



Refugee Placement and Medical Concerns Amid a Covid-19 Pandemic and an Economic Crisis

By Nayla Rush

In March 20, I wrote about the ongoing resettlement of refugees in the United States despite the Covid-19 outbreak.¹ From January 29 — the day the president’s Coronavirus Task Force was formed² — through June 17, 3,329 refugees of numerous nationalities (including the Democratic Republic of Congo, Burma, Afghanistan, Iraq, Sudan, Pakistan, Syria, and Iran) were resettled in California, Texas, New York, Michigan, and other states.³

Even after U.S. refugee admissions were officially suspended on March 19 following UN agencies’ announcement of the temporary suspension of the refugee resettlement program in view of the Covid-19 global health crisis, refugees were still being admitted into the United States, albeit in smaller numbers.⁴ On June 18, the International Organization for Migration (IOM) and UNHCR (United Nations High Commissioner for Refugees, the world body’s refugee agency) announced “the resumption of resettlement departures for refugees.”⁵

During this “suspension” period, from March 19 through June 17, 285 refugees were placed in American communities. Of those 285, around 40 of “Australia’s unwanted refugees” arrived in May from the small island nation of Nauru and Manus Island (part of the nation of Papua New Guinea) “despite coronavirus travel bans.”⁶ Those men were flown to Los Angeles to then be placed in 18 cities across the United States.⁷ According to Australian news, “Many of the refugees have underlying health conditions after years of detention and medical neglect on Manus Island and Nauru.”⁸

The fact that refugees from these islands are being admitted into American communities comes as no surprise; President Trump did vow to honor the deal made between the outgoing Obama administration and Malcolm Turnbull’s government to resettle Australia’s unwanted refugees in the United States. What is puzzling, however, is the timing: Why admit them (and other refugees) now, amid a health and economic crisis and knowing that refugees are especially susceptible to Covid-19? Most refugees are, in fact, forced to live in close quarters, in densely populated areas with weakened health systems.⁹ Simply put, “you can’t practice social distancing if you’re a refugee.”¹⁰

Contagious diseases are key in the determination of inadmissibility to the United States. The Immigration and Nationality Act (INA) requires all refugees applying for U.S. immigration to receive a medical screening to determine inadmissibility on health grounds.¹¹ Specific health-related conditions that pose a threat to public health (called Class A conditions) are grounds for inadmissibility when identified during the medical examination overseas. One class A condition is pandemic flu. New diseases can be added to the list by executive order of the president of the United States. President Trump has yet to update that list with the Covid-19 virus.

Quarantine regulations apply to everyone trying to enter the United States — whether legally or illegally — including refugees. Federal isolation and quarantine are authorized for several communicable diseases, including “severe acute respiratory syndromes; and *influenza caused by novel or re-emerging influenza viruses that are causing, or have the potential to cause, a pandemic.*”¹² (Emphasis added.)

There is no indication that refugees are being tested for the Covid-19 virus overseas or placed under quarantine upon arrival. We know, for instance, that no special pre-departure Covid-19 precautions or testing seem to have

Nayla Rush is a senior researcher at the Center for Immigration Studies.

been put in place for those refugees coming from Manus Island and Nauru. When asked about this issue, the Australian Home Affairs spokesperson remained vague, referring to general U.S. mandated pre-departure preparations. Father Giorgio Licini, the general secretary of the Catholic Bishops Conference of Papua New Guinea & Solomon Islands, said that “the men did not undergo coronavirus isolation in preparation for their departure.”¹³ We can assume this to be true of all refugees admitted during this crisis.

But even if they were, why welcome thousands of refugees in the midst of a health and economic crisis? Especially when we know that, on top of being vulnerable to the Covid-19 virus, refugees have specific health needs since they usually come from situations of poor hygienic conditions and health systems with a wide range of unmet health needs (including nutritional deficiencies, hepatitis B infection, tuberculosis infection, parasitosis, etc.) and mental health concerns such as alcohol and drug abuse.¹⁴ These health concerns can strain U.S. health and social systems, which are already overwhelmed because of the Covid-19 pandemic.

Resettlement agency representatives determine where refugees are resettled in the United States (usually, and for practical reasons, in states that host their local affiliates). They decide in which state to place a refugee, officially, in an attempt “to match the particular needs of each incoming refugee with the specific resources available in U.S. communities.”¹⁵ But how can states like New York, Michigan, and others (who had to deal with stringent stay-at-home orders, large numbers of Covid-19 cases and deaths, rising unemployment, and limited medical capacity and resources such as hospital beds, ventilators, testing etc.) embrace the arrival of refugees into their communities? Were state and local health officials notified of the placement of refugees? Were state residents — who are being asked to continue making enormous sacrifices — informed of such arrivals and risks?

Moreover, how can refugees achieve “self-sufficiency” in the United States when states are just now coming out of lock-down, businesses are going bankrupt, and the employment situation for both immigrants (legal and illegal) and the native-born is disastrous following April and May employment figures?¹⁶ Are they just to rely on parts of the relief funds and resources of the CARES Act that are made available to refugees?

Even the co-founder of Ads-Up, a network of Australians in the United States that supports the resettlement of “Australia’s unwanted refugees” here, admitted to the bad timing: “It’s an absolutely brutal time to be arriving in America. ... These guys are landing with barely more than the clothes on their backs and they’ll be looking for work alongside millions of recently unemployed Americans. Since Covid-19 hit, more than 100 refugees reached out to us for help, they’ve lost jobs and are struggling to pay rent and for basic supplies.”¹⁷

This report will cover the following points:

- Refugee arrivals by nationality and destination since the creation of the president’s Coronavirus Taskforce;
- Timeline of announcements by world health authorities and the U.S. government in response to Covid-19;
- Placement of refugees in American communities: who gets to decide in which states refugees are resettled;
- State and local say in the resettlement process, especially when state residents are asked to make important sacrifices amid a health and economic crisis;
- Medical screening of refugees before and after resettlement: inadmissibility to the United States on health-related grounds, overseas medical examination of refugees to determine admissibility, domestic medical examination for newly arriving refugees in the United States, medical examination for adjustment of status;
- Refugees’ specific health needs;
- Access to healthcare and benefits in the United States; and
- Relief funds and resources available to refugees following the CARES Act.

Refugees Keep Arriving Despite Covid-19 Pandemic and Suspension of the U.S. Refugee Resettlement Program

From January 29, 2020, (the day the president's Coronavirus Task Force to lead the U.S. government response to Covid-19 was formed) through June 17, the United States resettled 3,329 refugees (including 37 Iranians, a country particularly affected by Covid-19 and included in the travel ban). It is true that refugees being resettled are usually processed in their countries of first asylum and not in their home countries, but refugees are known to seek refuge in countries neighboring their own.

The top-10 countries of origin for the refugees resettled from January 29, 2020, to June 17, 2020, are as follows (all figures are gathered from the U.S. Refugee Processing Center portal unless noted otherwise): Democratic Republic of Congo, 1,048; Ukraine, 580; Burma, 304; Afghanistan, 227; Iraq, 160; Russia, 138; Pakistan, 127; Sudan, 108; Syria, 82; and Colombia, 78.¹⁸

The top-10 states where refugees were resettled from January 29, 2020, to June 17, 2020, are as follows: California, 367; Washington, 274; Texas, 231; New York, 213; Kentucky, 162; Ohio, 152; Illinois, 130; Michigan, 130; Pennsylvania, 127; and North Carolina, 112.

In view of the exceptional health hazards, knowing who was resettled where is indeed crucial.¹⁹

The refugee resettlement program was temporarily suspended by UNHCR and IOM because of the Covid-19 global health crisis, but refugees kept entering the United States, albeit in smaller numbers.²⁰ IOM and UNHCR announced the resumption of the resettlement program on June 18.²¹

Even after the official suspension on March 19 of the U.S. refugee resettlement program, refugees kept entering the United States. From March 19 through June 17, the United States resettled 285 refugees. IOM and UNHCR did explain²² on March 17 that the suspension was to “begin to take effect within the next few days as the two agencies attempt to bring those refugees who have already cleared all formalities to their intended destinations.” But resettlement to the United States has continued for not days but weeks after this suspension.

From March 19, 2020 through June 17, 2020, the United States resettled 285 refugees from 19 nationalities in the following cities:

- Afghanistan: 13 (one in Phoenix, Ariz.; two in San Diego, Calif.; six in Turlock, Calif.; one in Albany, N.Y.; one in Buffalo, N.Y.; one in Bensalem, Pa.; one in Ft. Worth, Texas);
- Bangladesh: one (in South Boston, Mass.);
- Burma: 55 (four in Glendale, Ariz.; one in Greeley, Colo.; eight in Atlanta, Ga.; two in Chicago, Ill.; two in Fort Wayne, Ind.; five in Marshalltown, Iowa; five in South Boston, Mass.; three in Grand Rapids, Mich.; four in Richfield, Minn.; two in Saint Paul, Minn.; one in Buffalo, N.Y.; one in Syracuse, N.Y.; one in Charlotte, N.C.; one in Portland, Ore.; one in Philadelphia, Pa; five in Dallas, Texas; one in Houston, Texas; five in Salt Lake City, Utah; three in Milwaukee, Wisc.);
- Democratic Republic of Congo: 19 (three in New Haven, Conn.; two in Lexington, Ky.; one in Kansas City, Mo.; five in Missoula, Mont.; three in Harrisburg, Pa.; two in Villanova, Pa.; three in Columbia, S.C.);
- Djibouti: one (in Louisville, Ky.);
- El Salvador: 30 (one in Los Angeles, Calif.; three in Reseda, Calif.; five in Turlock, Calif.; one in Doral, Fla.; four in Baltimore, Md.; five in Riverdale, Md.; one in Silver Spring, Md.; one in Chelsea, Mass.; four in Hamilton, N.J.; four in Cleveland, Ohio; one in Houston, Texas);
- Ethiopia: four (in Charlotte, N.C.);

- Guatemala: three (two in Mascoutah, Ill.; one in Charlotte, N.C.);
- Honduras: 12 (one in Doral, Fla.; one in Lawrenceville, Ga.; six in Framingham, Mass.; four in Harrisonburg, Va.);
- Iran: 18 (one in Sacramento, Calif., two in Turlock, Calif.; one in Atlanta, Ga.; three in Chicago, Ill.; one in Springfield, Mass.; one Austin, Texas; three in Dallas, Texas; one in Fort Worth, Texas; four in Houston, Texas; one in San Antonio, Texas);
- Iraq: six (one in Glendale, Ariz.; one in Weymouth, Mass.; one in Sterling Heights, Mich.; one in Minneapolis, Minn.; one in Durham, N.C.; one in Fort Worth, Texas);
- Lebanon: two (in Chicago, Ill.);
- Pakistan: 64 (five in Phoenix, Ariz.; one in Tucson, Ariz.; one in Atlanta, Ga.; eight in South Bend, Ind.; one in Bowling Green, Ky.; four in Baltimore, Md.; four in Hyattsville, Md.; four in Silver Spring, Md.; five in Ann Arbor, Mich.; one in Las Vegas, Nev.; one in Albany, N.Y.; two in Buffalo, N.Y.; six in High Point, N.C.; one in Raleigh, N.C.; 14 in Philadelphia, Pa.; four in Fort Worth, Texas; one in Houston, Texas; one in Newport News, Va.);
- Rwanda: three (in Wyoming, Michigan);
- Somalia: 10 (one in Glendale, Ariz.; one in Carol Stream, Ill.; one in South Boston, Mass.; one in Minneapolis, Minn.; one in Saint Paul, Minn.; one in Kansas City, Mo.; three in Buffalo, N.Y.; one in Portland, Ore.);
- Sri Lanka: three (one in El Cajon, Calif.; one in Buffalo, N.Y.; one in Columbia, S.C.);
- Sudan: 17 (one in Phoenix, Ariz.; one in Clearwater, Fla.; two in Baltimore, Md.; three in Kansas City, Mo.; one in Buffalo, N.Y.; four in Greensboro, N.C.; one in Portland, Ore.; one in Sioux Falls, S.D.; one in Chattanooga, Tenn.; one in Nashville, Tenn.; one in Milwaukee, Wisc.);
- Syria: 16 (five in Boise Idaho; two in Highland Park, N.J.; five in Syracuse, N.Y.; four in Greensboro, N.C.); and
- Vietnam: eight (in Salt lake City, Utah).

While the flow was almost halted during the last 10 days of March in accordance with the resettlement program's suspension — from March 19 to the end of March, only three refugees were resettled: on March 19, two Syrians were admitted and placed in Highland Park, N.J., and on March 24 one Salvadoran was placed in Los Angeles, Calif. — the pace picked up in April, May, and early June. From April 1 through June 17, 282 refugees were resettled in the United States.

Timeline of Actions to Combat the Coronavirus Spread and Admission of Refugees in the United States

This chronological layout of announcements and measures unfolding with the Covid-19 development is based on updates released by the World Health Organization (WHO)²³ and the Trump administration.²⁴

- **January 29:** The White House announced the formation of the Coronavirus Task Force to help monitor and contain the spread of the virus and provide updates to the president.
- **January 31:** The Trump administration declared Covid-19 a public health emergency; announced Chinese travel restrictions; and suspended entry into the United States for foreign nationals who pose a risk of transmitting the Covid-19.
- **February 29:** The Trump administration announced a level 4 travel advisory to areas of Italy and South Korea; barred all travel to Iran; and barred the entry of foreign citizens who visited Iran in the last 14 days.

- **March 11:** The World Health Organization (WHO) characterized the Covid-19 outbreak as a pandemic.
- **March 11:** President Trump announced travel restrictions on foreigners who had visited Europe in the last 14 days.
- **March 13:** President Trump declared a national emergency in order to access \$42 billion in existing funds to combat Covid-19.
- **March 14:** The Trump administration extended the European travel ban to include the UK and Ireland.
- **March 16:** President Trump announced “15 days to slow the spread” Covid-19 guidance. White House: “Stay Home For 15 Days To Slow The Spread Of Coronavirus.”
- **March 18:** President Trump announced the temporary closure of the U.S.-Canada border to non-essential traffic.
- **March 19:** The State Department issued a global level 4 health advisory, telling Americans to avoid all international travel due to Covid-19.
- **March 20:** The U.S. and Mexico agree to mutually restrict nonessential cross-border traffic.
- **March 27:** President Trump signed the Coronavirus Aid, Relief, and Economic Security (CARES) Act into law.
- **March 31:** President Trump officially issued “30 Days to Slow the Spread” guidance to mitigate the outbreak of Covid-19.
- **April 2:** HUD announced it was immediately making \$3 billion of CARES Act funding available to help America’s low-income families and most vulnerable citizens across the nation.
- **April 3:** President Trump announced that uninsured Americans will have their Covid-19 treatment covered, using funding from the CARES Act.
- **April 22:** President Trump took action to temporarily pause immigration for 60 days to protect American workers as we confront Covid-19.

Yet, despite all these measures, and many others, refugees are still being resettled into the United States.

Placement of Refugees, Who Gets to Decide?

As we witness refugees being placed into American communities in the midst of a health and economic crisis (and despite the suspension of the resettlement program), the question remains: Who gets to decide in which states refugees are placed? The answer is, resettlement agency representatives do.

Nine religious or community-based organizations, called resettlement agencies, have contracts with the Department of State to resettle refugees inside the United States.²⁵ These agencies maintain nationwide networks of local affiliates to provide services to refugees, including reception on arrival in the United States; placement; support with housing, furnishings, food, and clothing; community orientation; and help accessing health services and enrollment in various benefits and welfare programs; and referral to social service providers (including healthcare, employment, etc.)

As I underlined a couple of years ago, these agencies are mostly funded by the U.S. government, i.e. by American taxpayers.²⁶ Their leaders have been very critical of the Trump’s administration refugee policy that has lowered refugee admissions ceilings; but for these organizations, lower resettlement admissions also means less federal funding.

The Reception and Placement (R&P) of refugees is explained in the “Report to Congress on Proposed Refugee Admissions for FY 2020”:

*Unlike asylees, who arrive in the United States on their own, refugees selected for resettlement through USRAP [the United States Refugee Admissions Program] are eligible for R&P assistance. **Each refugee approved for admission to the United States is sponsored by a resettlement agency.** Several non-profit resettlement agencies participate in the R&P Program under a cooperative agreement with the Department of State. [Emphasis added.]²⁷*

Resettlement agency representatives determine where refugees are resettled in the United States:

*Representatives from the resettlement agencies meet frequently to review the biographic information and other case records sent by the RSC [overseas Resettlement Support Centers], seeking to match the particular needs of each incoming refugee with the specific resources available in U.S. communities. Through this process, they determine which resettlement agency will sponsor and **where each refugee will be initially resettled in the United States.** [Emphasis added.]²⁸*

Under the “Reception and Placement” program, “[I]nitial resettlement services are provided to newly arriving refugees by a local affiliate of one of the participating resettlement agencies. Thus, as a general matter, *refugees are not resettled in states that do not have any local affiliates* or in parts of states that do not have local affiliates within an allowable distance.”²⁹ (Emphasis added.)

State and Local Say in the Resettlement Process

Since President Trump gave state and local governments the ability to opt out of the refugee resettlement program altogether³⁰ (which was later blocked by a Maryland judge³¹), 42 governors (including Republicans) expressed their commitment to resettling refugees in their communities. Only Governor Greg Abbott of Texas announced that his state would not be participating in the refugee resettlement program in FY 2020.³² But refugees kept being placed in Texas (among other states). Since the creation of the president’s task force following the Covid-19 outbreak, 231 refugees were resettled in Texas.

The nationalities of the 231 refugees and the cities they were resettled in Texas from January 29 to June 17 are as follows:

- Austin: 19 (Afghanistan, one; Burma, seven; Democratic Republic of Congo, two; Eritrea two; Iran, one, Sri Lanka, six);
- Abilene: five (from Democratic Republic of Congo);
- Amarillo: 31 (Burma, four; Democratic Republic of Congo, 27);
- Clarendon: one (from Iraq);
- Dallas: 57 (Burma, 14; Democratic Republic of Congo, 23; Iran, four; Iraq, four; Senegal, one; Sudan, two; Syria, nine);
- Fort Worth: 28 (Afghanistan, five; Democratic Republic of Congo, seven; Iran, one; Iraq, five; Pakistan, eight; Sri Lanka, two);
- Houston: 60 (Afghanistan 10; Burma, two; Democratic Republic of Congo, 12; El Salvador, seven; Eritrea, five; Iran, nine; Iraq, four; Pakistan, five; Sudan, six);
- Midland: one (from Burma);
- San Antonio: 25 (Democratic Republic of Congo, 12; Eritrea, one; Iran, one; Iraq, 11); and
- Sugarland: four (from Ethiopia).

Was the governor of Texas informed of such arrivals and potential risks? Were these refugees tested for Covid-19 before or after admission? Were they quarantined or have medical follow-ups? Were the people of Texas consulted, or even informed?

What about residents of the state of Michigan who were asked to make enormous sacrifices under one of the most stringent stay-at-home orders in the country? A state that counted the third-highest number in the country of Covid-19 cases and deaths and had, by mid-April, over a quarter of its workforce file for unemployment benefits. And yet refugees were being resettled in Grand Rapids, Detroit, Lansing, and other cities in Michigan when, by the Michigan's chief medical executive's own admission, hospitals are overwhelmed: "We know that our hospitals, especially in Southeast Michigan, are at capacity. They're running out of ventilators. They're running out of [personal protection equipment]. They're taking care of patients in hallways."³³

From January 29 through June 17, 2020, 130 refugees were resettled in the state of Michigan.

The nationalities of those 130 refugees and the cities they were placed are as follows:

- Ann Arbor: 11 (Afghanistan, four; Democratic Republic of Congo, two; Pakistan, five);
- Dearborn: four (from Afghanistan);
- Detroit: nine (Iraq, four; Syria, five);
- Grand Rapids: 62 (Afghanistan, 13; Burma, 10; Democratic Republic of Congo, 39);
- Kalamazoo: one (from Afghanistan);
- Lansing: 25 (Afghanistan, five; Burma, seven; Democratic Republic of Congo, 13);
- Shelby Township: one (from Iraq);
- Sterling Heights: nine (from Iraq);
- Troy: four (from Iraq);
- Warren: one (from Iraq); and
- Wyoming: three (from Rwanda).

What about other states, such as New York (213 refugee admissions), Massachusetts (104), Illinois (130), or California (367)? When we know that the United States has more than 2.28 million confirmed Covid-19 cases and 121,070 related deaths.³⁴ At least 31,138 of those deaths occurred in New York, 7,770 in Massachusetts, 6,537 in Illinois, 6,061 in Michigan, and 5,362 in California.

Medical Screening of Refugees Before and After Resettlement

Refugees approved for resettlement in the United States have to undergo medical screening overseas to be cleared for admission into the United States. The screening is overseen by the U.S. Centers for Disease Control and Prevention (CDC) and implemented by the IOM or local physicians designated by U.S. embassies or consulates. The costs of the medical screening are borne by the U.S. government (and usually, so are those for medical treatment necessary to make an already approved refugee ready for travel). This medical examination is intended to exclude refugees with any contagious disease that could pose a public health threat from entering the United States and identify conditions that warrant medical follow-ups for those about to be welcomed in the United States. Upon arrival, refugees are also required to complete a domestic medical screening. Another medical examination is performed one year later when applying for an adjustment of immigration status to a lawful permanent U.S. residency (a green card).

Inadmissibility to the United States on Health-Related Grounds

Contagious diseases are key in the determination of inadmissibility to the United States. The Immigration and Nationality Act (INA) requires all refugees applying for U.S. immigration to receive a medical screening to determine inadmissibility on health grounds.³⁵ The two agencies in charge of this process are the Department of Health and Human Services (HHS) and the CDC, a sub-agency of HHS. Under the authority of INA and the Public Health Service Act,³⁶ the secretary of Health and Human Services promulgates regulations “outlining the requirements for the medical examination of aliens seeking admission into the United States [including refugees] and for those applying for permanent resident status.”³⁷ CDC’s Division of Global Migration and Quarantine (DGMQ) provides the Department of State and U.S. Citizenship and Immigration Services (USCIS) with medical screening guidelines for all examining physicians. This medical examination is aimed at identifying applicants with inadmissible health-related conditions.

The CDC’s DGMQ has the statutory responsibility “to make and enforce regulations necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the United States.”³⁸ (Emphasis added.) Quarantine regulations of the Public Health Service Act apply to everyone trying to enter the United States — whether legally or illegally — including refugees.³⁹ By executive order of the president, as amended April 11, 2005, and updated July 31, 2014, “federal isolation and quarantine are authorized for the following communicable diseases: cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; and viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named); severe acute respiratory syndromes; and *influenza caused by novel or re-emerging influenza viruses that are causing, or have the potential to cause, a pandemic.*”⁴⁰ (Emphasis added.)

The Federal Refugee Resettlement Program, created under the Refugee Act of 1980 (Section 412 of the Immigration and Nationality Act), was set to assist refugees in “achieving economic self-sufficiency as soon as possible after arrival in the United States.”⁴¹ (Emphasis added.)

The CDC’s DGMQ responsibilities under this act include:

- *Providing for the identification of refugees who have been determined to have medical conditions affecting the public health and requiring treatment;*
- *Assuring that State and/or local health officials at the resettlement destination of each refugee are promptly notified of the refugee’s arrival and provided with all applicable medical records;*
- *Providing for such monitoring of refugees identified with medical conditions affecting public health and requiring treatment, ensuring that they receive appropriate and timely treatment; and developing and implementing methods for monitoring and assessing the quality of medical screening and related health services provided to refugees awaiting resettlement to the United States. [Emphasis added.]*⁴²

First, why allow refugees in during a pandemic when the CDC has the obligation “to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the United States.” Second, since they were admitted, were they quarantined upon entry, did they receive any medical follow-up? Third, how can refugees achieve self-sufficiency in the United States amid an economic crisis that is not only impacting immigrants (legal and illegal), but the native-born as well? More importantly, were state and local health officials notified of the arrival of refugees?

Overseas Medical Examination of Refugees to Determine Admissibility

Medical examinations performed by “panel physicians” overseas are required for all immigrants entering the United States, including refugees.⁴³ These physicians are “medically trained, licensed, and experienced medical doctors practicing overseas who are appointed by the local US embassy or consulate.” Over 760 panel physicians are trusted to perform overseas pre-departure medical examinations “in accordance with requirements, referred to as technical instructions, provided by the

Centers for Disease Control and Prevention’s Division of Global Migration and Quarantine, Quality Assessment Program (QAP).”

Medical screening involves review of medical history and available records, and a physical examination that identifies physical or mental conditions that render applicants inadmissible for a visa (Class A condition), or other conditions that, although they do not render an alien inadmissible to the United States, are significant enough require extensive medical treatment (Class B conditions). Medical examinations are usually valid between three to six months and must be valid at the time of departure for the United States.

Class A and Class B Conditions

The “Medical Examination of Aliens” (Final Rule 42 CFR, Part 34- Revised in January 2016) regulation lists specific health-related conditions that are grounds for inadmissibility when identified during the medical examination (Class A condition).⁴⁴ Other significant health problems (Class B conditions) must be brought to the attention of consular authorities, but are not grounds for inadmissibility.

Class A Conditions. Refugees who, following health screening, are found with Class A conditions (i.e. with diseases that could pose a threat to public health) will not be allowed to resettle in the United States. Class A conditions include:

- Active tuberculosis;
- Untreated syphilis;
- Untreated gonorrhea;
- Hansen’s disease, which is also known as leprosy;
- Pandemic flu;
- Severe acute respiratory syndrome (SARS);
- Viral hemorrhagic fevers such as Marburg and Ebola;
- Cholera;
- Diphtheria;
- Plague;
- Smallpox; and
- Yellow fever.⁴⁵

The Class A list is open to change:

*New diseases may be added to the list in the event of a public health emergency, and the President of the United States can issue an Executive Order to make updates to the list of Class A conditions. The World Health Organization may also identify a global public health emergency that requires CDC to update or change the list of Class A conditions. [Emphasis added.]*⁴⁶

Other Class A conditions include “Physical or mental disorders with current associated harmful behavior or history of associated harmful behavior that is likely to recur; and Substance-related disorders.”

The Human Immunodeficiency Virus (HIV) was listed as a Condition A (i.e., as one of the inadmissible communicable diseases) until 2010. In 2009, HHS introduced a rule to remove it from that list. This rule was enacted on January 4, 2010.

As noted in the CDC Yellowbook section on “Health Information for International Travel”, an “immigrant or refugee who has an inadmissible class A condition may still be issued a visa after the illness has been treated or after a waiver of the visa ineligibility has been approved by the Department of Homeland Security United States Citizenship and Immigration Services.”⁴⁷

Class B Conditions. Class B conditions do not prevent a refugee from being admitted into the United States.⁴⁸ However, these health-related conditions are “significant enough to interfere with a person’s ability to care for themselves or their ability to attend work or school” and usually require extensive medical treatment or follow-up, including institutionalization.

Class B conditions include:

- Inactive or noninfectious tuberculosis;
- Treated syphilis and other sexually transmitted diseases;
- Hansen’s disease (leprosy), which has been treated or meets certain criteria;
- Certain substance-related disorders that are in remission; and
- Certain physical or mental disorders that don’t have associated harmful behaviors or behaviors that are likely to recur.

It is argued that refugees “exhibit an increased incidence of measles and tuberculosis compared with the U.S. population.”⁴⁹ Nevertheless, refugees are not screened for measles or latent tuberculosis.

Measles is a severely infectious vaccine-preventable disease. Refugees are allowed to enter the United States unvaccinated for measles and are given a grace period to receive the required vaccination. They are the only group of immigrants with such an exemption.⁵⁰

Refugees are not screened for latent tuberculosis infection (LTBI) prior to resettlement in the United States even though, according to CDC’s domestic tuberculosis guidelines, “[s]tudies have indicated that reactivation of latent tuberculosis infection (LTBI), rather than recent transmission, is the primary driver of TB disease in the United States, accounting for >80% of all TB cases.”⁵¹

Further notes from these guidelines:

*While TB is decreasing overall in the United States, there has been an increase in the percentage of TB cases in foreign-born individuals. For example, in 2017, 70% of TB cases were diagnosed in foreign-born persons in the United States, as opposed to 30% in 1993. **In cities that are home to many newly arriving immigrants and refugees, rates of TB can be well above the national average.** Additionally, the prevalence of drug-resistant TB or extrapulmonary TB cases, which are more challenging to diagnosis and manage, is **higher among foreign-born persons.** Because of the continued risk of reactivation and the time-limited nature of a single medical exam, **healthcare providers who serve refugees (including those treating refugees after the initial domestic medical screening) should maintain a high index of suspicion for TB disease, regardless of the results of their medical examination performed overseas.** [Emphasis added.]*

Studies also showed that “[f]oreign nationals develop TB infection at rates of infection seen in their *countries of origin* owing to reactivation of LTBI. Moreover, *refugees experience higher rates of TB disease after U.S. resettlement* than those seen among other foreign-born populations in the U.S.”⁵² (Emphasis added.)

Domestic Medical Examination for Newly Arriving Refugees in the United States

Refugees are required to undergo a health assessment within 30–90 days of resettlement in the United States. The CDC Domestic Checklist does not represent mandatory screening requirements; it is only used as a guideline for civil surgeons who are tasked with performing the medical evaluations of refugees.⁵³ The checklist is for asymptomatic refugees only; others, with specific medical complaints and issues, should undergo customized testing in accordance with their symptoms.

The Domestic Checklist includes the following examinations:

- History and physical examination, including nutrition and growth;
- Immunizations;
- Mental health screening;
- General laboratory testing, such as blood count, urinalysis, etc.; and
- Disease-specific laboratory testing for tuberculosis, exposure to lead, malaria, intestinal and tissue invasive parasites, and sexually transmitted diseases such as syphilis, Chlamydia, and gonorrhea. As of January 4, 2010, refugees are no longer tested for HIV infection prior to arrival in the United States.

This health assessment is ideally followed with referrals to specialty and mental health care, as well as linking refugees to a medical home. Refugees who are eligible for Medicaid are subsequently enrolled. For those who are not, the Office of Refugee Resettlement (ORR) provides Refugee Medical Assistance.⁵⁴ These benefits, similar to Medicaid, last up to eight months.

Medical Examination for Adjustment of Status

Resettled refugees are required by U.S. law to apply for a green card (permanent residence) one year after arrival. A medical examination performed by a U.S. physician authorized as a civil surgeon is required for this adjustment of status. The civil surgeon must complete parts of the Report of Medical Examination and Vaccination Record (Form I-693).⁵⁵

A complete medical examination record is generally not needed for most refugees since they already received a medical examination prior to admission unless the original examination revealed a Class A condition. Refugees do, however, need to establish compliance with U.S. vaccination requirements when they adjust their status. The refugee must submit the vaccination record portion completed by a designated civil surgeon.

The medical examination for adjustment of status identifies the following health conditions as grounds for inadmissibility:

- Communicable diseases (Class A conditions);
- Physical or mental disorders with associated harmful behavior; and
- Drug abuse or drug addiction.

Refugees' Specific Health Needs

Refugees resettled in the United States have particular health needs since “refugees often have high health morbidity and come from situations of poor hygienic conditions,” according to Immigrant Medicine contributing authors.⁵⁶ Wars and civil unrest can only worsen the existent poor health systems of developing countries from which most refugees come.

Moreover, as these authors emphasize, refugees of many backgrounds now enter the United States “with a wide array of unmet health needs, including nutritional deficiencies, anemia, hepatitis B infection, tuberculosis infection, parasitosis, and other acute and chronic physical illnesses.” Added to these physical health concerns are mental and emotional ones: “Mental health concerns (including alcohol and drug abuse) increasingly are garnering greater attention among the refugee resettlement and health communities.”

These health concerns can limit refugees' ability to integrate into U.S. society and cause strain on U.S. health and social systems.

According to tropical infectious disease experts:

*It has long been recognized that immigrants and refugees may carry significant disease burdens which are determined by geographic origin, ethnicity, and living and health conditions in countries of origin or departure. These migrants can suffer from a multitude of health conditions, including infectious diseases (such as tuberculosis and many tropical and parasitic diseases), malnutrition, reproductive health needs, and mental health disorders, often caused by tenuous circumstances in their countries of origin or departure. Such disease burdens can seriously hamper migrants' ability to successfully integrate and optimally contribute to their resettlement communities, and **may cause strain on health and social systems in the U.S.** Most of these health conditions are **not addressed during the required overseas medical examination process.** [Emphasis added.]⁵⁷*

Access to Health Care and Benefits in the United States

The State Department mandates basic resettlement services for 30 to 90 days that include a health assessment, referrals to specialty and mental health care, and, ideally, linking refugees to a medical home. Upon arrival, resettlement agencies refer refugees to local health services for a free-of-charge health assessment in order to identify and treat health problems that may impede employment and successful integration. Refugees eligible for Medicaid are enrolled soon after their arrival. For those who are not, ORR provides Refugee Medical Assistance (RMA). In most cases, the medical care support provided by ORR ends after eight months, at which point refugees must find other means to access the healthcare system.

Resettlement benefits and services funded by ORR extend beyond Reception and Placement (R&P) to facilitate refugee self-sufficiency. These are detailed in the “Report to Congress on Proposed Refugee Admissions for FY 2020”:

Beginning with arrival in the United States, and continuing after the R&P period ends, refugees, approved asylees, and other eligible groups benefit from special programs funded by the Department of Health and Human Services Office of Refugee Resettlement (HHS/ORR) and administered by the states, resettlement agencies, or community organizations.

Refugees not eligible for Medicaid can receive up to eight months of Refugee Medical Assistance (RMA) upon arrival. In addition, each refugee receives a medical screening within the initial resettlement period. ORR also provides health and mental health services through the Survivors of Torture and Refugee Health Promotion grant programs.

*ORR distributes Refugee Support Services (RSS) grants based on arrival numbers of ORR-eligible populations in each state. Refugees, approved asylees, and other ORR-eligible groups **can access RSS services up to five years after arrival.** These services may include employment services, on-the-job training, English language instruction, vocational training, case management, translation, social adjustment services, **health-related services**, childcare, and transportation. [Emphasis added.]⁵⁸*

Moreover, the Domestic Refugee Health Program “was established to facilitate collaboration between the Division of Global Migration and Quarantine, Centers for Disease Control and Prevention, and its domestic partners, to improve the health-care of refugees after their arrival in the United States, initiate surveillance activities to monitor medical conditions identified post-arrival, work together to ensure adequate follow-up of refugees with medical conditions identified overseas, and strengthen the resources available for post-arrival health assessments and follow-up activities.”⁵⁹

Relief Funds and Resources Available to Refugees Following the CARES Act

The Coronavirus Aid, Relief, and Economic Security (CARES Act) was passed by Congress and signed into law by President Trump on March 27, 2020.⁶⁰ This \$2 trillion economic relief package is said to deliver on the “Trump Administration’s commitment to protecting the American people from the public health and economic impacts of COVID-19.” But the CARES Act doesn’t only “work for all Americans”, it also works for legal immigrants here as well as for refugees (on American soil and overseas).

The CARES Act includes “Specific Refugee Funding”:

*There is \$350 million for the Bureau of Population, Refugees, and Migration (PRM) within the State Department to prevent and respond to COVID-19. PRM provides overseas assistance to refugees and initial funds for refugees resettled to the United States. We have urged PRM to **use either existing funding or CARES Act supplemental funds to address refugee needs during the COVID-19 crisis, including overseas assistance and direct support for refugees in the United States who may not be able to benefit from other CARES Act provisions.** As Congress considers further COVID-19 related legislation, we continue to seek additional funds for the Office of Refugee Resettlement (ORR) within the U.S. Department of Health and Human Services (HHS) to provide cash and medical assistance, housing and rent, utilities, transportation, food, and health needs to these refugees. [Emphasis added.]*

The Refugee Council USA (RCUSA), a coalition of 28 U.S.-based non-governmental organizations that claims it “promotes efforts to protect and welcome refugees”, published a “Covid-19 Resources” guide for refugees, community members, and resettlement workers on Covid-19 and relief efforts.⁶¹

Their “COVID-19 Legislation: Quick Facts and Analysis for Refugees and Resettlement Offices” explains how the Covid-19 relief legislation (CARES Act) applies to refugees and asylees, and how to access relief.⁶²

Congress has passed three packages of Covid-19 related legislation to provide direct assistance to Americans (including some refugees and immigrants), employers, and the healthcare system. Benefits include:

Direct Cash Payments. The IRS has updated its website with the following: “Economic impact payments: What you need to know”.⁶³ In general, adults who filed a 2019 tax return (or 2018 tax return), and have a Social Security number, and have a green card or meet IRS residency requirements (have lived in the United States for at least 31 days during 2020 and a total of 183 days during the last three years or are U.S. citizens) will *automatically* receive up to \$1,200 in cash payments (\$2,400 for married couples) and an additional \$500 per child (16 or younger).

Unemployment Insurance. There are many expansions and programs created for people unemployed as a result of Covid-19. Each state has its own work-history requirements to be eligible for unemployment insurance which may impact some refugees.

Paid Leave. Congress expanded access to paid sick leave and expanded family and medical leave. Congress provided two weeks of paid sick leave at the employee’s regular pay while quarantined, self-quarantined, or experiencing Covid-19 symptoms and seeking diagnosis. Congress provided an additional 10 weeks of expanded family and medical leave at two-thirds the employee’s regular pay to care for a child whose school or child-care is closed or unavailable due to Covid-19. Refugees can benefit, so long as they work for a covered employer.

Supplemental Nutrition Assistance (SNAP) Program.⁶⁴ The bill includes \$15.5 billion for projected application increases, however there is no increase in benefits. Prior legislation allotted \$500 million in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) for Covid-19-related job loss, allowed child- and adult-care centers to operate as feeding sites and waived all meal pattern requirements if Covid-19 disrupts the food supply, allows emergency SNAP to families whose children would have received meals if Covid-19 had not closed their schools, and enabled the Department of Agriculture to issue nationwide school meal waivers, eliminating paperwork for states and increasing flexibility.

Free Covid-19 Testing. Previous legislation provided a \$1 billion healthcare fund for Covid-19 testing for the uninsured through the National Disaster Medical System.⁶⁵ Anyone who is uninsured and not covered by Medicaid, the Children’s Health Insurance Program (CHIP), the Affordable Care Act (ACA) marketplace, or any other individual or group health plan is eligible for testing that will be paid for by this fund. This does not cover undocumented individuals.

Public Charge. The Department of Homeland Security’s USCIS posted an alert clarifying that it will not consider testing, treatment, or preventive care (including vaccines if a vaccine becomes available) related to Covid-19 in a public charge inadmissibility determination, even if the health care services are provided by Medicaid.⁶⁶

Answers to Further Questions

Can a Refugee Who Arrived in 2020 Receive a Recovery Rebate? Yes, but only once he or she has accrued “substantial presence” in the United States (after 183 days here in 2020). However, a refugee who arrived in 2020 cannot get the advance payment (which requires filing a 2019 return). It will just be a credit on their 2020 taxes.

Can a Refugee Who Arrived in 2019 Get the Advance on the Recovery Rebate Upon Filing a 2019 Tax Return? Maybe. If a refugee accrued “substantial presence” in 2019, yes. Usually, a refugee who was resettled to the United States prior to July 3, 2019, will have acquired “substantial presence” for 2019 and may file a tax return right away to automatically receive the advance. Refugees who arrived after July 2, 2019, will have not yet acquired (as of April 2020) “substantial presence” for purposes of this rebate, and should probably wait to file 2019 taxes until there are clearer instructions clarifying that all refugees who were admitted in 2019 should be treated as “resident aliens” for purposes of the rebate.

Furthermore, RCUSA released an informational flowchart “to help refugees and asylees see if they qualify for cash payments, expanded unemployment, and other benefits.”⁶⁷

Concluding Points

The Centers for Disease Control and Prevention’s DGMQ is responsible for making and enforcing regulations that prevent the introduction of communicable diseases from foreign countries into the United States. The Trump administration closed the border with Mexico, halting asylum claims and tapping into a law that allows the head of the CDC “to ban foreigners if their entry would create ‘a serious danger’ to the spread of communicable disease.”⁶⁸

The U.S. border with Canada has also been closed, and travel halted from China, Iran, Europe, the United Kingdom, etc. The United States has been on lock-down, but not for refugees from around the world.

Despite the suspension of the U.S. refugee resettlement program, as per the recommendation of UN agencies that deal with refugees (UNHCR and IOM), refugees were still being resettled here. Even after the presidential proclamation to temporarily halt immigration, refugees kept coming in.⁶⁹

Do we even know if they are being quarantined upon arrival? Federal isolation and quarantine, by executive order of the president and updated by President Obama in 2014, are authorized for communicable diseases that are causing, or have the potential to cause, a pandemic.⁷⁰

According to the Office of Refugee Resettlement, “The ultimate goal is to provide the types of assistance that will allow refugees to become economically self-sufficient as soon as possible after their arrival in the United States.”⁷¹ How can refugees achieve self-sufficiency when millions of Americans are filing for unemployment amid an extraordinary economic crisis?

Refugees admitted to the United States are entitled to healthcare, benefits, and social services. They can claim parts of the relief package available through the CARES act; they are entitled to ventilators, hospital beds, Covid-19 treatment, etc. And so should they. But why admit additional refugees into states that are struggling to provide their own residents with proper testing, hospital beds, ventilators, etc.? And how are these admissions still being engineered by resettlement agencies?

Refugees with Class A health-related conditions are faced with inadmissibility into the United States. New diseases may be added to the Class A list in the event of a public health emergency. The president of the United States can issue an executive order to make updates to the list of Class A conditions to include the Covid-19 threat. Will President Trump do that?

If the Covid-19 pandemic doesn’t warrant such protective measures, I’m not sure what does.

End Notes

- ¹ Nayla Rush, [“Refugees Are Being Resettled Despite the Coronavirus Outbreak: More than 3,000 resettled since late January when pandemic task force was created”](#), Center for Immigration Studies blog, March 20, 2020.
- ² [“Statement from the Press Secretary Regarding the President’s Coronavirus Task Force”](#), the White House, January 29, 2020.
- ³ Refugee Processing Center [website](#).
- ⁴ [“IOM, UNHCR announce temporary suspension of resettlement travel for refugees”](#), UN High Commissioner for Refugees, March 17, 2020.
- ⁵ [“Joint Statement: UN High Commissioner for Refugees Filippo Grandi and IOM Director General António Vitorino announce resumption of resettlement travel for refugees”](#), International Organization for Migration press release, June 18, 2020.
- ⁶ Stefan Armbruster, [“Dozens of refugees flown from Australia and PNG to US despite coronavirus travel bans”](#), SBS News, May 21, 2020.
- ⁷ Nayla Rush, [“Australia’s Unwanted Refugees Are Still Being Resettled in the U.S.”](#), Center for Immigration Studies blog, May 29, 2020.
- ⁸ Stefan Armbruster, [“Dozens of refugees flown from Australia and PNG to US despite coronavirus travel bans”](#), SBS News, May 21, 2020.
- ⁹ [“The coronavirus outbreak is a test of our systems, values and humanity”](#), UN High Commissioner for Refugees, March 12, 2020.
- ¹⁰ Rebecca Collard, [“You Can’t Practice Social Distancing if You’re a Refugee”](#), Foreign Policy, March 20, 2020.
- ¹¹ [“Immigration and Nationality Act”](#), U.S. Citizenship and Immigration Services, undated.
- ¹² [“CDC Domestic Refugee Health Program”](#), Centers for Disease Control and Prevention, June 8, 2016.
- ¹³ Stefan Armbruster, [“Dozens of refugees flown from Australia and PNG to US despite coronavirus travel bans”](#), SBS News, May 21, 2020.
- ¹⁴ [Immigrant Medicine](#), Patricia F. Walker and Elizabeth D. Barnett eds., United Kingdom: Elsevier, 2007.
- ¹⁵ [“Report to Congress on Proposed Refugee Admissions for FY 2020”](#), U.S. Department of State, September 26, 2019.
- ¹⁶ [“New Employment Figures Show Immigrants Hard Hit”](#), Center for Immigration Studies press release, May 8, 2020.
- ¹⁷ Stefan Armbruster, [“Dozens of refugees flown from Australia and PNG to US despite coronavirus travel bans”](#), SBS News, May 21, 2020.
- ¹⁸ Refugee Processing Center [website](#).
- ¹⁹ [“Refugee Arrivals, Fiscal Year, as of 17-June 2020”](#), U.S. Department of State, undated.
- ²⁰ [“IOM, UNHCR announce temporary suspension of resettlement travel for refugees”](#), UN High Commissioner for Refugees, March 17, 2020.

- ²¹ [“Joint Statement: UN High Commissioner for Refugees Filippo Grandi and IOM Director General António Vitorino announce resumption of resettlement travel for refugees”](#), International Organization for Migration press release, June 18, 2020.
- ²² *Ibid.*
- ²³ [“Rolling updates on coronavirus disease \(COVID-19\)”](#), World Health Organization, May 17, 2020.
- ²⁴ [“Timeline: The Trump Administration’s Decisive Actions to Combat the Coronavirus”](#), Donald J. Trump, April 27, 2020.
- ²⁵ [“Resettlement Agencies”](#), Office of Refugee Resettlement, July 17, 2012.
- ²⁶ Nayla Rush, [“Private’ Refugee Resettlement Agencies Mostly Funded by the Government”](#), Center for Immigration Studies blog, August 10, 2018.
- ²⁷ [“Report to Congress on Proposed Refugee Admissions for FY 2020”](#), U.S. Department of State, September 26, 2019.
- ²⁸ *Ibid.*
- ²⁹ [“Reception and Placement of Refugees in the United States”](#), Congressional Research Service, June 21, 2017.
- ³⁰ [“Executive Order on Enhancing State and Local Involvement in Refugee Resettlement”](#), the White House, September 26, 2019.
- ³¹ Bobby Allyn, [“Judge Blocks Trump’s Executive Order Allowing Local Officials To Reject Refugees”](#), National Public Radio, January 15, 2020.
- ³² Zolan Kanno-Youngs, [“Texas Governor Shuts State to Refugees, Using New Power Granted by Trump”](#), The New York Times, January 10, 2020.
- ³³ Jonathan Oosting, [“Whitmer strongly hints she’ll extend coronavirus stay-home order in Michigan”](#), Bridge Michigan, April 2, 2020.
- ³⁴ [“Coronavirus in the US: Latest COVID-19 news and case counts”](#), Live Science website, June 19, 2020.
- ³⁵ [“Immigration and Nationality Act”](#), U.S. Citizenship and Immigration Services, undated.
- ³⁶ [“Public Health Service Act, Section 319 Public Health Emergencies”](#), Association of State and Territorial Health Officials, reviewed May 2013.
- ³⁷ [“Medical Examination of Immigrants and Refugees”](#), Centers for Disease Control and Prevention, March 29, 2012.
- ³⁸ [“CDC Domestic Refugee Health Program”](#), Centers for Disease Control and Prevention, June 8, 2016.
- ³⁹ [“Quarantine and Isolation”](#), Centers for Disease Control and Prevention, September 29, 2017.
- ⁴⁰ [“Revised List of Quarantinable Communicable Diseases”](#), Federal Register, July 31, 2014.
- ⁴¹ [“The Refugee Act”](#), Administration for Children and Families, Office of Refugee Resettlement, August 29, 2012.
- ⁴² [“CDC Domestic Refugee Health Program”](#), Centers for Disease Control and Prevention, June 8, 2016.
- ⁴³ [“Panel Physician Portal”](#), Centers for Disease Control and Prevention, June 9, 2017.

- ⁴⁴ [“Final Rule 42 CFR Part 34: Medical Examination of Aliens – Revisions to Medical Screening Process”](#), Centers for Disease Control and Prevention, January 22, 2016.
- ⁴⁵ [“CDC Domestic Refugee Health Program”](#), Centers for Disease Control and Prevention, June 8, 2016.
- ⁴⁶ *Ibid.*
- ⁴⁷ [“CDC Yellow Book”](#), Centers for Disease Control and Prevention, July 18, 2019.
- ⁴⁸ [“CDC Domestic Refugee Health Program”](#), Centers for Disease Control and Prevention, June 8, 2016.
- ⁴⁹ Mi-Kyung Hong, Reshma E. Varghese, Charulata Jindal, and Jimmy T. Efirid, [“Refugee Policy Implications of U.S. Immigration Medical Screenings: A New Era of Inadmissibility on Health-Related Grounds”](#), *Journal of Environmental Research and Public Health*, September 2017.
- ⁵⁰ *Ibid.*
- ⁵¹ [“Domestic Tuberculosis Guidelines”](#), Centers for Disease Control and Prevention, February 20, 2019.
- ⁵² Mi-Kyung Hong, Reshma E. Varghese, Charulata Jindal, and Jimmy T. Efirid, [“Refugee Policy Implications of U.S. Immigration Medical Screenings: A New Era of Inadmissibility on Health-Related Grounds”](#), *Journal of Environmental Research and Public Health*, September 2017.
- ⁵³ [“Summary Checklist for the Domestic Medical Examination for Newly Arriving Refugees”](#), Centers for Disease Control and Prevention, August 7, 2019.
- ⁵⁴ [“Refugee Medical Assistance”](#), Administration for Children and Families, Office of Refugee Resettlement, May 3, 2019.
- ⁵⁵ [“I-693, Report of Medical Examination and Vaccination Record”](#), U.S. Citizenship and Immigration Services, February 14, 2020.
- ⁵⁶ *Immigrant Medicine*, Patricia F. Walker and Elizabeth D. Barnett, eds., United Kingdom: Elsevier, 2007.
- ⁵⁷ Richard L. Guerrant, David H. Walker and Peter F. Weller, [“Tropical Infectious Diseases”](#), Elsevier editions, 2006.
- ⁵⁸ [“Report to Congress on Proposed Refugee Admissions for FY 2020”](#), U.S. Department of State, September 26, 2019.
- ⁵⁹ [“CDC Domestic Refugee Health Program”](#), Centers for Disease Control and Prevention, June 8, 2016.
- ⁶⁰ [“The CARES Act Works for All Americans”](#), U.S. Department of the Treasury, March 2020.
- ⁶¹ [“COVID-19 Resources: Resources for refugees, community members, and resettlement workers on COVID-19 and relief efforts”](#), Refugee Council USA, undated.
- ⁶² *Ibid.*
- ⁶³ [“Economic impact payments: What you need to know”](#), Internal Revenue Service, March 30, 2020.
- ⁶⁴ [“SNAP Eligibility”](#), U.S. Department of Agriculture, information on this page is for October 1, 2019, through September 2020.
- ⁶⁵ [“Update on Access to Health Care for Immigrants and Their Families”](#), National Immigration Law Center, March 18, 2020.
- ⁶⁶ [“Public Charge”](#), U.S. Citizenship and Immigration Services website, updated March 23, 2020.

⁶⁷ [“The CARES Act, How Does Pandemic Relief Impact Me As A Refugee?”](#), Refugee Council USA, undated.

⁶⁸ Maria Verza and Ben Fox, [“US expels thousands to Mexico after largely halting asylum”](#), Star Tribune, April 9, 2020.

⁶⁹ [“Proclamation Suspending Entry of Immigrants Who Present Risk to the U.S. Labor Market During the Economic Recovery Following the COVID-19 Outbreak”](#), the White House, April 22, 2020.

⁷⁰ [“Legal Authorities for Isolation and Quarantine”](#), Centers for Disease Control and Prevention, February 24, 2020.

⁷¹ [“Office of Refugee Resettlement”](#), The Administration for Children and Families website, February 4, 2016.