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EASO Special Report: Asylum Trends and COVID-19

Date of release: 7 May 2020
Reference number: EASO/AKC/SAU/DARS/2020/148

European Asylum Support Office

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Disclaimer

This Special Report is marked as PUBLIC, which refers to non-classified information.

This document is produced by EASO's Situational Awareness Unit (SAU) on the basis of monthly data exchanged under the Early warning and Preparedness System (EPS) as well as external sources. The data provided to EASO by the EU+ countries (EU Member States, Norway and Switzerland) are provisional and unvalidated, and therefore may differ from validated data submitted to Eurostat (according to Regulation (EC) No 862/2007). This information should therefore be understood as giving an estimation of general trends at EU+ in as near to real time as possible.

This document includes EPS monthly data until March 2020 (at the date of release available for 28 EU+ countries).

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Executive Summary

During the first two months of 2020, prior to the outbreak of COVID-19, asylum-related migration to EU Member States plus Norway and Switzerland was much increased compared to most of the last two years. For example, more than 61 100 applications were lodged in February 2020, up by 14% compared to the same time a year ago. Citizens from Syria, Afghanistan, Venezuela and Colombia lodged the most applications, all in higher numbers than a year ago; Colombian applications, in particular, more than tripled compared to the beginning of 2019. In early March the situation was further exacerbated by the situation at the Greek border with Turkey, where several thousand migrants congregated and attempted to cross the border into Greece supported by the Turkish authorities. Overall in March, coinciding with the implementation of widespread emergency measures across the European Union and beyond, applications for asylum fell dramatically by 43% to just 34 700, the lowest level since the beginning of 2014. Analysis of open data on the nature and extent of general emergency measures, suggests that the number of measures was a strong predictor of the extent to which applications were reduced – in other words, countries that implemented the most emergency measures also had the largest drop in applications.

EASO has had to swiftly adjust its operational response to the rapidly changing environments across the four Member States where EASO provides direct Operational Support. This exercise is being conducted in a coordinated and planned manner in close communication with each of the national authorities and the EASO Headquarters and within the frameworks of the COVID directives being issued and updated nationally and with due regard to the relevant EASO Executive Director Decisions.

At the time of going to press, no processes requiring face-to-face contact (registration, asylum interviews) are being held in any of EASO's Operations. Instead, the tasks have been adjusted to reflect the situation, focusing on back-office workflows, mainly on backlog reduction, administrative actions in support of registration, Dublin support (on files not transfers), providing country of origin information, support to appeals, support to general capacity building activities including work concerning policy and procedural improvements. EASO is also actively engaged in the current relocation exercise of Unaccompanied Minors starting in Greece under the Commission coordination. Member State Expert nominations and new deployments have been temporarily suspended and most ongoing deployments ended.

According to data from the European Centre for Disease Prevention and Control (ECDC), the outbreak has so far been extraordinarily concentrated in the developed world. Europe is the most affected continent followed by North America with other continents lagging far behind. With 80% of all confirmed cases, but only 20% of the world's population, high income countries have been disproportionately affected by the outbreak: the USA currently has many more confirmed cases than any other country but Europe has the tightest cluster of highly affected countries with Spain and Italy ranking second and third in the world, and having more confirmed cases per capita than the USA. In the interests of early warning and preparedness, asylum and reception authorities in the EU+[1] should consider the risks of the virus taking hold in lower income countries because in recent years, these have been the source of most asylum seekers in the EU+.

There are three overlapping explanations for the unequal distribution of cases between high and low income countries. Firstly, the infection might be much more equally distributed around the globe than the data suggest, but poor testing and low quality data are painting a distorted picture. Secondly, lower income countries may be inherently more protected from the virus because of their climate or demographics. Finally, the less-connected low income countries may be temporarily buffered from the infection which is yet to take hold.

Some data suggest that low and lower-middle income countries may be at inherently lower risk of massive COVID-19 outbreaks because they are in warmer sunnier locations, plus their populations tend to be younger and less obese. In addition, fewer international connections and more rural populations could be responsible for delaying the outbreak, but this would be temporary especially if lockdowns unintentionally encourage internal travel. In any case, it is not unreasonable to assume that there are more cases than are being reported, but the scale of this disparity is unknown.

Overall, available data seem to suggest that low and lower-middle income countries may be at higher risk of latent COVID-19 outbreaks. According to the Joint Research Centre's (JRC) Epidemic Global Risk Index the countries of origin that tend to apply for asylum in the EU+ have medium to high vulnerability to hazards (including infections) and suffer from a lack of coping capacity. This is particularly the case for Afghanistan, Bangladesh, DR Congo, Eritrea, Somalia,

and Syria. Similarly, the main countries of origin also have far fewer hospital beds and medical doctors per capita. On top of this, regular handwashing is not possible without running water: 84% of all households in DR Congo do not have access to handwashing facilities, nor do more or less half of all households in Sudan, Somalia, Guinea, and Côte d'Ivoire. Similarly, social distancing is not possible for those living in overcrowded conditions: in Sudan 92 % of the urban population lives in slums, a situation that is also common in Somalia, Afghanistan, Bangladesh, and Nigeria. Finally, low levels of literacy may inhibit the spread of effective information, and lockdowns may not be possible if countries can't afford to compensate the stay-at-home population.

At the same time, the suspension of global coalition operations across the Middle East has left a power gap that ISIS is looking to exploit. Being self-contained, living in remote hideouts, drawing on independent food and water caches, and powering electronic devices with solar power, ISIS is already socially isolated and well-prepared for lockdowns. Since local troops are poorly equipped and distracted by disaster relief and enforcing nationwide curfews, when the virus has done its work, the international community may return to a regrouped ISIS once more present and more active across much of the so-called caliphate.

This analysis confirms that 'overall' asylum-related migration to the EU+ was increased in 2019, was further amplified at the beginning of 2020, and then was put under more pressure by the dramatic situation at the Greek border with Turkey. Following the outbreak of COVID-19, which is disproportionately concentrated in the developed world, travel bans and other emergency measures have almost completely eliminated the number of asylum applications being lodged in the EU+, despite guidance to the contrary. In the interests of early warning and preparedness, national asylum and reception authorities should reflect upon the medium to high risk that the outbreak will eventually take hold in the countries of origin and transit. In turn, indirect (i.e. recrudescence of ISIS) and direct consequences (famine, conflict and security risks) of the virus might affect asylum-related migration to the EU+, and contribute the most to new applications or the reception population.

Latest Asylum Trends

Many applications prior to the COVID-19 outbreak

The first two months of the year revealed persisting high levels of asylum applications.[2] In January, more than 65 300 asylum applications were lodged, very close to the peak registered in October 2019 (66 600); in February, there were more than 61 000 applications, despite being a short month. **Thus, before the COVID-19 outbreak, asylum trends were considerably higher than in most of the past two years** (Fig. 1).

In March, applications fell dramatically to just 34 737, the lowest level since the beginning of 2014. Asylum authorities across the EU+ were affected to different extents by the COVID-19 outbreak, mostly depending on the impact of the virus within the single countries and the extent of the restrictive measures implemented. As such, trends for March are not truly indicative of the overall asylum picture in the EU+.

Main citizenships of origin

In the first two months of 2020, most applicants were nationals of **Syria, Afghanistan, Colombia and Venezuela,** altogether lodging two in every five applications. The span between the top four and the remaining citizenships deepened visibly, with Venezuelans (~ 10 100) seeking international protection far more often than Iraqis (~ 4 700). In January, Syrians lodged almost 8 000 applications, whereas Colombians reached a record level, with nearly 5 300 applications; more than Venezuelans. Latin Americans, in fact, continued to apply in large numbers. Beside the top countries, nationals of Algeria, DR Congo and Morocco continued to be prominent.

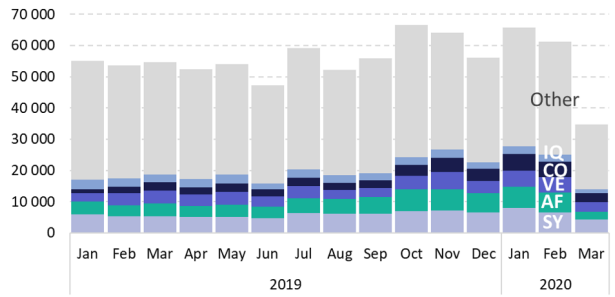

***Figure 1**. Evolution of asylum applications in the EU+ by top citizenships of origin, Jan. 2019 - Mar. 2020 (Data source: EASO)*

Elderly applicants

Amidst the corona virus outbreak, medical evidence shows that individuals over 60 years of age have higher hospitalisation rates and a likelihood to develop severe illnesses connected to the COVID-19 virus. Applicants older than 65 years old constituted a minority, overall lodging just 6 000 applications in 2019, or 1% of all applications, although increasing in the second half of the year. **By and large, Venezuelans made up the largest group of elderly applicants for international protection** (accounting for a quarter of all applications by this age group) (Fig. 2). As a result Spain received the lion's share of elderly applicants in the EU+ also at the beginning of 2020, together with Sweden and France.

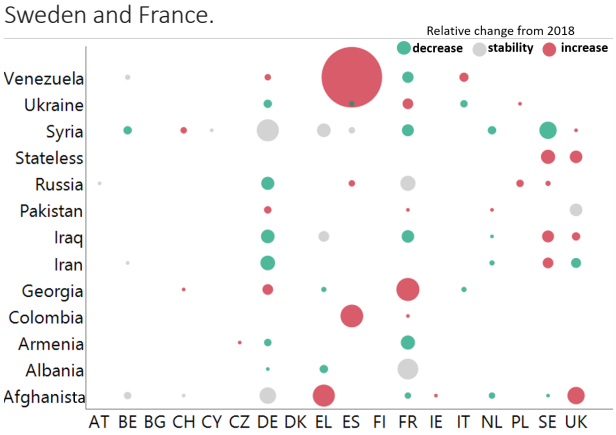

***Figure 2**. Applicants for international protection over 65 years old from selected citizenships (lodging at least 100 applications overall in 2019) in EU+ countries (Data source: Eurostat)*
***Note:** The size of the bubbles indicates the number of applications, whereas the colours indicate stability, increase (+ 10 % or more) or decrease (- 10 % or more) from 2018.*

Case closures exceeded inflows

Preliminary analysis of EASO data revealed that **the drop in the number of asylum applications lodged has resulted in a positive balance between inflows and outflows for the first time in almost a year**. For example, in March, there were more case closures than applications lodged, since decision-making did not drop to the same extent as asylum applications (Fig. 3). As a result, the number of applications awaiting a decision at first instance (with asylum authorities) did not increase - as was mostly the case in the previous two quarters - and stood at 489 500 at the end of March (-5 727 from February). More than 855 000 cases, however, were pending at all instances at the end of January, suggesting higher pressure on asylum authorities than appeal bodies.[3]

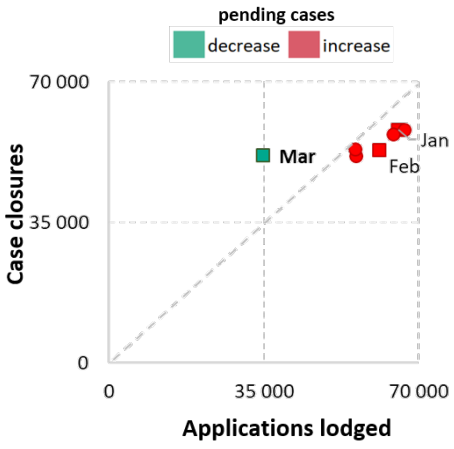

***Figure 3**: Applications lodged (x-axis) and cases closed (y-axis) in the EU+, Sep. 2019 - Mar. 2020 (Data source: EASO)*

Operational Update

COVID-19 Operational Response to Operating Plans Implementation

EASO has had to rapidly adjust its operational response to the rapidly changing environments across the four Member States where EASO provides direct Operational Support. This exercise is being conducted in a coordinated and planned manner in close communication with each of the national authorities and the EASO Headquarters, within the frameworks of the COVID directives being issued and updated nationally, and with due regard to the relevant EASO Executive Director Decisions.

At the moment, with the exception of Greece in a specific circumstance (see below), no processes requiring face to face contact (registration, asylum interviews) are being held in any of the Operations. Instead, the tasks have been adjusted to reflect the situation, focusing on back-office workflows, mainly on backlog reduction, administrative actions in support of registration, Dublin support (on files not transfers), providing country of origin information, support to appeals, support to general capacity building activities, including work concerning policy and procedural improvements, and also remote support in information provision and reception support through helplines.

EASO has, however, supported the pilot phase of the relocation exercise involving the relocation of 62 UAMs to Luxembourg (12) and Germany (50) by supporting the completion of Best Interest Assessments in Chios, Lesvos and Samos in conjunction with GAS and UNHCR for subsequent Best Interest Determination by the Greek authorities. Further, EASO is now actively engaged in the planning for the main relocation exercises in Greece and will introduce a new Relocation Measure in its 2020 Operating Plan for Greece to describe the activities foreseen for the relocation programme under the EU Commission coordination involving pledges for relocation of a further 1 600 UAMs.

Member State Expert nominations and new deployments have been temporarily suspended and most ongoing deployments ended.

EASO Centre for Operational Support has developed revised Operating Plans for each of the countries and is continuously reviewing these and will propose further revisions and possible amendments as necessary in the coming weeks. A new Measure on relocation is being included by amendment to the Greece Operating Plan. Further amendments may follow. With the different Country Operational Offices the phased resumption of activities is being actively planned. In the first instance this includes a phased testing of the resumption of remote asylum interviews (to reduce face-to-face work), but further steps are also being planned in respect of for example registration workflows and for further scaling of any testing of remote workflows. All will require extensive adaptation of the working environment, the introduction of new technologies and the establishment of a range of new Security, Health & Safety protocols and procedures to address COVID-19 issues. All activities are being developed in close partnership with the concerned national authorities

COVID-19 in the EU+ and Top Countries of Origin

Data used in this report on confirmed reported cases and deaths due to COVID-19 worldwide, current situation and trends, are based on the European Centre for Disease Control (ECDC) website, accessed on 29 April 2020. It should be noted that confirmed cases reflect cases definitions and testing practices followed in each reporting country. These might different across countries. Therefore, comparisons across countries should be done with caution.

More than 200 countries worldwide have already reported confirmed COVID-19 cases, however the epidemic evolved at different times, rates and magnitude in various areas of the world.

According to ECDC data on 29 April,[4] **the outbreak has so far been remarkably concentrated in the developed world.** In terms of the total number of confirmed cases, Europe is the most affected continent (~1 247 000) followed by North America (~1 037 000), but this is reversed when assessing the number of cases relative to population size (Fig.4). This is because the USA currently has many more confirmed cases than any other country, but Europe has the tightest cluster of highly affected countries with some countries such as Spain and Italy ranking second and third in the world, and having more confirmed cases per capita than the USA.

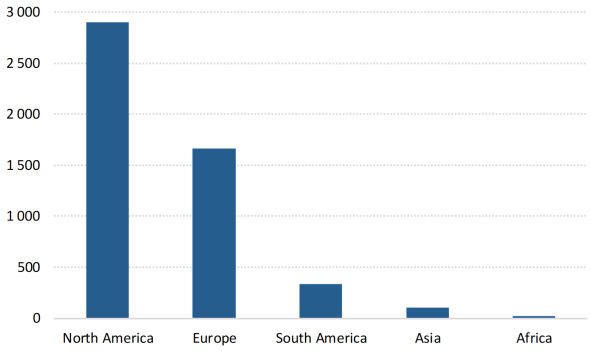

Figure 4. *Confirmed COVID-19 cases per million people by continent (Source: ECDC)*

In the EU+, countries that tend to receive the most applications **for asylum have also reported the most confirmed COVID19 cases – these include not only Spain and Italy but also the United Kingdom, Germany, and France.** So far bucking this trend, the number of cases in Greece is much more reduced but there have been several cases reported in Greek reception centres.[5]

Fewer cases in low and middle income countries

According to these data, infection rates are significantly lower away from North America and Europe (Fig.4). The apparently large differences between continents is much better explained in terms of the income category

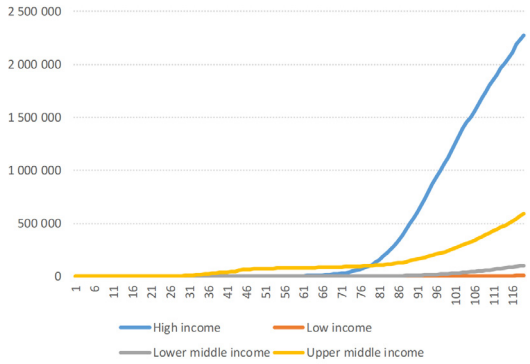

Figure 5. *Total confirmed COVID-19 cases by income category of the reporting country (Source: ECDC)*

of the individual reporting countries. Figure 5 illustrates very clearly that the number of cases, the rate of the spread and the timing of the outbreaks were all strongly related and ranked according to the income of each reporting country. **Overall low and lower-middle, and even upper-middle income countries[6] have reported far fewer confirmed cases** but almost certainly fewer tests are being performed plus lower income countries have lower statistical capacity which will become exacerbated should the infection take hold. In any case, an absence of evidence (which is the case here) should not be confused with evidence of absence.

COVID-19 situation in top countries of origin

Specifically, among the top Asian countries of origin of asylum applicants, **Iran** reported more than 100 confirmed COVID-19 cases as early as the end of February, reaching some 91 470 cases by the end of April. **Turkey** reported their first confirmed cases much later, on 12 March, but cases rose to 112 260 within a month. **Pakistan** and to a lesser extent **Iraq** and **Bangladesh** were the other Asian top countries of origin with most reported confirmed cases, with the epidemic evolving exponentially by end of March or later (in Bangladesh). **Afghanistan** had exceeded 1 700 cases by 28 April. **Lockdowns and high infection rates in Iran had forced many Afghans to return home, increasing the risk of transmission of the virus in the country.** Many others have been stuck, due to lockdowns, in the area of Pakistan.[7]

In **Syria**, fewer than 45 confirmed cases have been reported so far. **This low number probably reflects far fewer tests, poor healthcare provision, low capacity to track and report cases, plus much lower levels of international travel,** which would have isolated the Syrian population already before the outbreak. Future outbreaks in war-torn Syria are likely to go unreported at least for the time being.

Peru and Colombia were particularly affected South American countries, but the number of cases per capita is still relatively low across the continent (Fig.4). Flight restrictions almost halted the migration flow from Latin America to Europe; still many Venezuelans are trying to return home from Colombia, while concerns that the border closure between Colombia and Venezuela might lead to illegal border-crossing and boost organised crime were also raised.[8]

Far fewer COVID-19 cases and deaths have been recorded so far in Africa, accounting for just 1% of the total burden worldwide (Fig.5). **Egypt, Morocco and Algeria** reported the most confirmed cases in the region.

Data considerations

Between country comparisons and this analysis in general should be treated with caution because there are massive issues with data consistency, plus these data are based on case definitions, testing practices and medical/statistical capacities in each reporting country. The number of tests carried out is of course extremely important[9] but so is the way that they are carried out (random samples, or only when requested) as is the absorption capacity or the number of laboratories who can process the samples. **Recommendations** are in place but they **cannot be implemented to the same degree across all countries**, especially among poorer countries.[10]

Given that the virus makes no distinction between the rich and the poor, there is every reason to suspect that the virus will eventually take hold in extremely populous low income countries, whether or not the cases are formally reported. This may have huge implications for COVID-19 induced economic hardship, civil unrest and ultimately asylum-related migration.

COVID-19 and the Risk of ISIS Resurgence

While the international community works to contain the pandemic, some reports suggest that the Islamic State (ISIS) is seeking to exploit the coronavirus crisis and the chaos it has created. Although ISIS lost its leader to an American special operations raid in October 2019 and has lost much of its territorial caliphate, it now finds itself with more freedom to operate, and more experience of lockdowns.

In its regular newsletter Al-Naba, ISIS urged fighters to take advantage of the distraction and disruption caused by the virus, which might also be functional to its propaganda activities. On 6 February, Al-Naba labelled the virus a divine retribution to China, a statement later extended to comment on the mounting deadly toll in Iran.[11] Members have been banned from international travel but were reminded that they would receive divine protection from the illness if they still engaged in jihad. ISIS members might be at risk if they are away from medical care, relying on disparate health information and not covered by national measures, but in their favour they are self-contained, living in remote hideouts, drawing on independent food and water caches, and powering electronic devices with solar power. Ironically, they are already socially distanced and evidently well-prepared for lockdowns.

In many ways, the stars are aligned for a relaunch of ISIS: the suspension of global coalition operations has left a power gap that they are looking to exploit, plus they are no longer being pressured and chased from hideout to hideout because counterinsurgency operations have ceased. In Iran the coalition and NATO have both begun a two-month moratorium on their training activities, which was promptly followed by widespread withdrawals of trainers, and US troops have more or less withdrawn to a couple of well-defended bases. At the same time poorly equipped local troops are distracted by disaster relief and enforcing nationwide curfews. Similarly, in Iraq the global coalition announced in March that it stopped its combat, logistical and training operation. The COVID-19 outbreak accelerated the withdrawal of more international coalition troops from Iraq, and authorities in Iraqi Kurdistan warned that ISIS might exploit the situation to make territorial gains. On 30 March, ISIS prisoners managed to escape a prison in Hasakeh, and the smuggling of militants to Iraq would pose further threats to Iraqi security.[12] These militants would add up to an estimated force of some 30 000 members of the group still active in the border area between Syria and Iraq.[13]

The spread of COVID-19 has produced an uncertain future. The media is abound with stories of travel bans, lockdowns and social distancing, all of which are likely to have long lasting consequences on the economy and the way that the world does business. This analysis suggests that the uncertainty goes much further, with the capacity to wreak havoc in fragile and conflict-affected states,[14] especially those that rely on international peacekeeping missions to maintain some resemblance of stability. The next few months will be crucial, especially how and when coalition operations resume across the Middle East and the extent to which exacerbated wars and conflict situations result in increased internal and international displacements.

Risk Factors in Top Countries of Origin for Asylum Seekers in the EU+

A novel type of highly contagious virus

The COVID-19 disease outbreak began in China in late December 2019 and less than three months later turned into a pandemic (officially declared as such by the WHO on 11 March 2020). The virus causing the disease - Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2)- is **a novel type of coronavirus**.

The **case-fatality risk for COVID-19 is considered to be within the range 0.25 %–3.0 %**,[15] thereby not significantly different from seasonal coronaviruses.[16] **However, it appears to be much higher for older patients and such with chronic conditions.**[17] COVID-19 is **highly contagious**, with a reproduction number estimated to be between 2.2 and 3.6,[18] which means that each contagious person could spread the infection to two to four others on average. This is related to the fact that **an overwhelming majority of the persons infected with the disease are asymptomatic**[19] and so positive cases are often missed during screening.[20] Recently, it has also been found that 'SARS-CoV-2 has acquired mutations capable of substantially changing its pathogenicity'.[21] Despite the gradual increase of knowledge and abundance of datasets, there is **confusion about the interpretation of numbers**. In particular, a distinction between deaths with and by COVID-19 is rarely made, raising the question how many of the deaths might have occurred also without the COVID-19 infection.[22]

What would be the impact of the pandemic on countries of origin of asylum seekers to the EU+?

The borderline between pandemic and mass panic has been illustrated very well by the fear of an 'Italian scenario', referring to the fast spread of COVID-19 cases in particular in Northern Italy. Even an affluent region 'with an advanced healthcare system' was not able to cater for an extremely sudden increase in the number of patients in serious need, including non-COVID-19 patients, due to insufficient hospital capacity aggravated further by infected medical staff, and resulting in stunning mortality figures.[23] This example raises the question **what impact the pandemic could have on low and middle income countries around the world, many of which have been countries of origin of asylum seekers in the EU+**. The exponential growth in cases witnessed first in China and then in Italy[24] **need not be the scenario everywhere**, and the impact and feasibility of social distancing measures is likely to depend on social, cultural, political, and economic factors.[25]

Some are quite vulnerable and with limited coping capacity

The concern about the capacity of countries of origin of asylum seekers in the EU+ to fight the invisible enemy and deal with the epidemic is enormous. To illustrate the reasons for this concern, it is best to examine the INFORM[26] Epidemic Global Risk Index, developed in 2018 by the Joint Research Centre (JRC) as a modification to the existing overall Global Risk Index, adding the element of epidemics to each of the three dimensions of the original index: hazard and exposure, vulnerability, and lack of coping capacity. Given that the first dimension focuses on the likelihood of a risk to materialise, it is somewhat less important in the context of an existing and spreading epidemic.[27] Instead, the vulnerability dimension concerns 'the fragility of the socio-economic system, and the susceptibility due to low level of awareness, nutritional and health status' whereas the coping capacity focuses on 'the institutional and infrastructure resources'.[28] Plotting these two dimensions against each other (Fig. 6) shows that the **top 29 countries of origin of asylum seekers** (in the EU+ in 2019) **have medium to high vulnerability** (with the possible exception of Albania) **and their lack of coping capacity is also classified in the range of medium to high** (with the exception of China and Russia). In contrast, EU+ countries are generally on the opposite side of the spectrum. **Of particular concern are countries of origin such as Afghanistan and Somalia** (with a score higher than 6.5 on each dimension) **as well as Bangladesh, DR Congo, Eritrea, and Syria** (with a score higher than 6.5 on one of the dimensions).

Serious concerns about the healthcare sector and hygienic conditions

This overview underlines the **importance of both socio-economic factors and structural capacity** including of the healthcare and sanitation systems. With respect to the first category relevant factors include poverty, income, inequality, and dependency on foreign aid but important are also indicators such as internally displaced persons

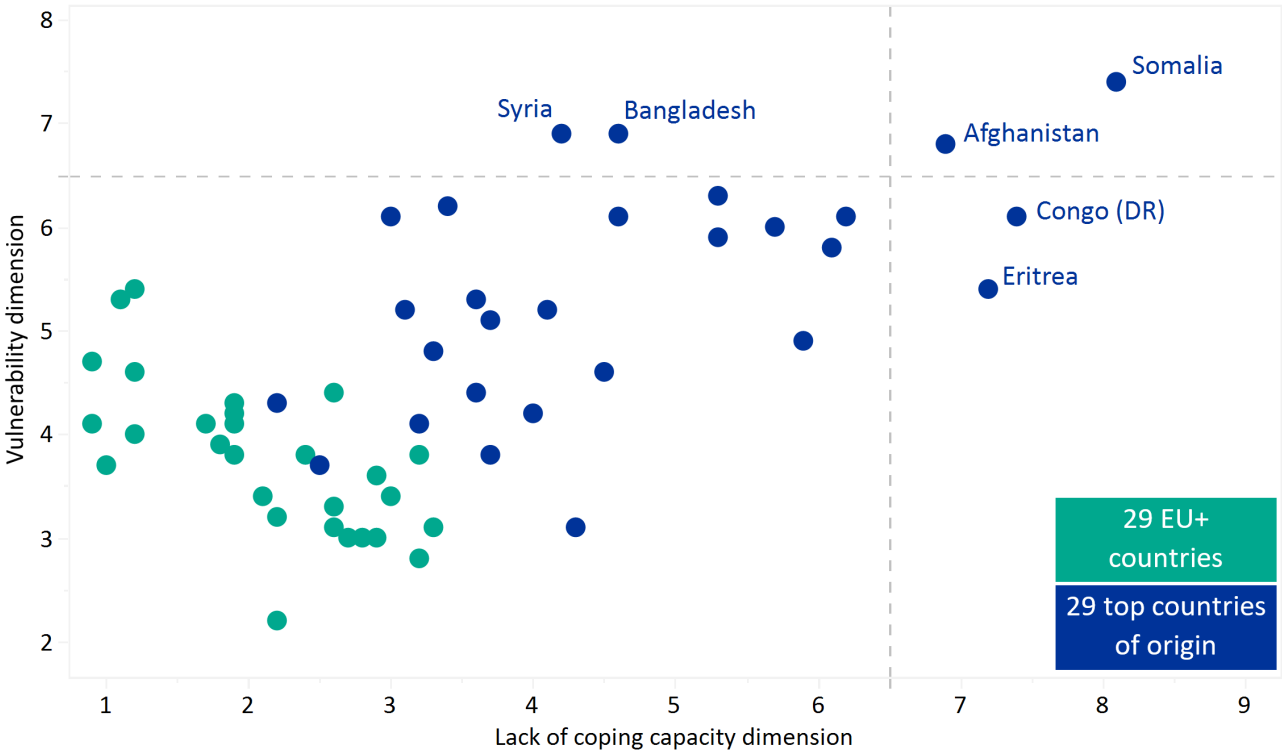

Figure 6. *Vulnerability vs lack of coping capacity, dimensions of INFORM Epidemic Global Risk Index (Data source: JRC)*
Note: *The index is based on multiple sources of data, with different reference periods depending on data availability. Each dimension ranges from zero to 10, with zero indicating the lowest and 10 the highest level.*

and refugees, spread of other communicable diseases, food security, intensity of movement patterns, and access to information.[29]

In terms of structural capacity, it is particularly important to consider the health sector. The **overall availability of beds in hospitals is generally limited** in countries of origin (except for Ukraine and Russia) and the **number of medical doctors is also insufficient** (except in Georgia and to some extent in Russia and Ukraine), again in opposition to the pattern in EU+ countries (Fig. 7). Furthermore, the last Ebola outbreak showed a disproportionately high infection rate of healthcare workers compared to the general population, and hence the current COVID-19 pandemic might put further stress on human resources in the healthcare system in low and middle income countries.[30] Concerns have been expressed about the danger of **healthcare staff becoming infected** due to the lack of sufficient protective equipment.[31] This creates a vicious circle, **exacerbating the negative consequences** of the COVID-19 epidemic **for patients with certain pre-existing non-communicable diseases**.[32] Finally, whether there would be sufficient availability of COVID-19 test kits remains an open question.

Beyond the health system, there are severe **concerns about hygienic services**. One of the key prevention measures for the current epidemic is the **washing of hands**, which **for many of the people in top countries of origin is not possible to do at home**. For example, in DR Congo 84% of the households do not have access to handwashing facilities. This percentage is also very high in Sudan (57%), Somalia (56%), Guinea (52%), Côte d'Ivoire (47%), and for many important countries of origin the coverage of handwashing facilities remains unclear.[33] **In some countries an incredibly high proportion of the population is living in slums**, further emphasising the lack of hygienic conditions and high population density. The situation is particularly grave in Sudan (92% of the urban population living in slums) and Somalia (74%) as well as in Afghanistan (63%), Bangladesh (55%), and Nigeria (50%), with missing data for many other relevant countries.[34] Finally, it is worth mentioning that **health literacy in some countries of origin might be rather low** (e.g. Afghanistan),[35] possibly related to lower income and lower education levels,[36] and this could contribute to the spread of COVID-19. Another important consideration is that in the context of strict containment measures **many people losing their jobs in urbanised cities could decide to move back to their rural areas of origin in order to have food, hence easily spreading the disease**.[37] Such an example of mass migration appeared recently in India amid the lockdown.[38] Finally, it is important to keep in mind that **older people might be disproportionately affected by the pandemic** not only because of their likely higher vulnerability to the virus and overall structural limitations in the health system but also because of reduced access to health care due to affordability and age discrimination.[39]

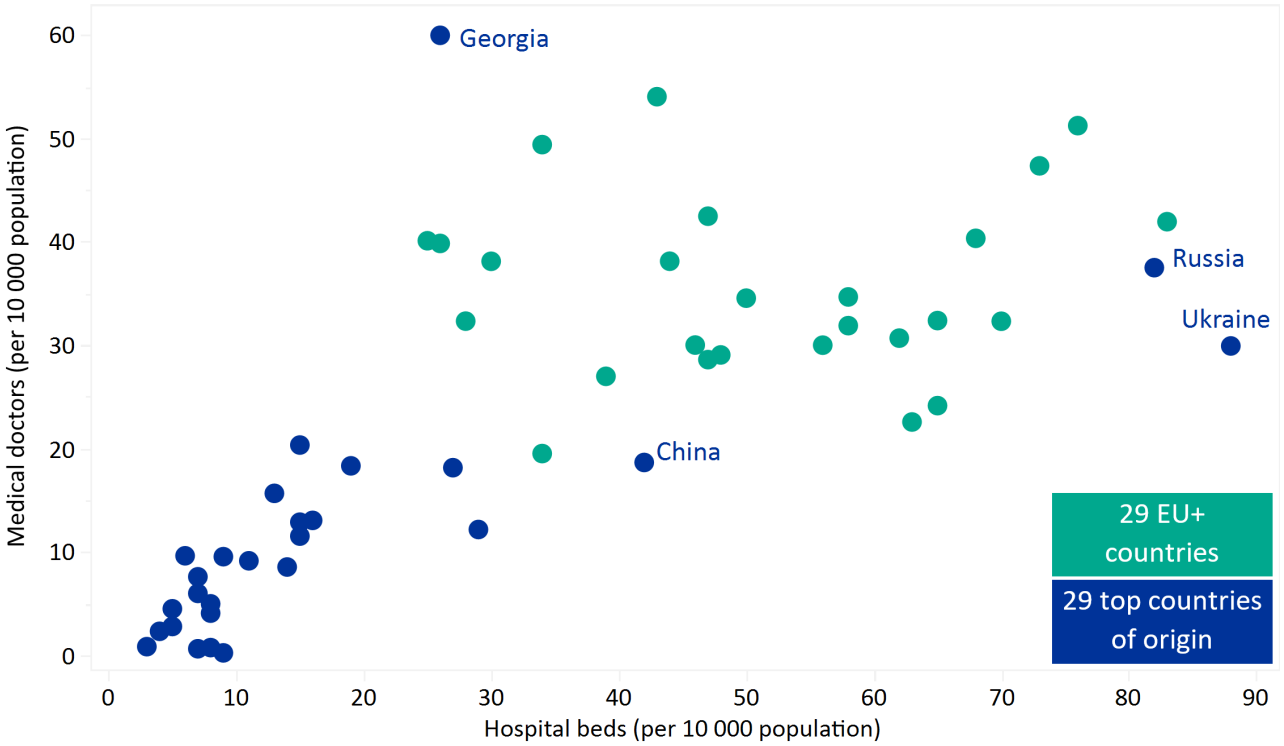

Figure 7. *Hospital beds vs medical doctors, each per 10 000 population (Data source: WHO)*

Note: *The figure displays the latest available data for each country, generally between 2013 and 2015 for hospital beds (with the exception of seven countries where the data are from the period 2004-2012) and between 2014 and 2016 for medical doctors. No data are available on both indicators for Palestine and on medical doctors for Venezuela.*

Several factors could mitigate the impact of the pandemic

On the other hand, the picture might not be entirely gloomy because **the scale and impact of the pandemic might be partially mitigated** by several factors. First, it is believed that respiratory viruses spread more in the winter season, and COVID-19 does not seem to be an exception.[40] Therefore, the southern hemisphere might be affected to a lesser extent due to **higher temperatures** but also 'climate-specific cultural differences (living more outdoors than indoors)' and 'the effect of UV light on the survival of the virus on surfaces'.[41] Although several studies have found that warm and wet weather conditions might contribute to reducing the spread of COVID-19, the level of analytical certainty is considered relatively low.[42]

Second, **wide-scale travel bans** have been assessed to contribute significantly to the reduction of (imported) cases,[43] hence contributing to the **delay in the spread** of the epidemic to key countries of origin (except for China and Iran). This delay in turn has offered some **time to take precautionary measures** and start preparing. For example, in Afghanistan, new testing facilities, hospitals, and isolation wards have been set up.[44] Although at the time of writing there was no established medication or treatment, many affected countries have been carrying out research projects on tests of different medicines and potential healing with convalescent plasma transfusion of immune patients.[45] Completion of such projects will take some time but interim data could also prove useful for adopting coping strategies, including in top countries of origin.

Third, in some countries **experience with past epidemics**, in particular Ebola, might prove to be useful as some infrastructure has already been put in place for screening and containing an epidemic.[46]

Fourth, as discussed, **older persons are more likely to suffer from severe COVID-19 cases**. Furthermore, a new not yet published study on China suggests that younger COVID-19 patients have shorter hospital stays.[47] **In most top countries of origin** of asylum seekers in the EU+, however, **the population is rather young**. The median age in the top 29 countries of origin ranges between 17 in Somalia and 41 in Ukraine (Fig. 8).[48] In fact only in five of them, it is higher than 32 years (Albania, China, Georgia, Russia and Ukraine). In contrast, the median age in EU+ countries ranges between 37 and 47.

Fifth, recent research has found that **obesity is a significant predictor of hospitalisation** and admission

to intensive care in particular.[49] **There is some variation in this regard across the top 29 countries of origin**.[50] **In 11 of them the percentage of the adult population, which is categorised as obese** (i.e. with a Body Mass Index equal to or higher than 30) **is rather low: ranging between four and 10 percent** (Fig. 8). Among the rest, the situation is similar to the EU+ countries, except for Turkey, where the level of adult obesity is higher.

Finally, although the top countries of origin were generally identified as having low coping capacity and insufficient medical resources, the **launching of innovative projects, particularly such enabled by contemporary information technologies**, might play an important role. One specific example of this is the use of 3D printers to produce face shields for health workers and other medical (protective) equipment, which has appeared in initiatives in Turkey,[51] Palestine,[52] and some third countries outside of the top 29 group, such as Tunisia[53] and North Macedonia.[54] In addition, recently a network of private universities in Africa (Honoris United Universities) developed a prototype for a new non-invasive respirator, which can be produced via 3D printing using open-source software and not requiring a patent.[55]

Importance of political and social factors for broader impact

In conclusion, although most of the main countries of origin of asylum seekers to the EU+ appear as not well prepared for the ongoing pandemic they might also possess certain characteristics mitigating the impact of the crisis. However, **the scale of the impact will depend on political and social factors and their interplay**. As a means to reduce the speed of contagion physical distancing measures were announced in many countries with COVID-19 cases, including bans on religious congregations. Quarantine is often used for suspected or confirmed cases of the disease. **The consistent implementation of such restrictive measures will be important for controlling the spread of the virus** and there are some concerns in this regard (e.g. Afghanistan).[56] Finally, the **loss of jobs and economic self-sufficiency due to containment measures might have profound impact on societies**, especially in low and medium income countries, where the state will not be able to provide additional support. In the context of lockdowns a combination of loss of income among the working poor, decrease in remittances and reduced exports in export-dependent economies could lead to a 'hunger pandemic' in many countries of origin.[57] **There is also potential of state violence and political instability** in the context of enforcing containment measures. Hence, while the direct consequence of the pandemic might be somehow manageable, the indirect impacts could be much stronger and felt by generations.

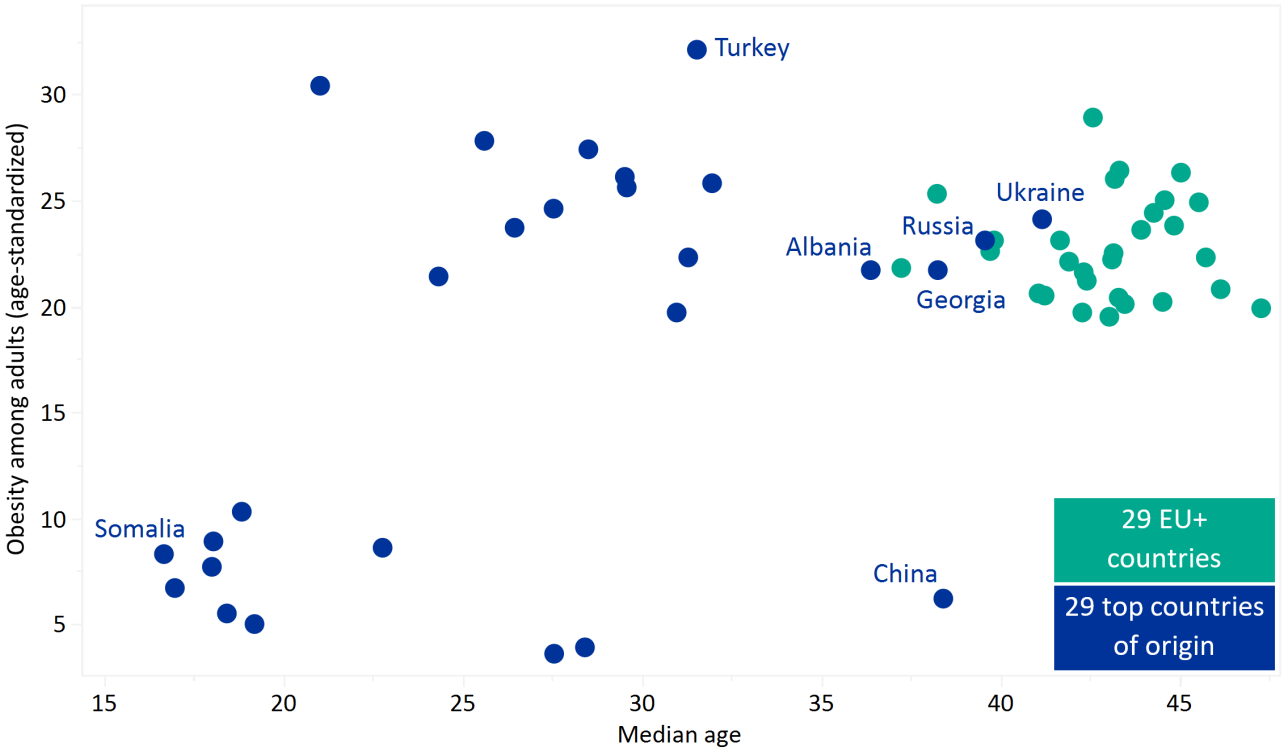

Figure 8. *Median age of the population vs percentage of obese among adults, i.e. with Body Mass Index≥30 (Data source: UN and WHO)*

Note: *Median age is based on 2020 estimates and the obesity data are for 2016. No data on obesity are available for Palestine (median age 21) and Sudan (median age 20).*

Migrants in Irregular Situations in the EU+ during the COVID-19 Pandemic

Migrants in irregular situations stuck in the EU+

As has been the case for many years, there are thought to be **significant numbers of people in the EU+ in irregular situations** including illegal stayers[58] and so-called failed asylum seekers (applicants who have been refused asylum). Although notoriously difficult to measure, estimations have ranged between 1.9 and 3.8 or even up to 4.8 million,[59] with those of working age largely expected to be engaged in casual employment, mainly in the areas of catering, tourism, construction, and of course, agriculture.[60]

The COVID-19 pandemic and the emergency measures now in place across the EU+, mean that these industries are suffering sudden and dramatic constrictions and so many people in irregular situations have lost their employment and their only source of income and homeward remittances. At the same time, they are no longer able to return to their countries of origin because of travel restrictions. This section discusses whether this large hidden population may in desperation **choose to apply for international protection as a way to regularise its stay and gain access to benefits such as healthcare.**

Access to the labour market

Many blue-collar jobs, i.e. those typified by people in an irregular position, have been completely eliminated. Employers are being advised to protect workers' health, rights and wages during the pandemic and even in some cases to sponsor returns to countries of origin.[61] Anyone engaged in illegal employment can face the issuance of return decisions or the loss of residence rights.[62] Many EU+ countries have taken measures to ensure the legal status of third country nationals stuck in the EU+ by extending residence permits so as to cover the expected duration of the COVID-19 epidemic.[63] However, these and other measures implemented by Member States to cushion the effects of the coronavirus on workers, are unlikely to be available for the undocumented population.

Shortage of non-EU seasonal workers

Following widespread restrictions on travel and some on applications for short-term work permits,[64] currently there is a massive shortage of non-EU seasonal workers.[65] Specifically, the media has been full of stories about the shortage of non-EU agricultural workers[66] who usually arrive each spring under the Seasonal Workers Directive[67] and then follow the harvest from south to north. It has been suggested that people in an irregular position and/or asylum seekers could be mobilised to somehow replace this labour force.[68] However, mobility restrictions inside the EU+ and even within each EU+ country, now limit the extent to which casual workers can move towards and between places of harvest. In response many countries are health screening and then importing workers from Eastern Europe under tailor-made schemes to address this important labour shortage.[69] Hence, employment opportunities for people in an irregular position may remain out of reach.

Access to healthcare

Free and easy access to healthcare to all is even more vital during the pandemic in order to protect individual and public health. Some countries such as Portugal and Greece have taken additional measures to ensure free public healthcare to irregular migrants.[70] However, overall irregular migrants might have less access to health care and even when this access is in principle available, it is unclear whether they would be prone to make use of it, out of fear of detection of irregular status and deportation. This might may have a negative impact on the further spreading of COVID-19.

Applying for asylum as an option?

Even though applying for asylum could be the last option for many illegal stayers, many EU+ countries have suspended, limited or modified their access to asylum procedures for specific or unlimited time periods.[71] However, **practical guidelines and recommendations have been issued in order to ensure continuity of the procedures by the Member States and respect of international refugee law and standards, while health protection measures are taken fully into account.**[72] Examples of best practices include online lodging of applications or remote personal interviews together with effective management of the backlog. In fact, at the end of 2019 more than a million cases were awaiting a decision at all instances in the EU+. Successful backlog management can facilitate and accelerate the provision of international forms of protections for people stuck in the asylum system. **It is not clear whether, following normalisation of access to asylum procedures, an influx of applications of migrants in irregular situations currently in the EU+ will emerge.**

Endnotes

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Abbreviations

DARS	EASO Data Analysis and Research Sector
ECDC	European Centre for Disease Prevention and Control
EPS	Early-Warning and Preparedness System
ISIS	Islamic State
JRC	Joint Research Centre
RSF	Resettlement Support Facility
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus-2
SAU	EASO Situational Awareness Unit
UAM	Unaccompanied Minor
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

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