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Perspective

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Management of cross-border mobilities during the SARS-CoV-2 pandemic in Europe and implications for public health provision to migrants

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Within the first year of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic 227 of 247 countries, territories or areas had issued different levels of border restrictions to control the spread of the virus.[1] Despite strong recommendations from the World Health Organization (WHO) against border-control measures, the majority of countries, including China, Australia, the USA and the European Union (EU) member states issued travel bans for different categories of passengers and people arriving from certain countries.[1] These measures have had major negative implications for cross-border movements of people, goods and services disrupting international economic and work supply chains, global distribution of medicines and vaccines and cross-border delivery of care. In this context, the WHO, the International Organization for Migration and others have specifically highlighted the disproportionate negative impact that border controls have had on populations on the move, such as low-skilled labour migrants and asylum seekers.[2]

Research has already highlighted the disproportionate impact of SARS-CoV-2 on ethnic minorities and migrants around the world (in terms of exposure, morbidity and mortality), urgently calling for better healthcare access and meaningful inclusion in pandemic response plans, for these communities.[2,3] In this perspective, we bring particular attention to migrants on the move during the pandemic—labour migrants (including internal EU workers and seasonal workers, migrants from outside of the EU), asylum seekers and other groups who may have crossed several geo-political territories involving diverse national health and public health infrastructures. We highlight how pre-existing gaps in cross-border infrastructures for infectious disease control (IDC), particular in the EU, were intensified by the pandemic and resulted in the exacerbation of vulnerabilities and inequities experienced by these migrant groups. In June 2022, the WHO published a draft of a convention on pandemic prevention, preparedness and response,[4] reflecting on this document, this perspective draws particular attention to the importance of addressing healthcare access for migrants on the move, which we think should be considered within the newly developed international guidelines and conventions. We highlight lessons learned from the SARS-CoV-2 pandemic and its border politics.

Enacting Cross-Border Public Health

Various international agreements for operating cross-border IDC infrastructures were already in existence before the pandemic of SARS-CoV-2. For instance, the International Health Regulations coordinated by the WHO aim to coordinate international detection and response to health emergencies. At the level of the EU, the European Centre for Disease Prevention and Control (ECDC) plays a key role in the cross-border management of public health threats, including through the EU framework for coordinating cross-border health emergencies. However, despite existing IDC infrastructures that aim to monitor and coordinate international public health emergencies, certain migrant populations, such as internal EU and external low-skilled labour migrants, asylum seekers and other migrants on the move have not been well enough considered within such infrastructures.[3,5] For example, in many European countries, migrants have been reported to have limited access to early TB diagnostics, continuity of care and general health services despite foreign-born nationals

comprising a key group for TB cases in Europe.[6] In addition, in Europe, certain migrant groups are under-immunised and often overlooked in the national vaccination programmes, and they may experience challenges with transferring and communicating their previous vaccination history across different countries with few systems in place to address this.[3] On-arrival and border screening is known to have many shortfalls, focusing often on a small subset of migrants and focusing on a narrow range of cross-border threats.[7]

These pre-existing gaps in incorporating the health of migrant communities within the larger infrastructures of cross-border IDC have been already reported by various researchers.[3,5,8] However, it is crucial to highlight that these gaps became further intensified as many countries, including in the EU, press forward with border-control policies as a key instrument in controlling the pandemic, thus creating additional obstacles for searching and delivering cross-border care.[9] Migrants on the move have been faced with additional barriers in accessing testing, treatment and vaccination.[9] This highlighted the clear gap in the existing cross-border IDC infrastructures that have often failed to consider and give equitable treatment to people who move beyond the borders of one country.

Crossing the Border

Although most EU countries have had different levels of cross-border restrictions in place throughout the pandemic, the European Commission developed guidelines early on in the pandemic that sought to ensure the unhindered mobility of goods and services considered essential by the EU. Although people moving those goods and services have been positioned at higher risk of SARS-CoV-2, as reported by the ECDC,[10] it has remained unclear whether any care infrastructures were put in place to protect these labour migrants who had to continuously be on a move, such as track drivers and seasonal workers.[5]

The EU cross-border economic infrastructures mean that a worker from Poland can be hired by a recruitment agency registered in Luxembourg to work in a factory located in The Netherlands, and this worker can be placed in communal housing in Germany from where he has to commute in crowded buses or cars. This complex network of mobility reflects the economic arrangements of capitalist European economies for cheap labour, and it also disperses and makes it difficult to assign responsibilities regarding healthcare provision for these workers. Many labour migrants, both from within and outside the EU, have no access to mainstream health systems in the countries in which they reside, or face substantial barriers to accessing it and are outside of the public health infrastructure.[11] In August 2020, the report by the ECDC indicated that the workers in food production, including agriculture, in the EU, many of whom are low-skilled labour migrants, were more exposed to, and at higher risk of being infected with SARS-CoV-2.[10] The report indicated that by summer 2020, 13 countries reported a total of 153 clusters and 3820 cases in this sector. For instance, Germany reported 1500 cases among slaughterhouse workers that resulted in the quarantine of 7000 employees, with similar outbreaks among EU labour migrants reported in The Netherlands, Belgium, Spain and Italy.[10] The high number of cases, according to the ECDC, was a result of limited preventative measures in the workplace, shared and overcrowded accommodation and transport used by labour migrants, reduced access to the healthcare system in the host country, as well as language difficulties in communicating with local health authorities.

Although the economic arrangements have been adapted to the needs for frequent mobility among low-skilled labour migrants, cross-border health infrastructures remained predominantly state-centred. Low-skilled labour migrants have experienced challenges in accessing healthcare services in different countries of their migration route prior to the pandemic, however, these challenges have become further exacerbated in the last 2 years because of the lack of clear guidance regarding who is responsible for providing care, organizing quarantine and ensuring access to vaccination.[5] Labour migrants who are required to move across geo-political borders and who do not settle in one country challenge the state-based organization of pandemic response and border politics. As global economic networks become more integrated and dependent on the mobility of labour, the international IDC infrastructures need to adapt to ensure that all migrants on the move can access care at any point in their migration trajectory.

Waiting at the Border

During the SARS-CoV-2 pandemic asylum seekers and refugees, as well as other marginalised migrants on the move, such as trafficked and undocumented migrants, have been positioned in an increasingly vulnerable position with a growing body of evidence indicating inequitable access to testing, treatment and vaccination.[8] For instance, in June 2021, the ECDC reported that migrants may have been disproportionately represented among SARS-CoV-2 cases, hospitalizations and deaths in some European countries. The explanations for this were overcrowded conditions of reception and detention centres, living in overcrowded houses, having to work in front-facing jobs and limited access to healthcare services, including lack of access to culturally competent public health information in an accessible language.[12] Large-scale outbreaks in camps were reported across Greece, Malta and The Netherlands; attributed to the lack of SARS-CoV-2 prevention measures and limited access to testing, treatment and vaccination.[8,12]

The poor access of asylum seekers and refugees, including undocumented migrants, to healthcare services in transit and host countries has been previously reported, yet they have not been adequately addressed, leaving these migrants at the margins of healthcare provision.[3] Having limited access to SARS-CoV-2 prevention and treatment, migrants on the move became the target of blame in media for spreading SARS-CoV-2.[2] As the world had become increasingly mobile, with people who had to move in search of work and safety, it is a critical moment to radically rethink the notion of mobility as a risk and rather focus on infrastructural limitations that put people on the move at higher risk of worse health outcomes.

Conclusion

Political choices made before the pandemic regarding migrants' access to various healthcare services have pre-determined the vulnerable position of this group, greater risk of exposure and

hospitalization with SARS-CoV-2.[2,3] In a globalised and interdependent world, it is crucial that national and international public health infrastructures address cross-border care and the health needs of the diverse mobile populations (Panel 1). It is essential to institutionally incorporate care for migrants on the move within the international IDC infrastructures, which means that migrants need to be included in national and international epidemiological surveillance for early detection and response to infectious threats; international health regulations, as we as the currently developing convention on pandemic prevention, preparedness and response by the WHO; should have a clear indication regarding who is responsible for providing care to people on the move; all migrant groups, documented and undocumented, must have equitable access to diagnostics, treatments and available vaccinations to ensure the health of both migrant and local communities.

Panel 1. Key considerations for the inclusion of migrant communities on the move in cross-border IDC infrastructures

- Future planning for cross-border IDC management must address the pre-existing inequities to ensure the health of both migrant communities and local populations.
- Migrant communities on the move, regardless of their legal status, who are transiting through or stationed in a specific territory must have access to healthcare services and vaccinations in these territories. Countries that are participating and benefiting from systems of labour migration must ensure that people arriving and transiting through their countries have access to healthcare services, are aware of their rights, and are facilitated, e.g. through language support, in accessing those services.
- Cross-border health guidelines and treaties, including the International Health Regulations, must better consider migrant communities on the move and ensure their equitable access to care services of different countries.
- There has to be a clear indication regarding who is responsible for care provision, including the continuity of care for migrants on the move. The institution responsible should ensure that epidemiological data from migrant communities is properly collected and included in systems for international surveillance and monitoring.
- Specific challenges with regards to healthcare access and inclusion into the international systems of epidemiological data collection and monitoring should be further studied and outlined for different groups such as asylum seekers, refugees, internal and external labour migrants within the EU and seasonal labour migrants.

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Conflict of interest

Authors declare no competing interests.

References

1. International Organisation for Migration. *Global Mobility Restriction Overview: Weekly Update*. International Organisation for Migration, 2021, https://migration.iom.int/sites/default/files/public/reports/DTM-COVID19 Global Overview Output 23.08.2021.pdf.
2. Lancet T. Protecting refugees during the COVID-19 pandemic. *Lancet* 2021; **397**:2309. https://doi.org/10.1016/S0140-6736(21)01366-0.
3. Greenaway C, Hargreaves S, Barkati S *et al*. COVID-19: exposing and addressing health disparities among ethnic minorities and migrants. *J Travel Med* 2020; **27**:taaa113. https://doi.org/10.1093/jtm/taaa113.
4. World Health Organization. *Draft Annotated Outline of a WHO Convention, Agreement or Other International Instrument on Pandemic Prevention, Preparedness and Response*. Geneva: World Health Organization.
5. Lal A, Erondu NA, Heymann DL, Gitahi G, Yates R. Fragmented health systems in COVID-19: rectifying the misalignment between global health security and universal health coverage. *Lancet* 2021; **397**:61–7. https://doi.org/10.1016/S0140-6736(20)32228-5.
6. World Health Organization. Report on the Health of Refugees and Migrants in the WHO European Region. In: *No Public Health without Refugee and Migrant Health*. Copenhagen, 2018.
7. Seedat F, Hargreaves S, Nellums LB, Ouyang J, Brown M, Friedland JS. How effective are approaches to migrant screening for infectious diseases in Europe? A systematic review. *Lancet Infect Dis* 2018; **18**:e259–71. https://doi.org/10.1016/S1473-3099(18)30117-8.
8. Kondilis E, Papamichail D, McCann S *et al*. The impact of the COVID-19 pandemic on refugees and asylum seekers in Greece: a retrospective analysis of national surveillance data from 2020. *eClinicalMedicine* 2021; **37**:100958. https://doi.org/10.1016/j.eclinm.2021.100958.
9. Benton M, Huang L. *Managing Mobility in the Pandemic Era Requires World to Buy in on Shared Principles*. Migration Policy Institute. https://www.migrationpolicy.org/news/managing-mobility-pandemic-shared-principles. Published 2022.
10. European Centre for Disease Prevention and Control. *COVID-19 Clusters and Outbreaks in Occupational Settings in the EU/EEA and the UK*. Stockholm: European Centre for Disease Prevention and Control.
11. Simon J, Kiss N, Laszewska A, Mayer S. *Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Labour Migrants in the European Region*. Copenhagen: World Health Organisaiton Regional Office for Europe, 2015.
12. European Centre for Disease Prevention and Control. *Reducing COVID-19 Transmission and Strengthening Vaccine Uptake among Migrant Populations in the EU/EEA*. Stockholm: European Centre for Disease Prevention and Control, 2021.