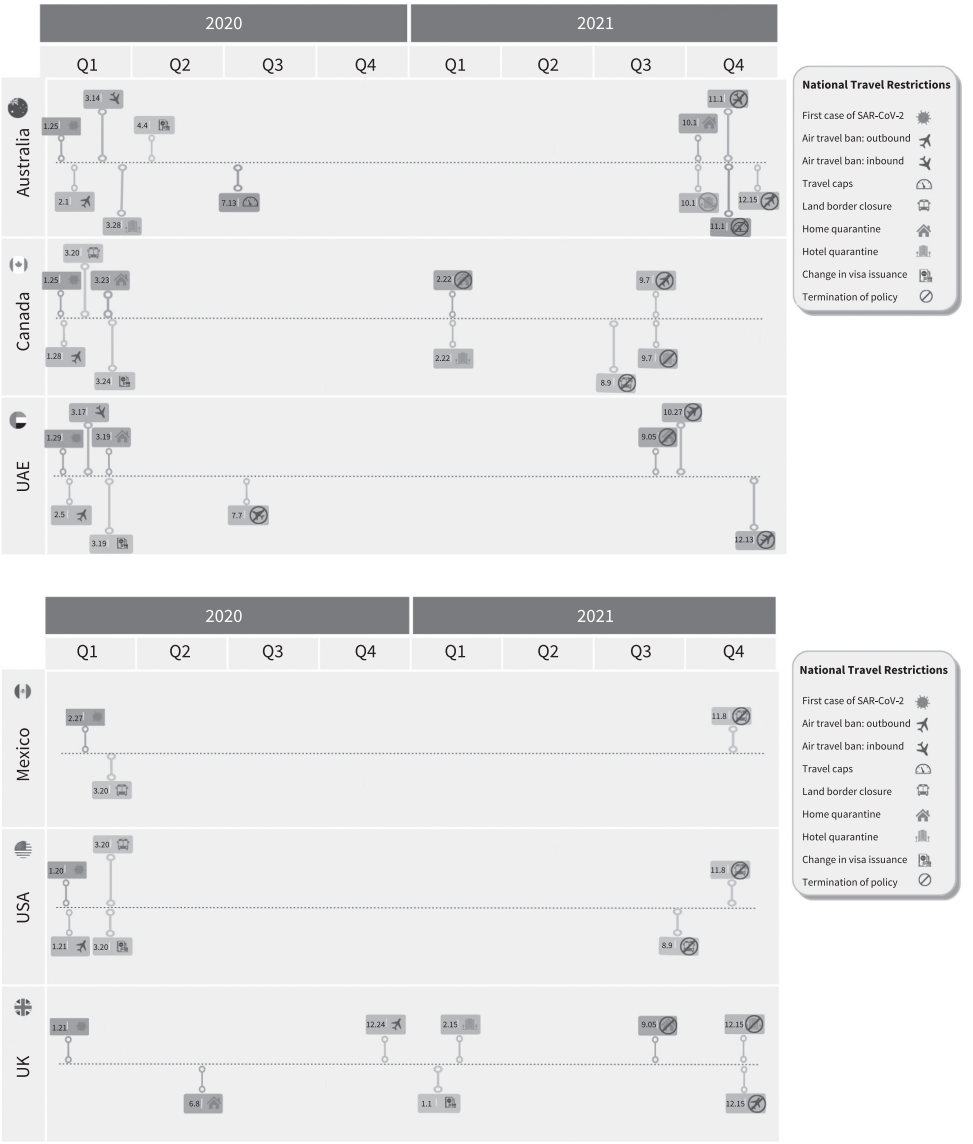

FIGURE 6.1. Timeline of containment measures and travel restrictions in response to COVID-19 pandemic in six case study countries.

Note: Inbound travel bans reflect first travel bans applied in 2020, regardless of number of countries banned. End of inbound air travel ban reflects last travel ban ended by 2021, for United States, United Kingdom, and United Arab Emirates. New bans enacted and ended between the first quarter of 2020 and the last ban ended in 2021 not shown. End of outbound travel ban for citizens from UAE and Australia only applicable for fully vaccinated residents. End of bans on ground travel for the United States represents the reopening of the two separate land borders, only applies to vaccinated travelers.

an exception for visitors from Beijing (Turak, 2020a). Mexico remained the most liberal, however, never imposing a travel ban at all. Case-study countries fell into two categories: those that banned travel from specific countries based on risk profiles, and those that imposed travel bans on all non-citizens or non-permanent residents. The United States and United Kingdom fell into the first category. The United States banned travel from Iran (Trump, 2020a) and the Schengen Area of Europe (Trump, 2020b) on March 13, 2020, and added the United Kingdom and Ireland (Wolf, 2020a) on March 16, 2020. The UK government did not impose a travel ban on non-essential international travel until December 2020,

instead issuing an (unenforced) advisory against non-essential travel on March 17, 2020 (Raab, 2020). The United Kingdom's first travel ban was for arrivals from South Africa ("Covid-19", 2020) on December 24, 2020, when the SARS-CoV-2 Beta variant began to spread rapidly; subsequent bans in January 2021 were on arrivals from South America and Portugal ("Covid", 2021). The United Kingdom and the United States added and removed countries from their travel ban lists throughout 2021, ultimately requiring proof of full vaccination and negative COVID-19 tests before entry in August (UK) and November (US) 2021.

In contrast, the United Arab Emirates, Canada, and Australia imposed bans on all incoming travelers, though with variability in the duration of the bans. The UAE initially banned travel to and from Lebanon, Turkey, Syria, and Iraq (Chmaytelli & Khalek, 2020), and then temporarily extended restrictions to all incoming flights (Turak, 2020b) on March 19, 2020. However, by May 2020, flights to Lebanon, Turkey, Syria, and Iraq had resumed, and tourists were soon welcomed back to Dubai (Turak, 2020c) (July) and Abu Dhabi ("Abu Dhabi to reopen to international tourists on Thursday," 2020) (December). In contrast, Canada banned incoming travel for all non-citizens and permanent residents from March 16, 2020 to September 2021 (Government of Canada announces easing of border measures for fully vaccinated travellers, 2021; Transport Canada, 2021). Under an exception, family members of Canadian nationals were permitted entry for stays of longer than 15 days in June 2020. Fully vaccinated U.S. citizens and permanent residents could enter Canada beginning in August 2021 (Canada Border Services Agency, 2020; Government of Canada announces easing of border measures for fully vaccinated travellers, 2021). Following concerns over variants, including the emerging Delta variant, flights to Mexico and Caribbean countries were canceled from January 31, 2021, to April 30, 2021 (Transport Canada, 2021).

Australia adopted and sustained some of the strictest travel bans globally (as did New Zealand) (Morrison, 2020a). Travel bans applied to all non-citizens and non-permanent residents beginning March 20, 2020, and ended for vaccinated travelers with specific visa categories (e.g., international students and skilled migrants) in December 2021. The United Arab Emirates and Australia also implemented restrictions on non-essential travel of their own citizens outside the country in mid-March 2020 (Morrison, 2020b; Turak, 2020b). Australia did not open travel to its citizens until it met its goal of at least 80% vaccination rate for its population over the age of 16, a target achieved on November 1, 2021 (Fernandez Simon, 2021). The nation delayed reopening to specific classes of visa-holders, including international students, skilled migrants, and travelers from Japan and South Korea, until December 15 to evaluate the effects of the Omicron variant, detected in late November 2021 (Australia sets out curbs for travellers from virus-hit Southern Africa, 2021; Fernandez Simon, 2021; Kershner, 2021). Australians who were outside of the country during the implementation of the initial ban were permitted to re-enter the country but were required to complete a hotel quarantine. To avoid overburdening these facilities, weekly caps, which varied for each state, determined the number of Australian citizens and permanent residents allowed back in (a measure replicated only in New Zealand) (Mennon, 2020; Morrison, 2020c). During September–October 2020, caps were slowly raised; the caps were lowered again during January–July 2021 due to outbreaks of the Delta variant (Pannett, 2021).

Finally, the land borders between the United States, Canada, and Mexico were closed under mutual accord to non-essential crossings from March 20, 2020, until October 21, 2021, when vaccinated travelers were allowed to cross (Notification of temporary travel restrictions applicable to land ports of entry and ferries service between the United States and Mexico, 2021; *U.S.-Canada joint initiative*, 2020; Wolf, 2020b, 2020c). However, flights were permitted to continue throughout the pandemic. Though many flights were canceled at the discretion of the airlines (González, 2020a, 2020b), and the Mexican government communicated a travel advisory discouraging non-essential international travel (Secretaría de Relaciones Exteriores, 2020), Mexico was one of few countries globally whose government did not mandate travel bans on international arrivals; Mexico became the third-most-visited country in 2020 (Castro & Arce, 2021). To attract tourists, in early 2021 some hotels and resorts advertised all-inclusive packages that offered COVID-19 tests (required by many home countries for entry upon return) and free or reduced accommodations in case of a positive COVID-19 test requiring a 14-day quarantine (Castro & Arce, 2021).

Although travel bans and restrictions were widely used as a mitigation strategy, their effectiveness and overall benefit were called into question due to their attendant social and economic risks. A Cochrane Rapid Review considered the effectiveness of international travel-related control measures to contain the COVID-19 pandemic and found that although most studies that assessed reducing or stopping cross-border travel showed benefits in terms of disease outcomes, there was low certainty of evidence and a wide range in effect sizes (Burns et al., 2021). Furthermore, researchers were concerned with the quality of the modeling strategies, which made up most of the evidence. Conversely, a scoping review found that border closures and international travel restrictions were associated with increased individual anxiety and depression due to migrants' uncertainties around reunification with family members in their home countries, financial insecurity and unemployment for cross-border commuters, and discrimination and xenophobia targeting migrants from banned countries (Klinger et al., 2021). At the country level, the pandemic disrupted supply chains and suppressed tourism industries (Klinger et al., 2021). A major criticism was that border closures often came too late. For example, case countries (excluding Mexico) implemented travel bans for 7 to 10 countries from southern Africa between November 24, 2021, when the Omicron variant was first detected in South Africa, and mid-December 2021. However, early detection of the variant in South Africa was likely a reflection of the nation's sophisticated pre-existing infrastructure for surveillance of contagious disease; indeed, soon after the UK ban, cases of the variant were detected in Europe (Mendelson et al., 2021). Overall, the effectiveness of travel-related control measures seems to be highly context dependent (i.e., levels of community transmission, travel volumes, exact specification, and timing of measure) and requires further study (Burns et al., 2021).

Quarantine

A common early containment measure implemented across all case countries was mandatory quarantines for arrivals. The United States implemented a 14-day home quarantine for travelers entering the country from China beginning in January 2020, adding other countries in March 2020 (*Fact Sheet*, 2020). However, enforcement and implementation for travelers from other countries was left to each state to decide (Marshall & Syed, 2020). By mid-March 2020, returning Canadians (Public Health Agency of Canada, 2020) and travelers arriving to the United Arab Emirates (Turak, 2020b) from any country were mandated to a 14-day home quarantine. In parallel, Australia implemented a mandated quarantine for returning nationals at government-approved hotels at the government's expense (Morrison, 2020b). However, for travelers arriving to the UAE, quarantine polices were relatively short-lived and varied from emirate to emirate—no quarantine was required in July 2020 for arrivals to Dubai who tested negative, while quarantine was required for unvaccinated people arriving in Abu Dhabi from countries not on the "green list" (*Abu Dhabi Emergency, Crisis and Disasters Committee approves home quarantine in the Emirate without use of wristbands*, 2021). In the United Kingdom, home quarantines were mandated on June 8, 2020 and enforceable by fine (Smout & MacLellan, 2020) as in Australia, the UAE, and Canada. The required quarantine was continually adjusted and lifted altogether for 75 countries by July 2020 (Reuters Staff, 2020b). However, there was some autonomy for each UK country to decide on the list of countries to quarantine, having diverged in their responses since May 2020 (Tatlow et al., 2021). By January 2021, the United Kingdom moved to quarantine arrivals in government-approved hotels, a system also enacted by Canada (Tunney, 2021) in mid-February 2021 due to concerns over the fast-spreading 2Beta variant (B. Johnson, 2021). In the United Kingdom, the stay was 10 days at the traveler's expense for travelers from a list of 30 countries (B. Johnson, 2021); in Canada, the stay was 3 days at the city of arrival, followed by an additional 11 days at the final destination (Tunney, 2021). The quarantine requirement was lifted for fully vaccinated Canadian travelers in July 2021 (Public Health Agency of Canada, 2021). The United Kingdom continued to remove countries from the required hotel quarantine list between the second and fourth quarter of 2021, removing the final seven countries from southern Africa on December 15 (Bowden, 2021; Covid-19, 2021; UK to remove all countries from COVID travel red list on Wednesday, 2021; Sandle, 2021; Street, 2021). Australia lifted the quarantine requirement for those traveling from New Zealand in October 2020 (Westcott, 2020) and for all fully vaccinated Australians in Australian states with 80% vaccination rates by November 2021 (Chapman,

2021; Fernandez Simon, 2021; NSW Government, 2020). When the hotel-based quarantine was lifted, the nation switched to a 7-day home-based quarantine (Kershner, 2021), except for those arriving from eight southern African countries for which the hotel-based quarantine was lifted on December 15 (Australian Government Department of Health and Aged Care, 2021). Mexico was the only case country to never impose a quarantine on international travelers upon arrival (Castro & Arce, 2021).

Visa Changes

Changes to and slowdowns of visa and refugee processes were another major barrier to international migration during the COVID-19 global pandemic. The UNHCR temporarily stopped departures in its resettlement program between March and June 2020 due to concerns for refugee health and rapidly closing borders of potential host countries (Moetaz, 2020). Though overall most of the case-study countries experienced slowdowns in lawful immigration processes due to closure of government facilities and courts, the COVID-19 pandemic also represented in some cases a serendipitous alignment with preexisting political agendas or created pressures for new ones.

In North America, U.S. land borders with Mexico and Canada closed by mutual accord on March 20, quickly following the United States' and Canada's bans on entry for non-essential international arrivals by air (Wolf, 2020b, 2020c). This closure also applied to refugees. On the U.S.–Canadian border, turning away refugees entering Canada from the United States represented a change in recent Canadian practice. Despite the 2004 Safe Third Country Agreement requiring refugees to request protection in the first country deemed safe, following U.S. president Donald Trump's attempts to suppress immigration in 2017, Canada had processed over 58,000 claims from refugees whose first port of entry was the United States (Canada court rules US "not safe" for asylum seekers, 2020). In July 2020, the Safe Third Country Agreement was overturned by a Canadian judge, who cited poor treatment of asylees in the United States, which could result in detainment or deportation (Schwartz, 2020). However, by October 2020, Canada's Federal Court of Appeals had granted the federal government's request to temporarily suspend the judge's decision (Hill, 2020). The Canadian government ended the policy of turning away asylum seekers in November 2021 (Reuters, 2021).

In the United States, restrictions on migration due to health considerations aligned with the anti-immigrant political agenda of the presidential administration in 2020. Not only had the administration cut asylee caps by 16% compared to the previous administration's last year in office (Norwood, 2020), bringing levels to their lowest point in the program's history, it had removed 4 of the 10 countries eligible for Temporary Protected Status (Gomez, 2018; Norwood, 2020). On the U.S.–Mexico border, the 2019 pre-COVID-19 pandemic Migrant Protection Protocol Program, also known as "Remain in Mexico," sent most potential asylees seeking to cross into the United States back across the border to one of seven towns in northern Mexico to await their court date (McCammon, n.d.). The COVID-19 pandemic provoked an intensification of the program. There had previously been a separate process for unaccompanied minors to stay in the United States while an assigned social worker determined the validity of their case (Yang & Dickerson, 2020). However, as of March 2020, children's cases were no longer processed in the United States; rather, children were deported back to their country of origin without there being any contact or safety plan with the family there (Yang & Dickerson, 2020). The program was briefly suspended in October 2021, as President Biden's administration aimed to fulfill a campaign promise, but was reinstated in December 2021 in compliance with a court order following a lawsuit filed by the states of Texas and Missouri (*DHS, Justice, and State prepare for court-ordered reimplementation of MPP*, 2021; Mayorkas, 2021).

Anti-immigrant goals of the Trump administration further manifested via enforcement of the rarely used public health law known as Title 42, created to "[suspend entry] and imports from places to prevent the spread of communicable diseases" (Suspension of entries and imports from designated places to prevent spread of communicable diseases, 1944). The law enabled the administration to return immigrants without allowing them to apply for asylum; the resulting rapid influx of barred and returned migrants created a public health challenge for Mexico (Martínez Caballero et al., 2021). As of December 2021, the Biden administration continued to defend the enforcement of Title 42 in court, with exceptions for children and families, despite campaign promises of more humane treatment of immigrants (*A guide to Title 42 expulsions at the border*, 2021, p. 42; Arias, 2021; Rose & Neuman,

2021). In addition, the immigrant visa process was slowed down and, in some cases, suspended altogether. On March 18, 2020, the State Department canceled all visa appointments due to closures at international consulates, temporarily suspending the issuance of new visas, with exceptions for seasonal and other temporary workers (*Suspension of routine visa services*, 2020; *Update on visas for medical professionals*, 2020). On April 23, 2020, the issuance of new visas for permanent residence was suspended for 60 days on the grounds that this would protect U.S. workers (Miroff et al., 2020). On June 22, 2020, the executive order was extended to suspend the issuance of visas for high-skilled labor, students, and other seasonal and hospitality industry workers (Shear & Jordan, 2020).

In the United Kingdom, the COVID-19 pandemic began during the final year of the UK's transition out of the European Union, five years after the initial "Brexit" decision (Brexit, 2020). The transition brought multiple visa changes to the United Kingdom that were planned before the COVID-19 pandemic and were fueled by anti-immigrant sentiment in Prime Minister Boris Johnson's government (Adam & Booth, 2018). In September 2021, the government authorized the Border Force in the English Channel to turn back boats carrying potential asylees under limited circumstances (Gillett, 2021). The measure, which was working its way through Parliament in December 2021, allowed the government to send asylum seekers to an offshore detention center or "safe" third country to await processing, a system that mirrors those used by the United States and Australia (McDonnell, 2021). Furthermore, the full implementation of "Brexit" on January 1, 2021, limited worker visas to high-skilled English speakers and, for the first time, required visas for workers from EU countries (Brexit, 2021; *Cabinet Office as an EU, EEA or Swiss citizen*, 2020). Due in part to methodological issues in the primary airport survey used to track migration and the change in policy coinciding with the second half of the COVID-19 pandemic, it may take some time for the United Kingdom to untangle the effects of the COVID-19 pandemic on migration from the effects of their policy change (*UK migration statistics lose their 'national statistics' status as ONS confirms problems measuring EU and non-EU net migration*, 2019).

In Australia, visa processing overall was not suspended, and visas for those exempt from the international arrival ban were prioritized (Ablong, 2020). On April 4, 2020, agricultural and other seasonal workers in the Seasonal Worker Programme and Pacific Labour Scheme received visa extensions for up to one year and flexibility to move to other regions once the crop season was complete in their current job (Coleman, 2020). In August 2020, recruitment for this class of worker visa in the Pacific Islands and Timor had resumed (Payne, 2020).

In the United Arab Emirates the vast majority of visas are tied to labor through the "kafala" sponsorship system. This resulted in mass outmigration as migrants lost their jobs during the initial months of the COVID-19 pandemic, as in the case of 50,000 Pakistani workers who were laid off and repatriated (Turak, 2020d). Low-wage earners, such as those from India and Bangladesh, were also vulnerable to wage theft and generally experienced difficulties paying for the limited repatriation flights organized by their home countries (Hashimi, 2020; Turak, 2020d). Meanwhile, UAE policy measures facilitating migration implemented during the COVID-19 pandemic took on added significance as the country recuperated from the economic downturn. In August 2020, the UAE normalized relations with Israel for the first time and made plans to allow direct flights between the nations ("Israel and UAE strike historic deal to normalise relations", 2020). Additionally, on November 15, 2020, the UAE expanded its "golden" visa program to high-skilled workers and those with advanced degrees, allowing visa holders to stay for stretches of 10 years (Reuters Staff, 2020c). Simultaneously, the UAE stopped issuing tourist and labor visas to residents of Pakistan and 12 other Muslim-majority countries (*UAE top diplomat acknowledges visa restrictions on Pakistan*, 2020). Yet, on February 1, 2021, the United Arab Emirates offered a path to naturalization for the first time. Immigrants could become citizens if they met specific criteria, including being a high-skill and high-income worker and being nominated by UAE royals or officials (Turak, 2021).

In the next section, we describe COVID-19 morbidity and mortality, as well as data on the mental health of immigrants during the pandemic by case study country. We will also review social policies implemented in each country during the COVID-19 pandemic, the extent to which these policies were inclusive of immigrants, and the implications for immigrant health. Chapter 18 also discusses social policies

related to the COVID-19 pandemic, but does not discuss immigrant health or migration.

IMMIGRANT HEALTH AND THE COVID-19 PANDEMIC

As of December 31, 2021, there were almost 6 million global total deaths attributed to COVID-19 (Wang et al., 2022). Although prior research found that immigrants to all major immigrant-receiving regions (e.g., the U.S., Canada, and Australia) tend to have better health and mortality profiles than their native-born counterparts, little is known regarding how a global infectious disease pandemic, such as COVID-19, might affect immigrants' health and well-being. This section examines the impact of the COVID-19 pandemic on the mental and physical health (i.e., morbidity and mortality) of immigrants to the world's major immigrant-receiving regions. To better understand immigrant populations' unique position, we begin by highlighting stylized immigrant health patterns, and then discuss immigrants' health during the COVID-19 pandemic.

Pre-COVID-19 Pandemic Immigrant Health Profiles

Compared to their native-born counterparts, upon arrival to their destination countries, many immigrants occupy a lower position in the social hierarchy, including having lower incomes and living in more socioeconomically disadvantaged neighborhoods (Borjas, 1987; Durden & Hummer, 2006; Portes & Rumbaut, 2014). Despite these characteristics, typically associated with worse physical health outcomes, research has documented that newly arrived adult immigrants tend to self-report more favorable physical health profiles (e.g., fewer chronic conditions and activity limitations) than their native-born adult counterparts. Indeed, researchers have documented this pattern of initial good health across all major immigrant-receiving regions, including the United States, Canada, the United Kingdom, and Australia (Antecol & Bedard, 2006).

Immigrants, however, are not able to maintain their initial health advantages. Relative to new immigrants, immigrants who have resided longer in the destination country tend to report worse health outcomes (Antecol & Bedard, 2006; Frisbie et al., 2001; Markides & Rote, 2019; Newbold, 2006; Read & Emerson, 2005). One possible explanation for the health erosion associated with time spent in the destination country is exposure to racism and discrimination (discussed in Chapter 5) as well as other negative social, economic, and environmental factors that adversely affect health (Hummer, 1996; Levine et al., 2014; Soto et al., 2011; Williams, 1999). Another explanation involves immigrant work conditions. Relative to natives, immigrants tend to work long hours in more hazardous conditions, which might make them more likely to experience greater health declines as they age in their destination countries (Moyce & Schenker, 2018).

Although previous research documents health advantages among immigrants, there is increasing concern about the impact of the COVID-19 pandemic on immigrants relative to native-born populations. The next section reports information on the distribution of social risk factors among immigrants that heighten vulnerability for COVID-19.

Distribution of Social Risk Factors for COVID-19 among Immigrants

In the early stages of the COVID-19 pandemic, governments and international agencies struggled to understand the exact mechanism making the virus both deadly and extremely infectious. However, as the pandemic progressed, disparities in COVID-19 morbidity and mortality in immigrant communities became apparent; many of these disparities were due to the unequal distribution of pre-existing risk factors, including increased exposure to the SARS-CoV-2 virus, increased exposure to discrimination and xenophobia, and differential access to mitigation resources due to documentation status.

During the early months of the pandemic, the primary strategy implemented by the United States, the United Kingdom, Canada, Australia, and the United Arab Emirates to slow viral transmission was physical distancing, which motivated many authorities to issue rigid restrictions on individuals' daily movement within national borders, often requiring everyone other than essential workers to remain in their homes as much as possible. In addition to being more likely than natives to live in group quarters, detention centers, or multigenerational households, where following COVID-19 safety protocols is nearly impossible, immigrants also comprise a disproportionate share of essential workers in many developed countries, placing them at increased risk of contracting the virus (Đoàn et al., 2021; Gelatt, 2020; Obinna, 2021).

In the United States, roughly 6 million immigrant workers occupy essential and front-line

jobs, putting them at higher risk than natives of contracting COVID-19 due to their inability to work from the safety of their homes (Gelatt, 2020). Goldman et al. (2021) showed that although White front-line workers are often overrepresented in high-risk jobs in the United States, after disaggregating the results by occupational standing, Latino and Black front-line workers are overrepresented relative to Whites and several Asian subgroups in low-standing occupations, such as grocery and food service, caregiving, and meatpacking, associated with high risk. As a result, they may be less likely to have adequate COVID-19 protections. Goldman et al.'s (2021) findings suggest that increased work exposures likely contributed to a high prevalence of COVID-19 among Latino and Black adults and underscores the need for measures to reduce potential exposure for workers in low-social standing occupations and for development of programs outside the workplace (work-related factors are discussed further in Chapter 12).

Moreover, high rates of infection were observed among immigrants in three occupational settings in the United States: nursing homes, meatpacking plants, and California farms (Y.H. Chen et al., 2021; Lewnard et al., 2020; McGarry et al., 2020; Saitone et al., 2021). Two of these occupations—meatpacking and farm work—likely comprise many undocumented immigrants (Ornelas et al., 2021; Svajlenka, 2021). Given the anti-immigrant rhetoric of the Trump administration, such workers may have been reluctant to get tested out of fear of deportation—potentially amplifying the spread of infection in workplaces (Bedford, 2021; Matthew et al., 2021). Latino immigrants are also overrepresented in the restaurant sector (Dubina, 2021), which conferred a higher likelihood of either losing their jobs or being required to work onsite and risk being infected. These patterns highlight that the COVID-19 pandemic may have exacerbated existing health and economic disparities. Given that immigration status greatly impacted one's ability to avoid exposures that increase the risk of contracting COVID-19, immigration status was an important social determinant of health during the pandemic (Castañeda et al., 2015).

Additionally, international migrants often had less access to protections from COVID-19 and mitigation strategies than natives. Migrants in developed and middle-income countries often move to meet demand for workers in volatile and precarious sectors of the economy (*ILO global estimates on migrant workers*, 2015). Despite performing essential jobs that allowed millions of people to avoid SARS-CoV-2 infection, many governmental programs aimed at addressing the pandemic's economic and medical consequences were inaccessible to migrants or excluded significant portions of the migrant populations based on documentation status. Although many immigrants arrived to their destination countries through official channels, others migrated through irregular channels, making them highly vulnerable to poor work conditions, particularly during a global infectious disease pandemic (Aldridge et al., 2018; Kennedy et al., 2015). Undocumented immigrants and various other classifications of non-permanent immigrant residents often had limited access to medical care, sick leave, or vaccines due to financial barriers, fear of being deported if they interacted with health systems, and/or being ineligible for vaccines (Cholera et al., 2020; Côté et al., 2021; Grasso et al., 2021; Greenaway et al., 2020; Nguyen et al., 2020; Obinna, 2021; Tosh et al., 2021). Furthermore, in countries with large undocumented or asylee populations in detention centers, detained migrants lived in high-risk conditions for SARS-CoV-2 infection. For example, in the United States and Australia, detention centers experience frequent movement of employees and lawyers in and out of the facilities; transfer of migrants to and from different facilities across the country; and shared sleeping quarters, bathrooms, and eating areas (Cholera et al., 2020; Tosh et al., 2021; Vogl et al., 2021, p. 46).

Across the globe, racial and ethnic minority groups were also disproportionately likely to get sick with and die from COVID-19 (Obinna, 2021). If the COVID-19 pandemic outcomes of Black immigrants in the United States mirror those of Black Americans, Black immigrants may have been hit particularly hard during the pandemic. For example, Black patients hospitalized in the United States with COVID-19 had higher observed mortality relative to White patients, which may be attributed in part to higher levels of preexisting comorbidities, such as obesity, diabetes, and hypertension in the Black population (discussed in further detail in Chapter 4). The COVID-19 pandemic may have exacerbated existing health disparities. However, this is not yet certain, since the healthy immigrant effect, which is highly dependent on duration of residence in the United States, may also protect Black immigrants from comorbidities such as hypertension and diabetes, much as it does for Mexican American

immigrants (Palarino, 2021). Although similar social structures impact the lives of immigrants in different parts of the world, major immigrant-receiving countries have unique factors that made life more dangerous for immigrants during the height of the COVID-19 pandemic.

Effects on Mental Health

These social risk factors affected not only the physical health of immigrant populations, but also their mental health. In the general adult population, a 2022 literature review found increased prevalence of distress and anxiety and depressive symptoms reported in the initial months of the pandemic (Manchia et al., 2022). However, there was also promising evidence of resilience, where some studies found respondents were unaffected or that the decline in mental health was not sustained over time (Manchia et al., 2022). Some hypothesized determinants included working in healthcare, feelings of employment precarity, infection with SARS-CoV-2, exposure to lockdown, availability of social support, health behaviors (including sleep and physical activity), and epigenetics (Manchia et al., 2022). However, research on the effects of the COVID-19 pandemic on the mental health of immigrants is limited. Particular attention should be paid to the pandemic's short-term and long-term effects on the mental health of immigrant youth and children of immigrants, as this age range is a critical period for social-emotional development of individuals who will have a long-term impact on society.

Immigrant youth and children of immigrants may experience various unique vulnerabilities. As described in a review on mental health and well-being among immigrants in the United States, children and youth may experience stress associated with the effects of war/other violence, economic challenges, separation from family and social networks, racism and discrimination, and risk of deportation of self or family members (Rodriguez et al., 2021). Children may also contend with intergenerational conflict as they may be quicker to integrate to the host country than their parents, and may experience greater societal pressure than their parents to do so (Rodriguez et al., 2021). This challenge may have become more salient during the COVID-19 pandemic, where lockdowns resulted in school closures and transition to remote learning. School closures posed one of the most impactful disruptions to daily life of children and youth, generally in the form of isolation from peers and school staff that offer social support, loss of access to food programs and mental health services, reduced physical activity, and a reduction in child protective service notifications (Viner, Russell, et al., 2021). Remote learning may have challenged immigrant parents, who may have experienced difficulties assisting with schoolwork, language barriers, or an inability to supervise due to work (Manchia et al., 2022; Viner, Russell, et al., 2021). For example, in one study of Korean immigrant parents in the United States surveyed during May–June 2020, challenges meeting their children's educational needs and language barriers related to educational needs were associated with increased parental stress (Hong et al., 2021).

Additionally, the COVID-19 pandemic resulted in a rise in racial discrimination and xenophobia, particularly anti-Asian discrimination, in several of the case countries (Haft & Zhou, 2021; Pan et al., 2021; Shang et al., 2021; Tan et al., 2021); this represented an additional stressor with negative effects on mental health (Berger & Sarnyai, 2015; Lee & Ahn, 2011; Suleman et al., 2018). Though adults may experience in-person discrimination that results in stress, youth may experience greater exposure through online sources. In a population-based sample of Chinese American families living in the United States, although parents and children reported similar in-person exposure to direct targeting by COVID-19-related racial discrimination (50.9% and 50.2%, respectively), children reported greater exposure to discrimination online than adults (45.7% vs. 31.7%, respectively) (Cheah et al., 2020). Greater perception of racial discrimination was statistically significantly associated with decreased psychological well-being, increased anxiety symptoms, and increased depressive and internalizing symptoms for parents and youth (Cheah et al., 2020). Overall, the impact of the pandemic on the mental health of immigrants and their children requires further study.

Country-Level COVID-19 Mortality Outcomes

Although the COVID-19 pandemic negatively affected the health and mortality profiles of immigrants across the globe, there was significant variation across nations. However, because the health systems of the

TABLE 6.4 COVID-19 CONFIRMED CASES AND DEATHS (AS OF DECEMBER 31, 2021)

	Reported COVID-19 Deaths	Reported COVID-19 mortality rate (per 100,000)	Estimated Excess Deaths	Estimated Excess Mortality Rate (per 100,000)
World	5,940,000	39.2	18,200,000	120.3
Australia	2,250	4.7	–18,100	–37.6
Canada	30,300	41.9	43,700	60.5
Mexico	418,000	170.2	798,000	325.1
United Arab Emirates	2,160	21.1	9,340	91.3
United Kingdom	173,000	130.1	169,000	126.8
United States	824,000	130.6	1,130,000	179.3

Note: We draw our table estimates from Wang et al. (2022). Wang et al. (2022) took a multi-step approach to estimate excess mortality due to COVID-19. First, an ensemble-based approach is used to predict expected deaths in the absence of the COVID-19 pandemic using a database of all-cause mortality. Excess mortality was calculated as the difference between observed mortality and expected mortality. COVID-19 mortality estimates have varied widely based on estimation strategy and data sources, so we acknowledge that these estimates are not definitive.

Source: Wang, H., Paulson, K. R., Pease, S. A., Watson, S., Comfort, H., Zheng, P., Aravkin, A. Y., Bisignano, C., Barber, R. M., Alam, T., Fuller, J. E., May, E. A., Jones, D. P., Frisch, M. E., Abbafati, C., Adolph, C., Allorant, A., Amlag, J. O., Bang-Jensen, B., . . . Murray, C. J. L. (2022). Estimating excess mortality due to the COVID-19 pandemic: A systematic analysis of COVID-19-related mortality, 2020–21. *The Lancet*, 399(10334), 1513–1536. https://doi.org/10.1016/S0140-6736(21)02796-3

case study countries do not report health data by both immigrant status and race/ethnicity, researchers can paint only a crude portrait of the pandemic's impact on immigrants in these places.

Table 6.4 shows reported total COVID-19- related deaths, mortality rate (per 100,000), estimated excess deaths due to COVID-19, and estimated excess mortality rate (per 100,000) from Wang et al. (2022). (January 1, 2020–December 31, 2021). Overall, the United States led the world in confirmed COVID-19 deaths and experienced the second highest reported COVID-19 mortality rate and estimated excess mortality rate among the six case countries, with 130.6 reported deaths per 100,000 population. Mexico experienced the highest reported COVID-19 mortality rate and estimated excess mortality rate among all case countries with 170.2 deaths per 100,000 population and 325.1 deaths per 100,000 population, respectively. The United Kingdom followed, the United States with 130.1 reported deaths per 100,000 population. Canada's COVID-19 mortality rate was about a third that of the United States, with 41.9 deaths per 100,000. Finally, the United Arab Emirates and Australia had the lowest mortality rates, at 21.1 and 4.7 COVID-19 deaths per 100,000 population, respectively.

Figure 6.2 shows the COVID-19 reported deaths during the period from March 30, 2020, to December 30, 2021. The United States experienced the greatest number of COVID-19 reported deaths of all reported countries. The United Kingdom experienced the second highest COVID-19 reported deaths until July 2020. After this point, Mexico's reported deaths converged and overtook that of the United Kingdom.The United Kingdom experienced the second highest COVID-19 reported deaths until July 2020. After this point, Mexico's reported deaths converged and overtook that of the United Kingdom. After the first COVID-19 Delta variant case was reported in October 2020, a similar pattern emerged, with Mexico again experiencing a steeper increase in COVID-19 deaths than the United States and the United Kingdom. Comparatively, Canada experienced lower reported COVID-19 deaths than the United States, the United Kingdom, and Mexico. Finally, Australia and the United Arab Emirates have maintained the lowest COVID-19 reported deaths of all case study countries.

To date, few countries have published health and mortality data during the pandemic that allow for analysis of both race/ethnicity and nativity status (i.e., whether individuals are native-born or foreign-born). However, to the degree that immigrants have health outcomes broadly like those of their native-born racial/ethnic counterparts, and to some extent greater vulnerabilities during the pandemic, the pandemic likely did not uniformly influence the health of all immigrants.

In the United Kingdom, most racial/ethnic minority groups experienced excess mortality compared to White British natives, with underlying chronic

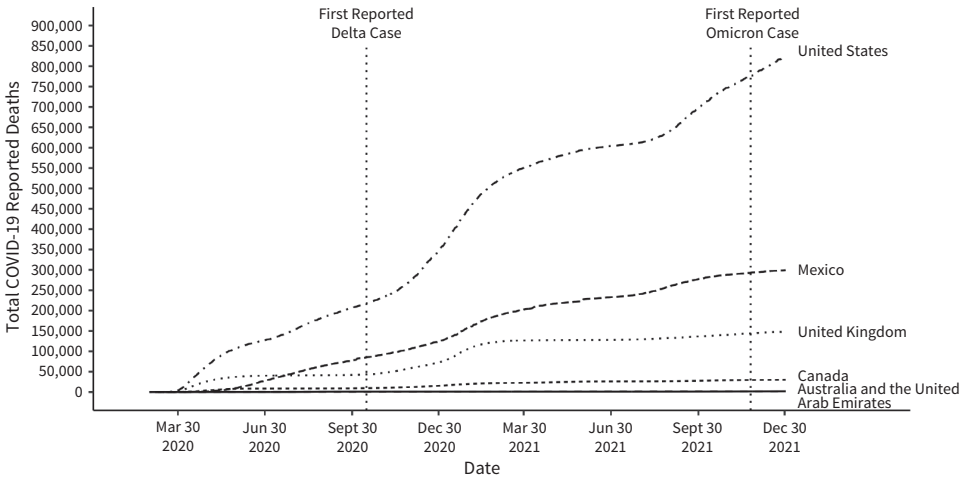

FIGURE 6.2. COVID-19 crude mortality rate by country.

Note: This table reports data as of December 31, 2021. Crude mortality rate is calculated as the number of COVID-19-related deaths in a given period divided by the population exposed to the risk of COVID-19 death during that period.

Source: Data from Ritchie, H., Mathieu, E., Rodés-Guirao, L., Appel, C., Giattino, C., Ortiz-Ospina, E., Hasell, J., Macdonald, B., Beltekian, D., & and Roser, M. (2020). Coronavirus pandemic (COVID-19). Published online at OurWorldInData.org. Retrieved from: https://ourworldindata.org/coronavirus [Online Resource]. Underlying data comes from the COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University: https://github.com/CSSEGISandData/COVID-19 and the United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects 2019 Revision via Our World in Data.

conditions, household composition, healthcare access, and occupational structure contributing to COVID-19 vulnerability (Bhala et al., 2020; Platt & Warwick, 2020). Specifically, Black Caribbean people and those who fell into the "other ethnic group" category, which included the Arab population, had substantially higher per-capita hospital deaths from COVID-19 compared to the White British population, whereas Pakistani and Black African groups had numbers of hospital deaths from COVID-19 comparable to those of the White British population (Platt & Warwick, 2020). Among National Health Service healthcare staff who died of COVID-19, a disproportionate number were racial/ethnic minorities (Bhala et al., 2020).

Although studies have not yet evaluated the impact of the COVID-19 pandemic on Black immigrants in the United States specifically, immigrants who experienced high levels of discrimination may have fared similarly to Black Americans. Andrasfay and Goldman (2021) estimated that COVID-19 would reduce U.S. life expectancy in 2020 by 1.13 years; however, the reduction in life expectancy for Blacks would be 3 times that of Whites, and the reduction for Latinos would be 4 times that of Whites. A review on the effects of COVID-19 on the health of the Latino population found that studies using national data reported that residents of areas with high densities of Latinos and Blacks had up to 4 times the odds of seropositivity compared to residents of predominantly White neighborhoods; Black and Latino deaths accounted for 53% of hospital mortality due to COVID-19 (Salgado de Snyder et al., 2021). Similar disparities were found at the state level, in addition to higher hospitalization rates and higher rates of infection in Latino children than other ethnic groups.

The Canadian government does not mandate systematic collection of potentially sensitive demographic data, such as race, because it may lead to increased discrimination against minority populations (Choi et al., 2021; *Population centre,* 2015). Provinces and health regions are the smallest geographic units for demographic information reporting, which limits our understanding of COVID-19 infection rates, morbidity, and mortality among vulnerable populations, such as immigrants. At the health-region level, the association between the presence of foreign-born residents and COVID-19 infections was negative in the first wave of the pandemic and positive in the second wave, except in the Toronto health region, where both waves demonstrated a positive association (Choi et al.,

2021). Toronto is seen as an immigrant gateway city, and the positive association between infection rates and the presence of foreign-born residents during both pandemic waves may be due to the city's urban geography and immigrants' limited access to resources that would help mitigate the pandemic's effects (Choi et al., 2021; Yu et al., 2007).

Overall, international migrants disproportionately shouldered the social and economic costs of the COVID-19 pandemic. In the 20 countries with the highest numbers of COVID-19 cases, immigrant populations were overrepresented among the infected, highlighting that social inequalities and other structural factors that shape immigrants' lives increased their exposure to the virus and worsened its impact (International Organization for Migration, 2021a, September 7).

COVID-19 PANDEMIC-RELATED SOCIAL POLICIES VIS-À-VIS INCLUSION OR EXCLUSION OF IMMIGRANTS

Pre-COVID-19 Context of Immigrant Reception

To understand the COVID-19 pandemic's impact on immigrants, it is crucial to acknowledge the pre-pandemic contexts of immigrant reception (Portes & Rumbaut, 2014). In each case-study country, migrants play a critical role in the economy but are excluded from many social and economic privileges. This imbalance reflects the subordinated social position of immigrants in these nations and the inequalities they face in accessing legal and social welfare systems. Below, we briefly review each country's pre-pandemic context of immigrant reception before delving into pandemic-related policies' inclusion or exclusion of immigrants.

Even before the pandemic, compared to local populations, immigrants in case-study countries faced greater barriers in accessing legal, health, and other public services (Ahmed et al., 2016; Pereira et al., 2012). These barriers were especially severe for undocumented immigrants, whose status negates their eligibility for a range of programs. These barriers were exacerbated by growing anti-immigrant sentiments influencing public policy. For example, the Trump administration was elected on a platform that advocated for harsher immigration policies and made unprecedented use of bureaucratic mechanisms to refashion the U.S. immigration system through executive authority, creating policies including family separation, asylum restrictions, the public charge rule, and the ban on immigration from several Muslim-majority countries (K. R. Johnson, 2017). These U.S. policies affected Mexico's border enforcement and its treatment of a growing number of Central American and South American caravans traversing Mexico in search of asylum in the United States. When these large caravans first appeared in Mexico beginning in 2017, they were well received by most Mexicans, but anti-immigrant sentiments increased over time with concerns over increasing violence in Mexico.

The United Kingdom also experienced rising nativism and public discord regarding migration in the years before the pandemic, which ultimately helped drive support for the 2016 referendum that led to the United Kingdom's exit from the European Union (Somerville & Walsh, 2021). Although Australia welcomes a significant number of refugees who enter Australia with legal authorization, the nation has also engaged in an offshore detention strategy to discourage asylum seekers' unauthorized arrival by boat (Inglis, 2018). In 2013, Australia resumed its offshore processing policy for asylum seekers and since then has forcibly transferred more than 3,000 asylum seekers to offshore processing camps in Papua New Guinea and Nauru (Australia, 2021). In contrast, Canada has one of the largest concentrations of immigrants, yet migration is largely regarded as a positive feature for their nation (Bloemraad, 2012).

While immigrants occupied a precarious position in most societies before the COVID-19 pandemic, the pandemic solidified anti-immigrant sentiments by pathologizing immigrants as "carriers of disease," and enabled the extension of state regulations under the guise of protecting public health. These pre-existing patterns of exclusion were then perpetuated in pandemic response policy programs (Y.-Y. Chen & Assefa, 2021). The pandemic exacerbated systemic inequalities by limiting immigrants' access to programs such as vaccine rollout plans, for which many immigrants were either ineligible or excluded from target/priority groups (Armocida et al., 2021; Obinna, 2021). This exclusion stands, even though compared to natives, immigrant workers are more exposed to economic and health-related risks related to COVID-19; furthermore, migrants served as a shield to native workers by allowing them to undertake less-risky jobs where they could avoid economic shock because of the nature of their jobs and

shift to a work-from-home environment (Bossavie et al., 2020).

The following section highlights economic and social policies implemented at the national level during the COVID-19 pandemic and their inclusion or exclusion of immigrants. Our policy review illustrates key policies implemented from March 2020 to December 2021 but is not meant to exhaustively cover all COVID-19-related social policies.

National COVID-19 Economic and Social Policy Responses

To mitigate migrants' social vulnerabilities exacerbated during the pandemic, there were calls to include and prioritize migrants in economic and social policy responses. Table 6.5 is a policy matrix identifying national policies instituted during the COVID-19 pandemic; policies cover economic, employment, family, housing, healthcare, and legal initiatives. Checkmarks reflect whether a nation instituted such a policy, while stars indicate that the policy is available to some immigrants, and the exclamation point indicates no explicit exclusion of any immigrant category.

Income Support

The pandemic significantly affected immigrants' economic status, and although most of the case countries instituted national economic stimulus programs in response to the COVID-19 pandemic, many immigrants were excluded from income support programs based on immigration status. For example, the United States instituted three direct relief payments, but these payments were exclusively provided to U.S. citizens and resident aliens with work-valid Social Security numbers. Additionally, the first round of payments was unavailable to households in which any member lacked a Social Security number, which is common among immigrant families (Cholera et al., 2020). The Australian COVID-19 Disaster Payment was restricted to Australian residents and work visa holders who were unable to earn income because of the pandemic. Canada provided the Canada Emergency Response Benefit, but it was restricted to those with social insurance numbers who had worked for at least a year before their application dates. Like the American and Australian income-support programs, this program excluded undocumented immigrants and those whose documentation was incomplete or missing. The UK government provided an additional £7 billion of funding for the United Kingdom's social security system, with changes to the Universal Credit and to disability, caregivers', and sickness benefits; however, the system excluded most immigrants except refugees and those with EU-settled status. The United Arab Emirates did not provide a national income support program in response to the COVID-19 pandemic, possibly because of its already robust social welfare benefits, which are exclusively provided to

	Economic			Family		Housing		Healthcare		Legal
	Income Support	Employment Protection	Sick Leave	Childcare Subsidies	Food and Nutrition Programs	Eviction Moratorium	Housing Assistance	COVID-19 Testing Program	COVID-19 Vaccination Program	Deportation
Australia	✓★	✓★[a]	✓★	✓★			✓★	✓★	✓★!	✓!
Canada	✓★[a]	✓★	✓★	✓★!	✓★!			✓★[c]	✓★!	✓!
Mexico			✓★					✓★!	✓★!	✓!
United Arab Emirates		✓★!			✓★!			✓★[c]	✓★[c]	✓!
United Kingdom	✓★[b]	✓★[c]	✓★[c]		✓★!	✓★!	✓★!	✓★!	✓★!	✓!
United States	✓★	✓★	✓★!		✓★	✓★!	✓★!	✓★!	✓★!	✓!

TABLE 6.5. National COVID-19 response policies and immigrant inclusion or exclusion

Note: These policies only include those instituted at the national level. The Black check marks symbolize that the country instituted this policy, while the stars symbolize that immigrants who are naturalized citizens, permanent residents, have documentation that allows employment, or refugees were included in the policy. The exclamation point reflects no explicit exclusion of any immigrant category from the policy as of December 31, 2021.

a. Restricted to those who worked for at least one year.

b. Only applies for those with EU settled status and refugees.

c. Unclear if immigration status is considered.

Emirati nationals. Mexico also did not provide a national income support program, likely because of the government's austere stance toward pandemic spending. Across all case countries, income support programs either were absent or had restrictions that excluded most immigrants, despite their economic vulnerability during the pandemic.

Employment Protection and Sick Leave

Employment protection represented another key component of COVID-19 social policy responses. In the United Kingdom, foreign nationals were eligible for the Coronavirus Job Retention Scheme and Jobs Support Scheme furlough programs if they were taxed as employees and registered for the Pay As You Earn income tax system. Australia instituted the JobKeeper and JobSeeker programs to keep employees in their jobs by covering wages and increasing workforce participation; however, people who had worked for less than 12 months were ineligible, so younger workers and many immigrants were excluded (Borland & Charlton, 2020). The United States also expanded unemployment benefits, but immigrants without work authorization were excluded (National Immigration Law Center, 2020).

Australia offered the Pandemic Leave Disaster Payment grant for individual territories to administer as a form of income, but only Australian residents and immigrants with work visas were eligible. Canada offered the Canada Recovery Sickness Benefit, but it required recipients to have earned some income in recent years and was limited to those who lived in Canada and had a valid social insurance number. Mexico offered a sick leave program, the Special Health Emergency Permit, which gave sick workers a subsidy covering 60% of their wages for 11 days. This subsidy was administered through the Instituto Mexicano del Seguro Social (Mexican Institute of Social Security) (*Mexican Social Security Institute allows processing of temporary disability certificates and subsidies online*, 2020). Immigrants to Mexico were eligible if they had a permanent residence visa or visitor visa, temporary residence visa, or student temporary resident visa with paid work permission (*Permiso COVID-19*, n.d.). The United Arab Emirate's Ministerial Order 279 established how private-sector employers could institute remote work, paid and/or unpaid leave, and temporary and permanent salary reduction for noncitizen employees (Regarding the stability of employment in private sector companies during the period of applying precautionary measures to contain the spread of the novel corona virus, 2020). Through the Families First Coronavirus Response Act, the U.S. government required specific public and private employers with fewer than 500 employees to provide paid sick leave or medical leave of up to two weeks for COVID-19-related reasons until the end of 2020, regardless of employees' immigration status; however, employers could deny leave to first responders and healthcare providers (Lahoud, 2020). The United States is the only high-income economy among the case countries that did not have a long-term national paid leave mandate for all workers, instead creating a temporary rule in September 2020 which expired in December 2020 (Romig, 2022; Paid leave under the Families First Coronavirus Response Act, 2020). Although many of these employment protection and sick leave policies did not explicitly exclude immigrants, requirements for identification numbers and authorization prevented those without documentation from accessing some of these services.

Childcare Subsidies and Food and Nutrition Programs

To supplement these work policies, many nations instituted family and nutrition programs to support those experiencing economic insecurity. Australia, Canada, and the United States were the only case-study nations to offer childcare initiatives during the pandemic. Australia initiated the Additional Child Care Subsidy to help cover short-term childcare costs that caused temporary hardship, but this subsidy was restricted to those with citizenship or visas (*ACCS temporary financial hardship*, 2021). The Canadian government passed the Canada-wide Early Learning and Child Care Plan to provide affordable and accessible childcare for working parents, but it was unclear whether all immigrants were eligible regardless of status. The United States' Families First Coronavirus Response Act provided sick leave and expanded family and medical benefits for those who had been employed for at least 30 calendar days, without explicit legal status requirements. The United States, United Kingdom, Canada, and United Arab Emirates also created specific food-assistance programs during the pandemic. In the United States, the Coronavirus Pandemic Electronic Benefit Transfer (P-EBT) policy provided free-and-reduced-lunch-eligible schoolchildren, regardless of immigration status, with emergency nutrition benefits loaded onto EBT cards (*U.S. Department of Agriculture*, 2021). The

United Kingdom instituted the Local Authority Emergency Assistance Grant for Food and Essential Supplies, providing local authorities with financial aid to support people in need of food and other necessities. The United Kingdom also made a short-term extension of its school meals program to allow children with temporary immigration status who were excluded from certain welfare benefits to receive free school meals. The Government of Canada funded $300 million through the Emergency Food Security Fund to Canadian food banks and national food rescue organizations to meet the needs of food-insecure people in Canada. Finally, the United Arab Emirates created the 10 Million Meals campaign, a food drive to distribute meals to support the UAE's vulnerable and low-income individuals and families affected by COVID-19. Overall, the family and nutrition programs in our case-study countries were less restrictive than the income support and employment protection programs.

Eviction Moratoriums and Housing Assistance

National housing policies were less common across countries than income and family support programs, but the policies that were offered were more inclusive. The United Arab Emirates and Mexico do not currently offer national housing support policies, but the United States, Australia, Canada, and the United Kingdom offer some housing assistance. In the United States, the Coronavirus Aid, Relief, and Economic Security (CARES) Act instituted a nationwide eviction moratorium from March 2020 until July 2020, then a Centers for Disease Control and Prevention (CDC)–imposed nationwide federal moratorium prevented residential evictions from September 2020 to August 2021 (McCarty & Perl, 2021). The US Homeowner Assistance Fund provided financial support to prevent mortgage delinquencies, foreclosures, and loss of utility services for homeowners experiencing financial hardship (*Homeowner Assistance Fund*, n.d.). The United States also instituted the Emergency Rental Assistance Program to provide funding for states, territories, and local governments to distribute to households unable to pay rent or utilities bills (*Emergency Rental Assistance Program*, n.d.). There was no immigration status eligibility requirement for any of the U.S. programs. Australia offered rent assistance for those who paid rent and were receiving payments from any Centrelink programs (pension, caregiver payment, living allowance, youth allowance, special benefit, family tax benefit, parenting payment, JobSeeker payment, or farm household allowance), but many programs were limited to citizens and Australian residents (*Rent Assistance*, n.d.). The United Kingdom's Coronavirus Act 2020 delayed when landlords could evict social-housing and private tenants, but there were no other national housing policies (*Guidance for Landlords and Tenants*, n.d.). Although housing programs were less robust across countries than economic policies, they provided more examples of inclusion.

COVID-19 Vaccination Programs

Though vaccine campaigns were generally inclusive of immigrants regardless of immigration status, immigrants were not explicitly prioritized. There have been calls for equitable inclusion of migrants in nations' mass COVID-19 vaccine campaigns because migrants are overrepresented in essential jobs that increase their vulnerability to COVID-19 (Artiga et al., 2021; International Organization for Migration (2021b, December 8). In the United States, Canada, United Kingdom, and Australia, COVID-19 vaccines were free for everyone regardless of citizenship status and health insurance. In the United Kingdom, there was no immigration check for overseas visitors receiving testing, vaccination, or treatment for COVID-19. The U.S. Department of Homeland Security supported COVID-19 vaccines for all individuals regardless of status and did not conduct enforcement operations near vaccine distribution sites and clinics (*DHS statement on equal access to COVID-19 vaccines and vaccine distribution sites*, 2021). The United Arab Emirates prioritized free vaccines for medically eligible citizens, their household workers, and residents, but there was no mention of whether "residents" included all types of migrants (*Vaccines against COVID-19 in the UAE*, 2022). Immigrant workers were not explicitly excluded in UAE national policy, but, apart from front-line heroes (healthcare professionals, housekeeping, waste disposal, and other staff), there was no explicit mention of immigrants or designation of them as part of priority groups for working essential jobs (*Inclusion of vulnerable migrant groups in COVID-19 vaccination strategies in the UAE*, 2021). In Mexico, migrants waiting to cross into the United States became eligible to receive the COVID-19 vaccines on the same schedule as Mexican nationals,

but migrant-serving organizations reported that vaccine distribution was lacking (Chavez, 2021; Diaz, 2021; Secretaría de Salud, 2021; *Solicitantes y refugiados pueden vacunarse en México*, 2021). Vaccine campaigns have expanded care access for immigrants, but concerns about barriers to vaccine access remain.

COVID-19 Testing Programs

Similar to the vaccine campaigns, testing initiatives for SARS-CoV-2 did not explicitly focus on migrants and, in some cases, actively excluded them from testing protocols. For example, the U.S.CARES Act limited testing for noncitizens in three ways: insurance coverage, access to low-cost providers, and availability of testing (*Immigrant access to COVID-19 testing and treatment*, n.d.). In the United States, free SARS-CoV-2 testing for the uninsured was supported through state Medicaid, but none of the COVID legislation altered Medicaid eligibility, so many immigrants did not have coverage for the cost of treatment (National Immigration Law Center, 2020). However, the Biden administration purchased 500 million over-the-counter at-home tests to be distributed for free, beginning in January 2022, to all households that wanted them, regardless of immigration status. In the United Kingdom and Mexico, COVID-19 testing was free for noncitizens, regardless of documentation status. The Australian government offered testing at COVID-19 clinics in different territories, and free rapid antigen tests were available for those with Commonwealth concession cards, which were exclusively provided to citizens and legal residents. The United Arab Emirate's COVID-19 testing program was unclear regarding immigrants' eligibility. In Canada, COVID-19 testing programs were managed by provinces, with the federal government and some provincial/territorial governments providing free rapid COVID-19 tests to some organizations, but there were no clear guidelines about immigration status requirements.

Deportation

In contrast to the health campaigns, which were largely successful, deportation policies did not adequately address the public health implications of continued deportations. Although there were temporary deportation moratoriums across all the countries at the beginning of the pandemic, all nations resumed deportations. Deportations place not only migrants but also receiving countries and host countries at great risk (Kassie & Marcolini, 2020). Although Canada's guardian angels program extended a path to permanent residency for some front-line essential workers, it did not apply to asylum seekers in other sectors; overall, Canada's restrictive border control measures entailed deporting significant numbers of migrants (Christoff, 2021; Government of Canada, 2021). During the pandemic, the United Arab Emirates conducted police raids on, detained, and mass-deported hundreds of nationals of African countries, many of whom were domestic workers, with no due process (*Amnesty International,* 2021). The Mexican government bused Guatemalans and immigrants of other nationalities to the Mexican side of the El Ceibo border crossing with Guatemala with no coordination with Central American governments (Mexico, 2021). US Immigration and Customs Enforcement (ICE), the UK Home Office, and the Australian government have continued deportations despite bans on public overseas travel and reports of SARS-CoV-2 spreading due to deportation flights (Loweree et al., 2020; Ryan et al., 2020; D. Taylor, 2021). Deportation policies reveal the contradictory nature of COVID-19 pandemic policies that conflict with public health concerns.

CONCLUSION AND IMPLICATIONS

The COVID-19 pandemic caused a major disruption in international migration. With only a couple of exceptions—namely, Mexico and Canada—the UN estimated immigrant stock in 2020 was lower than expected in the case countries. Additionally, the governing bodies in each of these countries used varying degrees of stringency in their containment measures to accomplish safety and, at times, national political goals. From the review of COVID-19 mortality data, immigrant health during the COVID-19 pandemic, and national COVID-19-related social policies, several important trends emerged with implications for immigrants' health.

First, the pandemic magnified pre-existing marginalization of immigrants in society, which further underscores the importance of immigration status as a social determinant of health (Castañeda et al., 2015). Mortality statistics highlight the COVID-19 pandemic's uneven impact on health. The United States and Mexico have the highest reported rates of COVID-19 deaths. Importantly, none of the six case-study countries reported national data that disaggregated

COVID-19 morbidity and mortality statistics by race/ethnicity and immigration status.

Second, it is clear that there are connections among high infection rates, mortality, and mental health outcomes and that these are associated with barriers to financial, medical, and emotional support and resources. Unlike immigrants, native-born individuals have the advantage of access to their countries' pandemic-related social policies established to protect and support families, workers, and the general population. Immigrants do not have the same access to these policies; across the six case-study countries, who was included in social policies varied by documentation status. The COVID-19 pandemic also highlighted how governments may codify racism and xenophobia in whom they choose to help in a public health crisis, as seen in the U.S. and UK examples.

Third, though an exploration is beyond the scope of this chapter, internal migrants experienced many similar vulnerabilities to international migrants and represent a far more prevalent migration experience, particularly in low- and middle-income countries such as India (Barker et al., 2020; Irudaya Rajan et al., 2020). Internal migrants are more likely to be involved in the informal sector of the labor market and to be at risk of job loss or loss of work hours, resulting in greater food insecurity and inability to send money to family members (Barker et al., 2020; Das, 2020). Further, lockdowns left many internal migrants isolated in locations distant from family and at risk of mental and physical health challenges due to lack of support (Irudaya Rajan et al., 2020). Surprisingly, remittance flows remained resilient after an initial fall at the beginning of the pandemic, and even increased as COVID-19 infection rates in migrant home countries increased (Kpodar et al., 2021).

Using data available through December 2021, it is difficult to draw conclusions regarding the direct effects of COVID-19 pandemic-related restrictions and other COVID-19-related risks on immigrants' mental health outcomes on regional and global scales; most existing studies used limited convenience sampling or nationally representative samples that are not disaggregated by nativity status (Bhala et al., 2020; Daly et al., 2021; Généreux et al., 2021; Grasso et al., 2021; Martínez-Vélez et al., 2021; McCartan et al., 2021; Platt & Warwick, 2020; Regehr et al., 2021; Rossell et al., 2021). Furthermore, the limited literature on the COVID-19 pandemic's mental health impact underscores the necessity for more research, particularly on immigrant children and children of immigrants. Although some studies have examined the mental health impact of the COVID-19 pandemic in regard to youth generally (Smitherman et al., 2021; Viner, Bonell, et al., 2021; Viner, Russell, et al., 2021), particularly concerning school closures, few studies have examined the pandemic's effects on children of immigrants and immigrant children in spite of their heightened exposure to various social risk factors (Browne et al., 2021; Rothe et al., 2021; Song, 2021). Additionally, interpersonal racism and xenophobia became more salient during the COVID-19 pandemic; while incidents of racism increased across all racial/ethnic minority groups, anti-Asian attacks increased most dramatically (Addo, 2020; Human Rights Watch, 2020; Ruiz et al., 2020).

In the aftermath of the COVID-19 pandemic, nations will need to develop policies to address the health-related and economic vulnerabilities that have become even more apparent during its course. To properly mitigate the pandemic's impact, national response plans must carefully consider immigrants, including vulnerabilities highlighted by the Office of the United Nations High Commissioner for Human Rights such as "inaccessibility of services; language and cultural barriers; cost; a lack of migrant-inclusive health policies; legal, regulatory and practical barriers to health care . . . [and,] in too many instances, prejudice" (Office of the United Nations High Commissioner for Human Rights, 2020). For a plan to be successful, countries must first find the political will to address the pandemic's impact on their immigrant population and to acknowledge the critical role that immigrants play in the success of their nation in an increasingly globalized world.

APPENDIX

Country	Nationalities of Immigrants	Percent of Immigrant Total	Destination Countries of Emigrants	Percent of Emigrant Total
United States	Mexico	22.68%	Mexico	26.22%
	China	5.72%	Canada	9.29%
	India	5.25%	United Kingdom	7.43%
	Philippines	4.04%	Germany	4.38%
	El Salvador	2.82%	Australia	3.94%
United Kingdom	India	9.61%	Australia	26.69%
	Poland	9.57%	United States	15.15%
	Pakistan	6.33%	Canada	11.24%
	Ireland	4.64%	Spain	6.39%
	Germany	3.64%	Ireland	6.20%
United Arab Emirates	India	39.83%	Kuwait	12.36%
	Bangladesh	12.57%	Canada	10.59%
	Pakistan	11.43%	Oman	8.66%
	Egypt	10.32%	United States	6.35%
	Philippines	6.48%	United Kingdom	5.63%
Canada	India	7.45%	United States	34.84%
	China	7.24%	United Kingdom	4.56%
	Philippines	6.56%	Australia	2.44%
	United Kingdom	5.57%	France	1.20%
	United States	2.83%	Italy	1.09%
Australia	United Kingdom	16.72%	United Kingdom	25.24%
	China	8.50%	United States	16.70%
	New Zealand	7.95%	New Zealand	11.60%
	India	7.54%	Canada	3.89%
	Philippines	3.73%	Italy	3.50%
Mexico	United States	71.87%	United States	49.01%
	Guatemala	4.16%	Canada	0.37%
	Spain	2.22%	Spain	0.23%
	Colombia	1.82%	Guatemala	0.08%
	Venezuela	1.63%	Germany	0.07%

Note. Based on UN international migrant stock mid-year 2019 estimates. International migrants for United States, Canada, United Kingdom, and Australia referred to the foreign-born population in the country. Mexico included a combination of foreign-born population and refugees or people in refugee-like situations based on reports by the Office of the United Nations High Commissioner for Refugees. UAE estimates included refugee data as well, in addition to foreign citizens rather than foreign-born population.

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