



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333
October 8, 2020

SENT VIA EMAIL

Austin Evers
American Oversight
1030 15th Street NW
Suite B255
Washington, District of Columbia 20005
foia@americanoversight.org

Dear Mr. Evers:

This letter is our final response to your Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry (CDC/ATSDR) Freedom of Information Act (FOIA) request of March 18, 2020, assigned #20-00970-FOIA.

We located 93 pages of responsive records; no information was withheld from release. Further, additional CDC SARS-CoV2/COVID-19 guidance can be found at:
<https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance-list.html?Sort=Date%3A%3Adesc>.

In accordance with the Department's implementing regulations, 45 CFR Part 5, no FOIA processing fees are due for your request.

If you need any further assistance or would like to discuss any aspect of the records provided, please contact either our FOIA Requester Service Center at 770-488-6399 or our FOIA Public Liaison at 770-488-6277.

Sincerely,

Roger Andoh
CDC/ATSDR FOIA Officer
Office of the Chief Operating Officer
Phone: (770) 488-6399
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Enclosure

Original request

#20-00970-FOIA

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

**ORDER UNDER SECTIONS 362 & 365 OF THE PUBLIC HEALTH SERVICE ACT
(42 U.S.C. §§ 265, 268):**

**EXTENSION OF ORDER SUSPENDING INTRODUCTION OF CERTAIN PERSONS
FROM COUNTRIES WHERE A COMMUNICABLE DISEASE EXISTS**

I am extending the Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists issued on March 20, 2020 until 11:59 p.m. EDT on May 20 or until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, whichever is sooner. I may further amend or extend the March 20, 2020 Order as needed to protect the public health.

I issued the March 20, 2020 Order pursuant to §§ 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. §§ 265, 268, and the Act's implementing regulations, which authorize the Director of the Centers for Disease Control and Prevention (CDC) to suspend the introduction of persons into the United States when the Director determines that the existence of a communicable disease in a foreign country or place creates a serious danger of the introduction of such disease into the United States, and the danger is so increased by the introduction of persons from the foreign country or place that a temporary suspension of such introduction is necessary to protect the public health.

The March 20, 2020 Order suspended introduction of certain "covered aliens" into the United States for a period of 30 days. The March 20, 2020 Order defined "covered aliens" as follows:

Persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land Port of Entry ("POE") or Border Patrol station at or near the United States border with Canada or Mexico, subject to exceptions. This order does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE.

In addition, the March 20, 2020 Order did not apply to "persons whom customs officers of DHS determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests."

The March 20, 2020 Order was based on the following determinations:

- COVID-19 is a communicable disease that poses a danger to the public health;
- COVID-19 is present in numerous foreign countries, including Canada and Mexico;
- There is a serious danger of the introduction of COVID-19 into the land POEs and Border Patrol stations at or near the United States borders with Canada and Mexico, and into the interior of the country as a whole, because COVID-19 exists in Canada, Mexico, and the other countries of origin of persons who migrate to the United States across the land borders with Canada and Mexico;
- But for a suspension-of-entry order under 42 U.S.C. § 265, covered aliens would be subject to immigration processing at the land POEs and Border Patrol stations, and during that processing many of them (typically aliens who lack valid travel documents and are therefore inadmissible) would be held in the common areas of the facilities, in close proximity to one another, for hours or days; and
- Such introduction into congregate settings of persons from Canada or Mexico would increase the already serious danger to the public health to the point of requiring a temporary suspension of the introduction of covered aliens into the United States.

COVID-19 has continued to spread since the March 20, 2020 Order. Canada and Mexico continue to see increasing numbers of COVID-19 infections and deaths. In addition, the United States has seen many states experience exponential growth in the number of confirmed COVID-19 cases, which has strained the healthcare system and prompted dramatic public health responses at the local, state, and Federal levels. Millions of Americans are now complying with local and state stay-at-home orders, engaging in social distancing, and taking other precautions calculated to slow the spread of, and protect others from, COVID-19. At the Federal level, the U.S. Departments of Health and Human Services (HHS) and Homeland Security (DHS) are working with public and private stakeholders to rapidly procure, distribute, and increase the supply of scarce medical and healthcare resources such as personal protective equipment (PPE), ventilators, and therapeutics for the American public. The entire country has mobilized to save lives by limiting face-to-face contact and reserving medical and healthcare resources for those who need them most. At a time when these domestic efforts are ongoing and effective, it would be counterproductive and dangerous to undermine those efforts by permitting the introduction of persons from outside the United States who pose a risk of transmission of COVID-19 within DHS facilities or the U.S. interior.

Further, the determinations made in support of the March 20, 2020 Order remain correct. If anything, they have become more compelling. I therefore conclude that the March 20, 2020 Order should remain in effect until 11:59 p.m. EDT on May 20.

COVID-19 is Continuing to Spread in Canada, Mexico, and the United States

Since the March 20, 2020 Order, the number of COVID-19 cases globally, including in Canada, Mexico, and the United States, has continued to increase.

Canada

As of April 13, 2020, Canada has reported 24,804 confirmed cases of COVID-19, and a total of 734 deaths. Canada has tested 422,200 people for COVID-19.¹ The Public Health Agency of Canada estimates that 72% of infections are the result of community transmission. Canadian modeling indicates that, with the use of strong epidemic controls resulting in a 2.5% infection rate, Canada could see 940,000 people with infections, 73,000 hospitalizations, and 23,000 people requiring intensive care over the course of the COVID-19 pandemic.²

Canada has implemented and maintained robust public health measures to slow the spread of COVID-19, including closures of public schools and cancelation of public events.³ Non-essential businesses have been closed across the country.

Mexico

As of April 12, 2020, Mexico has reported 3,844 confirmed cases of COVID-19 and 233 deaths.⁴ Nevertheless, based on public health surveillance, Mexico estimates that its current case count is 26,519. Mexico's modeling, based on World Health Organization (WHO) reporting from China, assumes a 0.2% infection rate with 250,656 infected people during the acceleration phase of the pandemic.⁵ Of those people, 70% (175,459) are anticipated to seek medical care.⁶ Among people seeking medical care, it is projected that 80% (140,367) will be ambulatory patients, 14% (25,564) will need to be hospitalized without intensive care, and 6% (10,528) will require intensive care.⁷

¹ Government of Canada, Coronavirus disease (COVID-19): Outbreak Update (Apr. 13, 2020), <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html?topic=tilelink#a2>.

² Public Health Agency of Canada, COVID-19 in Canada: Using Data and Modeling to Inform Public Health Action (Apr. 9, 2020), available at <https://www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirus-infection/using-data-modelling-inform-eng.pdf>.

³ See generally Kristin Rushowy, The Star, Ontario Schools Will Remain Closed Until at Least May 4. But Kids Can Expect Marks (Mar. 31, 2020), <https://www.thestar.com/politics/provincial/2020/03/31/ontario-schools-wont-open-until-at-least-may.html>; Ryan Rocca, Global News, Coronavirus: City of Toronto Cancels Events Through June 30, including Pride Parade (updated Apr. 1, 2020), <https://globalnews.ca/news/6758350/coronavirus-toronto-cancels-events-pride-parade/>.

⁴ World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report – 83 (Apr. 12, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200412-sitrep-83-covid-19.pdf?sfvrsn=697ce98d_4.

⁵ Secretaria De Salud, COVID-19: Comunicado Tecnico Diario (Mar. 17, 2020), available at https://www.gob.mx/cms/uploads/attachment/file/541879/COVID-19_-_Presentacion_Comunicado_Tecnico_Diario_2020.03.17.pdf.pdf.

⁶ *Id.*

⁷ *Id.*

On March 30, 2020, Mexico's General Health Council declared a "State of Health Emergency" and suspended all non-essential activities in the public and private sectors until April 30, 2020.⁸ The order granted full authority to the Secretariat of Health to take action to address the pandemic across Mexico. The central guidance of the Mexican health authorities is to maximize social distancing and that people should only leave their homes for essential activities, such as to procure food or medical care.⁹ State and local authorities in several Mexican states also are enforcing non-essential business closures and self-quarantine measures.

United States

As of April 13, 2020, the United States has reported 554,849 confirmed cases of COVID-19 across the United States and 21,942 deaths.¹⁰ Community transmission of COVID-19 is occurring in many locations across the United States. Several cities and states have experienced widespread, sustained community transmission to the extent that their healthcare and public health systems are at risk of being overwhelmed. This includes parts of states and territories at or near borders of the United States which are reporting large increases in new COVID-19 cases since the March 20, 2020 Order.¹¹

In addition to practicing rigorous hygiene and social distancing and limiting non-essential travel,¹² CDC's guidance to the general public has expanded to include the recommendation that individuals wear face coverings when out in public.¹³ CDC expects widespread transmission of COVID-19 in the United States will occur and, in the coming months, most of the U.S. will be exposed to COVID-19.¹⁴ Nevertheless, not all areas of the United States are currently experiencing high rates of infection or numbers of confirmed cases. Generally speaking, COVID-19 is currently concentrated along the East, West, and Gulf Coasts and in the Great Lakes region;

⁸ U.S. Department of State, U.S. Embassy and Consulates in Mexico, Health Alert – Mexico COVID-19 Update (Apr. 10, 2020), <https://mx.usembassy.gov/health-alert-mexico-covid-19-update-04-10-2020/>.

⁹ *Id.*

¹⁰ CDC, Cases in U.S. (updated Apr. 13, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.

¹¹ The New York Times, Coronavirus in the U.S.: Latest Map and Case Count (Apr. 13, 2020), <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states>; *see also* CDC, Coronavirus Disease 2019 (COVID-19): Cases in U.S.: States Reporting Cases of COVID-19 to CDC (Apr. 14, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html#cumulative>.

¹² CDC, COVID-19: How to Protect Yourself and Others (last reviewed Apr. 8, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html>.

¹³ CDC, COVID-19: How to Wear a Cloth Face Covering (last reviewed Apr. 9, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>.

¹⁴ CDC, Testing for COVID-19 (Mar. 21, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html>.

there are significantly fewer cases in the interior of the United States.¹⁵ Limiting the spread of COVID-19 in these less affected areas is a critical component of the overall U.S. strategy to “flatten the curve,” which requires limiting the number of foci, or infected individuals, who may enter these areas.

Joint Efforts

On March 20, 2020, the United States and Canada jointly decided to restrict all non-essential travel across the U.S.-Canadian border for 30 days, with limited exceptions for U.S. citizens and others entering Canada for essential business, provided these individuals have not been outside Canada or the United States in the 14 days prior to requesting entry into Canada. Foreign nationals, excluding those arriving from the U.S., will not be allowed into Canada, subject to certain exceptions.¹⁶ The Canadian government is requiring individuals returning home to Canada to self-isolate for 14 days upon their return.¹⁷ Individuals exhibiting symptoms of COVID-19 are not permitted to enter Canada, except for Canadian citizens or permanent residents.¹⁸

Similarly, on March 20, 2020, the United States and Mexico announced a joint initiative temporarily restricting all non-essential travel across their border in an effort to combat the spread of COVID-19.¹⁹

Availability of Rapid COVID-19 Testing

Since the March 20, 2020 Order, rapid testing for COVID-19 has been developed that can provide results in approximately 15 minutes and manufacturers are currently ramping up production and distribution of rapid COVID-19 testing.²⁰ Although rapid COVID-19 testing could

¹⁵ See Johns Hopkins University, COVID-19 United States Cases by County, <https://coronavirus.jhu.edu/us-map>.

¹⁶ See Notification of Temporary Travel Restrictions Applicable to Land Ports of Entry and Ferries Service Between the United States and Canada, 85 Fed. Reg. 16548 (Mar. 24, 2020).

¹⁷ Government of Canada, Coronavirus disease (COVID-19): Canada’s Response, <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/canadas-reponse.html?topic=tilelink>

¹⁸ *Id.*

¹⁹ U.S. Department of Homeland Security, Joint Statement on U.S.-Mexico Joint Initiative to Combat the COVID-19 Pandemic (Mar. 20, 2020), available at <https://www.dhs.gov/news/2020/03/20/joint-statement-us-mexico-joint-initiative-combat-covid-19-pandemic>.

²⁰ For instance, on March 27, 2020, Abbott received emergency use authorization from the U.S. Food and Drug Administration (“FDA”) for the fastest available point-of-care test for COVID-19. Abbott, “Detect COVID-19 in as Little as 5 Minutes” (Mar. 27, 2020), <https://www.abbott.com/corpnnewsroom/product-and-innovation/detect-covid-19-in-as-little-as-5-minutes.html>; see generally U.S. Food and Drug Administration, Emergency Use Authorizations, <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#covid19ivd>. Rapid COVID-19 testing will significantly reduce the time needed to confirm a suspected diagnosis of COVID-19, which currently may take as long as three to four days. See CDC, Order Suspending Introduction of Certain Persons from Countries where a Communicable Disease Exists (Mar. 20, 2020), available at https://www.cdc.gov/quarantine/pdf/CDC-Order-Prohibiting-Introduction-of-Persons_Final_3-20-20_3-

ameliorate some of the public health concerns associated with congregate detention in DHS border facilities, rapid COVID-19 testing is not yet widely available, and demand outstrips supply. Moreover, once it is available, rapid COVID-19 testing should be prioritized to certain key locations, such as hospitals treating high numbers of COVID-19 patients, where the ability to quickly determine whether doctors and nurses have been infected with COVID-19 could increase the availability of care providers by eliminating the need for these individuals to self-isolate while awaiting test results.

Determination and Implementation

Based on the foregoing, I find that the global presence of COVID-19, including in Canada, Mexico, still presents a danger of further introduction of COVID-19 into the United States. This is true notwithstanding the community transmission of COVID-19 in many locations across the United States. There are many locations in the United States near our borders with Canada and Mexico that have not yet experienced widespread community transmission. The on-going COVID-19 pandemic, including in Canada and Mexico, remains a serious danger to such locations.

In the March 20, 2020 Order, I found the risks troubling partly because outbreaks of COVID-19 in POEs or Border Patrol stations would lead U.S. Customs and Border Protection to transfer persons with acute presentations of illness to local or regional healthcare providers for treatment, which would exhaust the local or regional healthcare resources or at least reduce the availability of such resources to the domestic population, and further expose local or regional healthcare workers to COVID-19. Millions of Americans are complying with local and state stay-at-home orders, engaging in social distancing, and taking other precautions calculated to slow the spread, protect others, and relieve the strain on the healthcare system. Their efforts would be significantly undermined if outbreaks of COVID-19 in land POEs or Border Patrol stations crippled the DHS workforce and local or regional healthcare systems.

I consulted with DHS before issuing this Order and requested that DHS continue to implement the March 20, 2020 Order because CDC does not have the capability, resources, or personnel needed to alternatively issue quarantine or isolation orders.²¹

[p.pdf](#); see also CDC, Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19) (updated Apr. 8, 2020), <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>. When a case of COVID-19 is suspected, the sooner that confirmatory test results are available, the more quickly treatment and isolation and quarantine measures can be implemented, lowering the risk of infecting others. See CDC, Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) (updated Mar. 24, 2020), <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>.

²¹ As previously discussed in the March 20, 2020 Order, CDC relies on the Department of Defense, other federal agencies, and state and local governments to provide both logistical support and facilities for federal quarantines. See 42 U.S.C. § 268(b) (requiring customs officers to aid in the enforcement of quarantine regulations). CDC lacks the resources, staffing, and facilities to quarantine covered aliens. Similarly, DHS has informed CDC that in the near term, it is not financially or logistically practicable for DHS to build additional facilities at POEs and Border Patrol stations for purposes of quarantine or isolation.

The March 20, 2020 Order shall remain in effect until 11:59 p.m. EDT on May 20, or until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, whichever is sooner. I may further amend or extend the March 20, 2020 Order as needed to protect the public health.

This Order is not a rule subject to notice and comment under the Administrative Procedure Act (APA). In the event this order qualifies as a rule subject to notice and comment, a delay in effective date are not required because there is good cause to dispense with prior public notice and the opportunity to comment on this order and a delay in effective date.²² Given the public health emergency caused by COVID-19, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay the issuing and effective date of this order. In addition, because this order concerns ongoing discussions with Canada and Mexico on how to best control COVID-19 transmission over our shared borders, it directly “involve[s] . . . a . . . foreign affairs function of the United States.” 5 U.S.C. § 553(a)(1). Notice and comment and a delay in effective date would not be required for that reason as well.

The March 20, 2020 Order shall remain in effect until 11:59 p.m. EDT on May 20, 2020.

In testimony whereof, the Director, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, has hereunto set his hand at Washington, D.C., this 19th day of April, 2020.



Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention

²² See 5 U.S.C. §§ 553(b)(B) and (d)(3).

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

**ORDER UNDER SECTIONS 362 & 365 OF THE PUBLIC HEALTH SERVICE ACT
(42 U.S.C. §§ 265, 268):**

**AMENDMENT AND EXTENSION OF ORDER SUSPENDING INTRODUCTION OF
CERTAIN PERSONS FROM COUNTRIES WHERE A COMMUNICABLE DISEASE
EXISTS**

I. Introduction

I am amending the Order Suspending Introduction of Certain Persons from Countries Where a Communicable Disease Exists, issued on March 20, 2020 (hereinafter, March 20, 2020 Order or Order) and extended on April 20, 2020 (hereinafter, April 20, 2020 Extension or Extension), to clarify that it applies to all land and coastal Ports of Entry (POEs) and Border Patrol stations¹ at or near the United States' border with Canada or Mexico that would otherwise hold covered aliens in a congregate setting. I am extending the duration of the Order until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, and continuation of the Order is no longer necessary to protect the public health. Every 30 days, the Centers for Disease Control and Prevention (CDC) shall review the latest information regarding the status of the COVID-19 pandemic and associated public health risks to ensure that the Order remains necessary to protect the public health. Upon determining that the further introduction of COVID-19 into the United States is no longer a serious danger to the public health necessitating the continuation of this Order, I will publish a notice in the Federal Register terminating this Order and its Extensions.

II. History of Order

A. March 20, 2020 Order

I issued the March 20, 2020 Order pursuant to sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. §§ 265, 268, and the Act's implementing regulations, which authorize the Director of CDC to suspend the introduction of persons into the United States when the Director determines that the existence of a communicable disease in a foreign country or place creates a serious danger of the introduction of such disease into the United States, and the danger is so increased by the introduction of persons from the foreign country or place that a temporary suspension of such introduction is necessary to protect the public health.

The March 20, 2020 Order suspended introduction of certain "covered aliens" into the United States for a period of 30 days. The March 20, 2020 Order described "covered aliens" as follows:

¹ As explained below, air POEs are excluded from the Amended Order and Extension because they do not present the same public health risk as land and coastal POEs.

Persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land Port of Entry (POE) or Border Patrol station at or near the United States border with Canada or Mexico, subject to exceptions. This order does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE.

The March 20, 2020 Order also did not apply to “persons whom customs officers of DHS determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests.”

The March 20, 2020 Order was based on the following determinations:

- COVID-19 is a communicable disease that poses a danger to the public health;
- COVID-19 is present in numerous foreign countries, including Canada and Mexico;
- There is a serious danger of the introduction of COVID-19 into the land POEs and Border Patrol stations at or near the United States’ borders with Canada and Mexico, and into the interior of the country as a whole, because COVID-19 exists in Canada, Mexico, and the other countries of origin of persons who migrate to the United States across the land borders with Canada and Mexico;
- But for a suspension-of-entry order under 42 U.S.C. § 265, covered aliens would be subject to immigration processing at the land POEs and Border Patrol stations, and during that processing many of them (typically aliens who lack valid travel documents and are therefore inadmissible) would be held in the common areas of the facilities, in close proximity to one another, for hours or days; and
- Such introduction into congregate settings of persons from Canada or Mexico would increase the already serious danger to the public health to the point of requiring a temporary suspension of the introduction of covered aliens into the United States.

B. April 20, 2020 Extension

On April 20, 2020, I extended the March 20, 2020 Order until 11:59 p.m. EDT on May 20, 2020. The April 20, 2020 Extension found that the determinations of the March 20, 2020 Order remain correct, and further determined that the suspension of introduction of covered aliens should continue for another 30 days based on the increasing numbers of COVID-19 infections in Canada, Mexico, and the United States, and the highly dynamic domestic health care landscape.

As detailed below, the Order has proven effective in reducing the risk of COVID-19 within POEs and Border Patrol stations, and the latest information on the status of the pandemic in Canada, Mexico, and the United States justifies issuing this Amendment and Extension until I determine that the serious danger of further introduction of COVID-19 into the United States has ceased to be a danger to the public health.

III. The Order has reduced the risk of COVID-19 transmission in POEs and Border Patrol stations

Recent DHS data indicates the March 20, 2020 Order and April 20, 2020 Extension have significantly mitigated the specific public health risk identified in the initial Order by significantly reducing the population of covered aliens held in congregate settings in POEs and Border Patrol stations, thereby reducing the risk of COVID-19 infection among DHS personnel and others within these facilities.

DHS has provided CDC with statistical information on the impact of the Order and Extension, which supports my decision to further extend the suspension. For example, following issuance of the March 20, 2020 Order, DHS data on operational encounters with covered aliens demonstrate that the population of covered aliens held in POEs and Border Patrol stations was reduced by 88 percent. Specifically, in the 46-day period preceding the March 20, 2020 Order (i.e., February 3, 2020 to March 20, 2020), there was a daily average of 3,249 covered aliens in custody at POEs and Border Patrol stations. In the 47-day period following the March 20, 2020 Order (i.e., March 21, 2020 to May 6, 2020), there was a daily average of 395 covered aliens in custody, with approximately 100 aliens in CBP facilities at any given time. By significantly reducing the number of covered aliens held in POEs and Border Patrol stations, the Order and Extension have reduced the density of covered aliens held in congregate custody within these facilities, which reduces the risk of exposure to COVID-19 for DHS personnel and others in POEs and Border Patrol stations.

IV. Conditions in Canada, Mexico, and the United States warrant continued implementation of the Order

Since the April 20, 2020 Extension, COVID-19 has continued to spread. Canada and Mexico continue to see increasing numbers of COVID-19 infections and deaths. In the United States, many states continue to experience growth in the number of confirmed COVID-19 cases, as more states enter the acceleration phase of the pandemic. Although certain early hotspots are beginning to see improvement, and certain areas of the country are beginning a phased reopening of their communities, millions of Americans continue to comply with stay-at-home orders and practice social distancing, most schools and businesses remain closed, and health care providers across the country continue to strive to meet the demand for COVID-19-related care. Epidemiologically speaking, the United States as a whole remains in the acceleration phase of the

pandemic.² Accordingly, there remains a serious risk to the public health that COVID-19 will continue to spread to unaffected communities within the United States, or further burden already affected areas. At this critical juncture, it would be counterproductive to undermine ongoing public health efforts by relaxing restrictions on the introduction of covered aliens who pose a risk of further introducing COVID-19 into the United States.

A. Canada

As of May 9, 2020, Canada has reported 66,780 confirmed cases of COVID-19, and a total of 4,628 deaths. Canada has tested 1,067,595 people for COVID-19.³ The Public Health Agency of Canada believes that the COVID-19 pandemic may have reached its peak, but expects that the number of confirmed COVID-19 cases will continue to increase.⁴ The Canadian government estimates that 81 percent of COVID-19 cases are the result of community transmission.⁵ Canadian modeling indicates that, with the use of strong epidemic controls resulting in a 2.5 percent infection rate, Canada could see 940,000 people with infections, 73,000 hospitalizations, and 23,000 people requiring intensive care over the course of the COVID-19 pandemic.⁶ Canada continues to enforce robust public health measures to slow the spread of COVID-19; non-essential businesses and public schools remain largely closed, and public events remain cancelled.⁷

B. Mexico

As of May 9, 2020, Mexico has reported 29,616 confirmed cases of COVID-19 and 2,961 deaths.⁸ The Mexican Health Ministry believes that there are approximately 8 additional cases for

² CDC, Situation Summary (updated Apr. 19, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html>; see also Dr. Anne Schuchat, MMWR and Morbidity and Mortality Weekly Report, U.S. Dep't. of Health and Human Services, Public Health Response to the Initiation and Spread of Pandemic COVID-19 in the United States, February 24–April 21, 2020 (May 8, 2020), available at <https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e2.htm#suggestedcitation>

³ Government of Canada, Coronavirus disease (COVID-19): Outbreak Update (May 9, 2020), <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html?topic=tilelink#a2>.

⁴ Government of Canada, Epidemiological Summary of COVID-19 Cases in Canada (May 9, 2020), <https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html>.

⁵ *Id.*

⁶ Public Health Agency of Canada, COVID-19 in Canada: Using Data and Modeling to Inform Public Health Action (last updated May 3, 2020), <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/covid-19-using-data-modelling-inform-public-health-action.html>.

⁷ Schools in Quebec are scheduled to re-open May 11 with restrictions. See Solarina Ho, CTV News (May 4, 2020) <https://www.ctvnews.ca/health/coronavirus/when-will-school-resume-what-we-know-province-by-province-1.4923667>; see also generally Marc Montgomery, Radio Canada International (May 5, 2020) <https://www.rcinet.ca/en/2020/05/05/covid-19-the-2020-summer-of-fun-events-that-werent/>.

⁸ World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report – 110 (May 9, 2020), https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200509covid-19-sitrep-110.pdf?sfvrsn=3b92992c_4.

each confirmed case of COVID-19.⁹ On April 21, 2020, government officials announced that Mexico has entered Phase III of the COVID-19 pandemic, the Mexican government's highest level of public health emergency.¹⁰ As the pandemic continues, there are media reports of hospitals in Mexico City turning away potential COVID-19 cases and fears that Mexico lacks sufficient ventilators.¹¹ Mexico's initial modeling, based on Chinese data reported by the World Health Organization (WHO), assumed a 0.2 percent infection rate with 250,656 people infected during the acceleration phase of the pandemic.¹² Of those people, 70 percent (175,459) are anticipated to seek medical care.¹³ Among people seeking medical care, it is projected that 80 percent (140,367) will be ambulatory patients, 14 percent (25,564) will need to be hospitalized without intensive care, and 6 percent (10,528) will require intensive care.¹⁴ Non-governmental models and estimates indicate that Mexico may have between 620,000 and 730,000 symptomatic COVID-19 cases.¹⁵

C. United States

As of May 9, 2020, the United States has reported 1,274,036 confirmed cases of COVID-19 and 77,034 deaths.¹⁶ Community transmission of COVID-19 is continuing in many locations across the United States. Public health measures to slow the spread of COVID-19 so as to avoid

⁹ Mexico News Daily, New Model Show Highest Number of Virus Cases Will Come Sooner Than Expected (Apr. 24, 2020), <https://mexiconewsdaily.com/news/coronavirus/new-model-shows-virus-cases-will-come-sooner-than-expected/>.

¹⁰ James Pasley, MSN News Insider, Mexico has Moved to "Phase 3" – its Most Serious Level of Coronavirus Alert – and Faces a Looming Outbreak. Here's how it got to this Point (Apr. 23, 2020), <https://www.msn.com/en-us/news/other/mexico-has-moved-to-phase-3-e2-80-94-its-most-serious-level-of-coronavirus-alert-e2-80-94-and-faces-a-looming-outbreak-heres-how-it-got-to-this-point/ss-BB135RGq/>.

¹¹ Andrea Navarro, Bloomberg, Mexico City Top Hospitals Reach Capacity, Reject Virus Patients (Apr. 28, 2020), <https://www.bloomberg.com/news/articles/2020-04-28/mexico-city-top-hospitals-reach-capacity-reject-virus-patients>.

¹² Secretaria De Salud, COVID-19: Comunicado Tecnico Diario (Mar. 17, 2020), available at https://www.gob.mx/cms/uploads/attachment/file/541879/COVID-19_-_Presentacion_Comunicado_Tecnico_Diario_2020.03.17.pdf.pdf.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ See Jorge Galindo, Javier LaFuente, El País, The Magnitude of the Epidemic in Mexico (May 8, 2020), <https://elpais.com/sociedad/2020-05-08/la-magnitud-de-la-epidemia-en-mexico.html>; Juan Montes, The Wall Street Journal, Death Certificates Point to Much Higher Coronavirus Toll in Mexico (May 8, 2020), <https://www.wsj.com/articles/death-certificates-point-to-much-higher-coronavirus-toll-in-mexico-11588957041>; Azam Ahmed, Hidden Toll: Mexico Ignores Wave of Coronavirus Deaths in Capital (May 8, 2020), <https://www.nytimes.com/2020/05/08/world/americas/mexico-coronavirus-count.html>.

¹⁶ CDC, Cases in U.S. (updated May 9, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.

overwhelming health care systems have, to date, largely proven successful.¹⁷ However, several cities and states, including several located at or near U.S. borders, continue to experience widespread, sustained community transmission that has put their healthcare and public health systems remain at risk of being overwhelmed.¹⁸

CDC continues to recommend that all Americans practice vigorous hand hygiene, engage in social distancing, limit non-essential travel,¹⁹ and wear cloth face coverings when out in public.²⁰ Nevertheless, not all areas of the United States are currently experiencing high rates of infection or numbers of confirmed cases.²¹ Limiting the spread of COVID-19 to un- or less-affected areas, and slowing the spread of COVID-19 in highly impacted areas, involves limiting the number of foci, or infected individuals, who may enter these areas. Such efforts are critical as individual states begin to ease public health restrictions on businesses and public activities in an effort to mitigate the economic and other costs of the COVID-19 pandemic.²²

V. The Order is amended to apply to land and coastal POEs and Border Patrol stations at or near the border with Canada or Mexico that would otherwise hold covered aliens in a congregate setting

As noted above, the March 20, 2020 Order and April 20, 2020 Extension defined “covered alien” in terms of the public health risk associated with permitting individuals who have traveled from Canada or Mexico to be introduced into a congregate holding area “in a *land* Port of Entry (POE) or Border Patrol station at or near the United States borders with Canada and Mexico.” Due to the highly contagious nature of the virus that causes COVID-19 and the mode of transmission, it is determined that the continued introduction of potentially infected individuals into these

¹⁷ Judy Woodruff, Interview with Vice President of the United States Michael Pence, PBS News Hour (Apr. 17, 2020), <https://www.pbs.org/newshour/show/our-health-care-system-has-not-been-overwhelmed-by-covid-19-says-pence>.

¹⁸ See Johns Hopkins University, COVID-19 United States Cases by County, <https://coronavirus.jhu.edu/us-map>; see also Letter from Chris D. Van Gorder, President & CEO, Scripps Health, & Daniel L. Gross, Executive Consultant, Sharp HealthCare COVID-19 Strategic Response, to Hon. Alex M. Azar, Secretary of the U.S. Dep’t. of Health & Human Services, and Hon. Chad F. Wolf, Acting Secretary of the U.S. Dep’t. of Homeland Security (Apr. 28, 2020), available at <https://www.voiceofsandiego.org/wp-content/uploads/2020/04/Border-Concerns-Letter-Scripps-Health-Sharp-HealthCare-4.28.20.pdf>; see also Letter from Hon. Kristin Gaspar, Supervisor, Third District, San Diego County Board of Supervisors, to Hon. Michael Pence, Vice President of the United States (Apr. 19, 2020), available at <https://www.krqe.com/news/border-report/san-diego-county-official-asks-white-house-to-help-mexico-control-covid-19/>.

¹⁹ CDC, COVID-19: How to Protect Yourself & Others (last reviewed May 11, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html>.

²⁰ CDC, COVID-19: Use of Cloth Face Coverings to Help Slow the Spread of COVID-19 (last reviewed May 11, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>.

²¹ See Johns Hopkins University, COVID-19 United States Cases by County, <https://coronavirus.jhu.edu/us-map>.

²² Executive Office of President and CDC, Guidelines for Opening Up America Again (Apr. 16, 2020), <https://www.whitehouse.gov/openingamerica/>.

facilities poses a public health risk given the role of these facilities and their personnel not only in carrying out immigration functions, but also in ensuring safe border crossings for essential goods and persons, and in law enforcement activities such as preventing terrorism and drug trafficking. Because the limited medical capacity in POEs and Border Patrol stations presents a significant obstacle to safely managing the risk of COVID-19 among covered aliens held in these facilities, the public health risk is best addressed by suspending the introduction of covered aliens into land and coastal POEs and Border Patrol stations.²³

After consulting with DHS regarding its various operations and ability to rapidly stand-up the containment measures and medical capacity needed to deal with the COVID-19 pandemic, CDC determined that protecting the public health of the United States necessitated temporarily suspending the introduction of covered aliens into the congregate holding areas of POEs and Border Patrol stations at or near the United States' border with Canada and Mexico. CDC understands that, at least in theory, it is possible to expand and retrofit POEs and Border Patrol stations with the structural and engineering controls necessary to contain COVID-19, and that DHS personnel could be equipped with the necessary PPE and trained in clinically-informed practices to more safely interact with covered aliens. However, CDC believes such an endeavor would be ill-advised in that it would consume a significant amount of scarce medical resources that could otherwise be used to meet the needs of the domestic population. Nor could such interventions—particularly those involving structural and engineering additions or changes to hundreds of DHS facilities—be implemented quickly enough to mitigate the current risk of allowing covered aliens to be introduced into POEs and Border Patrol stations. As noted above, the Order has effectively reduced the population of covered aliens in POEs and Border Patrol stations at or near the border, thereby significantly reducing the risk COVID-19 spreading within these facilities.²⁴

The intent of the March 20, 2020 Order and April 20, 2020 Extension was to suspend the introduction of individuals who have traveled from Canada or Mexico who would otherwise likely have been held in the congregate holding areas of POEs or Border Patrol stations at or near the border with Canada or Mexico, where they could transmit COVID-19 to the DHS personnel and other individuals in those facilities. The public health risk addressed by the Order and Extension was the risk of transmission in the congregate holding areas of POEs and Border Patrol stations created when individuals who have traveled from Canada or Mexico are held for significant periods of time in these facilities because they lack valid documentation for entry into the United States. This public health analysis was based, in part, on the operational issues identified by DHS, and on the observations of the United States Public Health Service Scientist Officer who visited the El Paso del Norte POE on March 12-13, 2020. For the purposes of the public health analysis and risk determinations, it is irrelevant whether a particular POE or Border Patrol station is

²³ The various screening and documentation requirements to board an aircraft justify the exclusion of air POEs from the scope of this Order because they do not pose the same public health risk as land and coastal POEs. In addition, DHS has informed CDC that air POEs do not tend to hold large numbers of persons for the more extended processing that occurs at land and coastal POEs.

²⁴ See *supra* Section III.

designated by DHS as a “land” or “coastal” facility.²⁵ The relevant factor is whether the facility receives individuals who have traveled from Canada or Mexico and are likely to be held in a congregate setting within a POE or Border Patrol station at or near the border.

DHS has informed CDC that many POEs and Border Patrol stations service both land and coastal borders, such that covered aliens who are apprehended while attempting to enter the United States by a coastal border are held in the same facilities that temporarily hold covered aliens apprehended while crossing into the United States over the land borders with Canada and Mexico.²⁶ These facilities are substantially similar in all respects relevant to the public health analysis. DHS has informed CDC that, like their land-based counterparts, coastal POEs and Border Patrol stations generally have one or more congregate areas where covered aliens are held for processing, and are not structured or equipped to manage covered aliens exposed to or infected with COVID-19, nor to protect DHS personnel and other individuals within those facilities, including other aliens, from exposure to COVID-19. Similarly, covered aliens at coastal POEs and Border Patrol stations spend periods of time (i.e., hours or days) in the congregate holding areas of these facilities while they are processed for immigration purposes that are material from a public health perspective. All POEs and Border Patrol stations lack medical resources sufficient to provide the appropriate level of care required by those infected with COVID-19 and would be forced to rely on local health systems, many of which are straining to meet the medical needs of the domestic population.²⁷

Land and coastal POEs and Border Patrol stations are not structured or equipped to implement recommended COVID-19 screening, isolation/quarantine, or social distancing protocols for even small numbers of covered aliens. As noted in the March 20, 2020 Order, the holding areas of POEs and Border Patrol stations were designed for the purpose of short-term processing and holding in a congregate setting. The vast majority of these facilities lack the areas needed to effectively isolate or quarantine covered aliens while COVID-19 test results are pending. Moreover, the process of screening and isolating/quarantining covered aliens suspected of COVID-19 infection would require covered aliens to move throughout various sections of the facility, creating a risk of exposure to all nearby—including DHS personnel and other aliens.

I hereby amend the March 20, 2020 Order and April 20, 2020 Extension by adding the modifier “coastal” so that this Amended Order and Extension expressly applies to land and coastal

²⁵ DHS has advised CDC that “coastal borders” refers to any U.S. border that is adjacent to a waterway, rather than land. DHS has further advised CDC that “waterway” refers to any large body of water (e.g., Pacific Ocean, Atlantic Ocean, and Gulf of Mexico). For the purpose of this Order, “coastal” applies to any waterway from which persons traveling through Canada and Mexico may enter the United States (e.g. Pacific, Gulf of Mexico, Lake Michigan, Rio Grande).

²⁶ Indeed, the DHS enforcement statistics cited in the March 20, 2020 Order included apprehensions of inadmissible aliens who attempted to cross a U.S. coastal border. *See* Exhs. 2-3, Order Suspending Introduction of Certain Persons from Countries where a Communicable Disease Exists (Mar. 20, 2020), available at https://www.cdc.gov/quarantine/pdf/CDC-Order-Prohibiting-Introduction-of-Persons_Final_3-20-20_3-p.pdf.

²⁷ *See* CDC, COVID View Weekly Summary (updated May 8, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>.

POE and Border Patrol stations operated by DHS at or near the border with Canada or Mexico. Accordingly, the definition of “covered alien” is amended as follows:

Persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land or coastal Port of Entry (POE) or Border Patrol station at or near the United States border with Canada or Mexico, subject to exceptions.²⁸

This Amendment and Extension does not alter any of the exclusions or exceptions to the March 20, 2020 Order or April 20, 2020 Extension. Like the March 20, 2020 Order and April 20, 2020 Extension, the Amended Order and Extension does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE. The Amended Order and Extension also does not apply to persons whom customs officers determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests.²⁹ DHS shall consult with CDC concerning how these types of case-by-case, individualized exceptions shall be made to help ensure consistency with current CDC guidance and public health assessments.

VI. Extended Duration Subject to Recurring 30 Day Review

As discussed above, the number of confirmed cases of COVID-19 in Canada, Mexico, and the United States continue to increase. The COVID-19 public health emergency determination by the Secretary of HHS has remained in effect since February 4, 2020.³⁰ As individual states in the United States enter different phases of the pandemic, the demand for COVID-19-related care and the challenges of providing that care are rapidly changing. Although some states are beginning to relax restrictions and plan for the reopening of their communities, the reopening process will occur in phases that are closely tied to local infection rates, as well as other considerations. As the United States collectively determines how to best balance protecting public health with resuming normal activities, it is critical that the country continues to adhere to existing containment strategies, where possible—including the suspended introduction of covered aliens.

²⁸ CDC recognizes that in certain limited instances, a fact-based inquiry may be required to determine whether individuals are covered aliens within the meaning of the Amended Order and Extension. For example, it may be unclear whether individuals who arrive at a coastal border by boat departed from Mexico, or another country, such as Haiti. CDC defers to DHS regarding the operational considerations necessary to address such scenarios.

²⁹ In addition to CBP and U.S. Coast Guard officers, customs officers include any agent or other person, including foreign law enforcement officers, authorized by law or designated by the Secretary of Homeland Security to perform the duties of a customs officer. *See* 19 U.S.C. § 1401(i).

³⁰ Determination of Public Health Emergency, 85 Fed. Reg. 7316 (Feb. 7, 2020); *see also* HHS Secretary, “Renewal of Determination That A Public Health Emergency Exists,” April 21, 2020, available at: <https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-21apr2020.aspx>.

Furthermore, although stay-at-home orders and social distancing have been an important part of controlling the COVID-19 pandemic and “flattening the curve,” these strategies alone cannot eliminate the risk of COVID-19 in the United States. Lasting protection from COVID-19 will be achieved with a widely-available vaccine that confers immunity to the uninfected, widely-available therapeutics for those who are infected, or some combination of both.³¹ While there is unprecedented collaboration between public and private stakeholders to develop vaccines and therapeutics for COVID-19, a widely available finished product is still months away.

The public health risks that are the basis for this Amended Order and Extension are unlikely to abate in the coming months. Covered aliens cannot be introduced into the congregate holding areas of land and coastal POEs and Border Patrol stations without significantly increasing the risk of infection among DHS personnel and others in those facilities. Accordingly, this Amended Order and Extension shall remain in effect until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health.

CDC shall reassess the Order every 30 days to determine whether the latest relevant information regarding the COVID-19 pandemic warrants continued implementation, or whether the Order should be modified or terminated.

VII. Determination and Implementation

Based on both the foregoing and additional insight gained over the past two months, I find that the determinations underlying the March 20, 2020 Order and April 20, 2020 Extension remain correct, and that the situation in Canada, Mexico, and the United States continues to require suspension of the introduction of covered aliens into land and coastal POEs and Border Patrol stations at or near the border in order to protect the public health from COVID-19.

The March 20, 2020 Order and April 20, 2020 Extension were based on the risk of introduction of individuals who have traveled through Canada and Mexico into the congregate settings of POEs and Border Patrol stations. Because COVID-19 is a contagious disease spreading throughout Canada and Mexico, individuals coming from these countries pose a risk of introducing or spreading COVID-19 into the United States once they enter POEs and Border Patrol stations at or near the border. Because covered aliens lack proper immigration documentation for entering the United States, they would have been likely to spend a material amount of time (i.e., hours or days) in the congregate holding areas of POEs and Border Patrol stations while they undergo immigration processing. POEs and Border Patrol stations have capacity only for short-term processing and holding of inadmissible aliens. They were never intended to provide the medical screening, monitoring, and isolation functions needed to contain COVID-19, especially on the scale demanded by the ongoing pandemic. As POEs and Border Patrol stations lack appropriate medical capabilities, any COVID-19-related care of covered aliens would have to be met by local healthcare systems in the United States, which are already straining to respond to the needs of the domestic population.

³¹ CDC does not consider Remdesivir to be a therapeutic for COVID-19 for the purposes of the Amended Order and Extension because Remdesivir is not currently approved by the Food and Drug Administration to treat COVID-19.

Moreover, due to their lack of legal immigration status, there is significant uncertainty that covered aliens would be able to effectively self-quarantine, self-isolate, or otherwise comply with existing social distancing guidelines, if they were conditionally released. CDC and local public health jurisdictions simply lack the resources and personnel necessary to effectively monitor covered aliens who would otherwise be conditionally released into the United States but for the Order. Accordingly, covered aliens must be returned to the country from which they entered the United States, to their country of origin, or to another appropriate location.

The statistical information provided by DHS shows the March 20, 2020 Order and April 20, 2020 Extension have significantly reduced the number of covered aliens in custody at POEs and Border Patrol stations, practically eliminating one channel through which COVID-19 can enter the United States. In light of the current lack of a widely-available vaccine or therapeutic for COVID-19, protecting the public health warrants further extending the Order.

Accordingly, I determine that COVID-19 remains a contagious disease that is present in many countries including Canada and Mexico; covered aliens arriving from those countries pose a risk of further introducing or spreading COVID-19 into the United States while they are held in the congregate holding areas of POEs and Border Patrol stations at or near the border; and this risk is serious enough to require suspending the introduction of such covered aliens into all land and coastal POEs and Border Patrol stations at or near the border with Canada or Mexico that would otherwise hold covered aliens in a congregate setting.

I consulted with DHS before issuing this Amended Order and Extension and requested that DHS continue to implement the operational plan developed to carry out the March 20, 2020 Order and April 20, 2020 Extension because CDC does not have the capability, resources, or personnel needed to alternatively issue quarantine or isolation orders.³²

This Amended Order and Extension applies to all persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in any land or coastal POE or Border Patrol station at or near the border with Canada and Mexico, subject to exceptions.

This Amended Order and Extension does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE. Additionally, this Amended Order and Extension does not apply to persons whom customs officers determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian,

³² As previously discussed in the March 20, 2020 Order, CDC relies on the Department of Defense, other federal agencies, and state and local governments to provide both logistical support and facilities for federal quarantines. *See* 42 U.S.C. § 268(b) (requiring customs and Coast Guard officers to aid in the enforcement of quarantine regulations). CDC lacks the resources, staffing, and facilities to quarantine covered aliens. Similarly, DHS has informed CDC that in the near term, it is not financially or logistically practicable for DHS to build additional facilities at POEs and Border Patrol stations for purposes of quarantine or isolation.

and public health interests. DHS shall consult with CDC concerning how these types of case-by-case, individualized exceptions shall be made to help ensure consistency with current CDC guidance and public health assessments.

This Amended Order and Extension is not a rule subject to notice and comment under the Administrative Procedure Act (APA). In the event this order qualifies as a rule subject to notice and comment, a delay in effective date is not required because the foregoing discussion shows that there is good cause to dispense with prior public notice and the opportunity to comment on this order and a delay in effective date.³³ Given the public health emergency caused by COVID-19, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay the issuing and effective date of this Order. In addition, because this Order concerns ongoing discussions with Canada and Mexico on how to best control COVID-19 transmission over our shared borders, it directly “involve[s] . . . a . . . foreign affairs function of the United States.” 5 U.S.C. § 553(a)(1). Notice and comment and a delay in effective date would not be required for that reason as well.

This Amended Order and Extension goes into effect at 12:00 a.m. Eastern Daylight Time (EDT) on May 21, 2020 and shall remain in effect until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, and the continuation of the Order is no longer necessary to protect the public health. Upon making this determination, I will publish a notice in the Federal Register terminating this Order and its Extensions. CDC shall reassess the Order every 30 days to determine whether current conditions warrant continued implementation, modification, or termination of the Order. I may further amend or extend the Order as needed to protect the public health.

In testimony whereof, the Director, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, has hereunto set his hand at Washington, D.C. this 19th day of May, 2020.



Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention

³³ See 5 U.S.C. § 553(b)(B) and (d)(3).

**US DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

**ORDER UNDER SECTIONS 362 & 365 OF THE PUBLIC HEALTH SERVICE ACT
(42 U.S.C. §§ 265, 268):**

**ORDER SUSPENDING INTRODUCTION OF
CERTAIN PERSONS FROM COUNTRIES
WHERE A COMMUNICABLE DISEASE EXISTS**

I. Purpose and Application

I issue this order pursuant to Sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. §§ 265, 268, and their implementing regulations, which authorize the Director of the Centers for Disease Control and Prevention (CDC) to suspend the introduction of persons into the United States when the Director determines that the existence of a communicable disease in a foreign country or place creates a serious danger of the introduction of such disease into the United States and the danger is so increased by the introduction of persons from the foreign country or place that a temporary suspension of such introduction is necessary to protect the public health.

This order applies to persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land Port of Entry (POE) or Border Patrol station at or near the United States borders with Canada and Mexico, subject to the exceptions detailed below. The danger to the public health that results from the introduction of such persons into congregate settings at or near the borders is the touchstone of this order.

This order is necessary to protect the public health from an increase in the serious danger of the introduction of Coronavirus Disease 2019 (COVID-19) into the land POEs, and the Border Patrol stations between POEs, at or near the United States borders with Canada and Mexico. Those facilities are operated by U.S. Customs and Border Protection (CBP), an agency within the U.S. Department of Homeland Security (DHS). This order is also necessary to protect the public health from an increase in the serious danger of the introduction of COVID-19 into the interior of the country when certain persons are processed through the same land POEs and Border Patrol stations and move into the interior of the United States.

There is a serious danger of the introduction of COVID-19 into the land POEs and Border Patrol stations at or near the United States borders with Canada and Mexico, and into the interior of the country as a whole, because COVID-19 exists in Canada, Mexico, and the other countries of origin of persons who migrate to the United States across the United States land borders with Canada and Mexico. Those persons are subject to immigration processing in the land POEs and Border Patrol stations. Many of those persons (typically aliens who lack valid travel documents and are therefore inadmissible) are held in the common areas of the facilities, in close proximity to one another, for hours or days, as they undergo immigration processing. The common areas of such facilities were not designed for, and are not equipped to, quarantine, isolate, or enable social distancing by persons who are or may be infected with COVID-19. The introduction into

congregate settings in land POEs and Border Patrol stations of persons from Canada or Mexico increases the already serious danger to the public health to the point of requiring a temporary suspension of the introduction of such persons into the United States.

The public health risks of inaction are stark. They include transmission and spread of COVID-19 to CBP personnel, U.S. citizens, lawful permanent residents, and other persons in the POEs and Border Patrol stations; further transmission and spread of COVID-19 in the interior; and the increased strain that further transmission and spread of COVID-19 would put on the United States healthcare system and supply chain during the current public health emergency.

These risks are troubling because POEs and Border Patrol stations were not designed and are not equipped to deliver medical care to numerous persons, nor are they capable of providing the level of care that vulnerable populations with COVID-19 may require. Indeed, CBP typically transfers persons with acute presentations of illness to local or regional healthcare providers for treatment. Outbreaks of COVID-19 in land POEs or Border Patrol stations would lead to transfers of such persons to local or regional health care providers, which would exhaust the local or regional healthcare resources, or at least reduce the availability of such resources to the domestic population, and further expose local or regional healthcare workers to COVID-19.^[1] The continuing availability of healthcare resources to the domestic population is a critical component of the Federal government's overall public health response to COVID-19. Action is required.

As stated above, this order applies to persons traveling from Canada or Mexico (regardless of their country of origin) who would otherwise be introduced into a congregate setting in a land POE or Border Patrol station at or near the United States border with Canada or Mexico, subject to exceptions. This order does not apply to U.S. citizens, lawful permanent residents, and their spouses and children; members of the armed forces of the United States, and associated personnel, and their spouses and children; persons from foreign countries who hold valid travel documents and arrive at a POE; or persons from foreign countries in the visa waiver program who are not otherwise subject to travel restrictions and arrive at a POE. Additionally, this order does not apply to persons whom customs officers of DHS determine, with approval from a supervisor, should be excepted based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests. DHS shall consult with CDC concerning how these types of case-by-case, individualized exceptions shall be made to help ensure consistency with current CDC guidance and public health assessments.

DHS has informed CDC that persons who are traveling from Canada or Mexico (regardless of their country of origin), and who must be held longer in congregate settings in POEs or Border Patrol stations to facilitate immigration processing, would typically be aliens seeking to enter the United States at POEs who do not have proper travel documents, aliens whose entry is otherwise contrary to law, and aliens who are apprehended near the border seeking to unlawfully enter the United States between POEs. This order is intended to cover all such aliens.

^[1] An outbreak of COVID-19 among CBP personnel in land POEs or Border Patrol stations would impact CBP operations negatively. Although not part of the CDC public health analysis, it bears emphasizing that the impact on CBP could reduce the security of U.S. land borders and the speed with which cargo moves across the same.

For simplicity, I shall refer to the persons covered by this order as “covered aliens.” I suspend the introduction of all covered aliens into the United States for a period of 30 days, starting from the date of this order. I may extend this order if necessary to protect the public health.

II. Factual Basis for Order¹

1. COVID-19 is a global pandemic that has spread rapidly

COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, that was first identified as the cause of an outbreak of respiratory illness that began in Wuhan, Hubei Province, People’s Republic of China (China).²

COVID-19 appears to spread easily and sustainably within communities.³ The virus is thought to transfer primarily by person-to-person contact through respiratory droplets produced when an infected person coughs or sneezes; it may also transfer through contact with surfaces or objects contaminated with these droplets.⁴ There is also evidence of asymptomatic transmission, in which an individual infected with COVID-19 is capable of spreading the virus to others before exhibiting symptoms.⁵ The ease of transmission presents a risk of a surge in hospitalizations for COVID-19, which would reduce available hospital capacity. Such a surge has been identified as a likely contributing factor to the high mortality rate for COVID-19 cases in Italy and China.⁶

Symptoms include fever, cough, and shortness of breath, and typically appear 2-14 days after exposure.⁷ Manifestations of severe disease have included severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure.⁸ According to the WHO, approximately 3.4% of reported COVID-19 cases have resulted in death globally.⁹ This

¹ Given the dynamic nature of the public health emergency, CDC recognizes that the types of facts and data set forth in this section may change rapidly (even within a matter of hours). The facts and data cited by CDC in this order represent a good-faith effort by the agency to present the current factual justification for the order.

² Centers for Disease Control and Prevention, Situation Summary (Mar. 15, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html>.

³ Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (Mar. 10, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

⁴ *Id.*

⁵ Centers for Disease Control and Prevention, Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) (Mar. 7, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

⁶ Ariana Eunjung Cha, Washington Post, Spiking U.S. Coronavirus Cases Could Force Rationing Decisions Similar to Those Made in Italy, China (Mar. 15, 2020), available at <https://www.washingtonpost.com/health/2020/03/15/coronavirus-rationing-us/>.

⁷ Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19) (Mar. 16, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>.

⁸ *Supra*, note 4.

⁹ WHO Director-General’s Opening Remarks at the Media Briefing on COVID-19 (Mar. 3, 2020), available at

mortality rate is higher among older adults or those with compromised immune systems.¹⁰ Older adults and people who have severe chronic medical conditions like heart, lung, or kidney disease are also at higher risk for more serious COVID-19 illness.¹¹ Early data suggest older people are twice as likely to have serious COVID-19 illness.¹²

As of March 17, 2020, there were over 179,112 cases of COVID-19 globally in 150 locations, resulting in over 7,426 deaths; more than 4,226 cases have been identified in the United States, with new cases being reported daily and over 75 deaths due to the disease.¹³

Unfortunately, at this time, there is no vaccine against COVID-19, nor are there any approved therapeutics available for those who become infected. Treatment is currently limited to supportive care to manage symptoms. Hospitalization may be required in severe cases and mechanical respiratory support may be needed in the most severe cases. Testing is available to confirm suspected cases of COVID-19 infection. Testing requires specimens collected from the nose, throat or lungs; specimens can only be analyzed in a laboratory setting. At present, results are typically available within three to four days.¹⁴ There is currently no rapid test for COVID-19 that can provide results at the time of sample collection, although efforts are underway to develop such a test.

On January 30, 2020, the Director General of the WHO declared COVID-19 to be a Public Health Emergency of International Concern under the International Health Regulations.¹⁵ The following day, the Secretary of Health and Human Services (HHS) declared that COVID-19 is a public health emergency under the Public Health Service Act (PHSA).¹⁶ On March 11, 2020, the

<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---3-march-2020>.

¹⁰ *Supra*, note 4.

¹¹ *Id.*

¹² *Id.*

¹³ Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Cases in U.S. (Mar. 17, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-in-us.html; World Health Organization, Coronavirus disease 2019 (COVID-19) Situation Report – 57 (Mar. 17, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200317-sitrep-57-covid-19.pdf?sfvrsn=a26922f2_2, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200317-sitrep-57-covid-19.pdf?sfvrsn=a26922f2_2.

¹⁴ Centers for Disease Control and Prevention, Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19) (Mar. 13, 2020), available at <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>.

¹⁵ World Health Organization, Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV) (January 30, 2020), [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov)).

¹⁶ U.S. Dept. of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, Determination that a Public Health Emergency Exists (January 31, 2020), <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

WHO officially classified the global COVID-19 outbreak as a pandemic.¹⁷ On March 13, 2020, the President issued a Presidential Declaration that COVID-19 constitutes a National Emergency.¹⁸ Likewise, all U.S. states, territories, and the District of Columbia have declared a state of emergency in response to the growing spread of COVID-19.¹⁹

Global efforts to slow the spread of COVID-19 have included sweeping travel limitations. Countries such as Japan, Australia, Israel, Russia, and the Philippines have imposed stringent restrictions on travelers who have recently been in China, the epicenter of the pandemic. Similar travel restrictions have since been imposed on individuals from places experiencing substantial outbreaks, including the Islamic Republic of Iran (Iran), South Korea, and Europe. In many countries, individuals are being asked to self-quarantine for 14 days—the outer limit of the COVID-19’s estimated incubation period—following return from a foreign country with sustained community transmission.²⁰

In the United States, the President has suspended the entry of most travelers from China (excluding Hong Kong and Macau), Iran, the Schengen Area of Europe,²¹ the United Kingdom (excluding overseas territories outside of Europe), and the Republic of Ireland, due to COVID-19.²² CDC has issued Level 3 Travel Health Notices recommending that travelers avoid all nonessential travel to China (excluding Hong Kong and Macau), Iran, South Korea, and most of Europe.²³ The U.S. Department of State has issued a global Level 4 Do Not Travel Advisory advising travelers to avoid all international travel due to the global impact of COVID-19.²⁴ In

¹⁷ World Health Organization, WHO Director-General’s opening remarks at the media briefing on COVID-19 – 11 (March 11, 2020), <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>.

¹⁸ Message to Congress on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak (March 13, 2020) <https://www.whitehouse.gov/briefings-statements/message-congress-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>.

¹⁹ National Governors Assn., Coronavirus: What You Need to Know, (last updated March 17, 2020) <https://www.nga.org/coronavirus/#states>.

²⁰ James Asquith, [Update] Complete Coronavirus Travel Guide – The Latest Countries Restricting Travel, (March 16, 2020), <https://www.forbes.com/sites/jamesasquith/2020/03/15/complete-coronavirus-travel-guide-the-latest-countries-restricting-travel/#2fdc3b7d715b>.

²¹ For purposes of this order, the Schengen Area comprises 26 European states: Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, and Switzerland.

²² Proclamation on the Suspension of Entry as Immigrants and Nonimmigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus (March 14, 2020) <https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-certain-additional-persons-pose-risk-transmitting-coronavirus-2/>.

²³ Centers for Disease Control and Prevention, Travelers’ Health, COVID – 19 in Europe, Warning – Level 3, Avoid Nonessential Travel – Widespread Ongoing Transmission (March 11, 2020) <https://wwwnc.cdc.gov/travel/notices/warning/coronavirus-europe>.

²⁴ U.S. Dept. of State, Bureau of Consular Affairs, Global Level 4 Health Advisory – Reconsider Travel (March 15, 2020) <https://travel.state.gov/content/travel/en/traveladvisories/ea/travel-advisory-alert-global-level-4-health-advisory-issue.html>.

addition, CDC has recommended that travelers, particularly those with underlying health conditions, avoid all cruise ship travel worldwide.²⁵ The U.S. Department of State has similarly issued guidance that U.S. citizens should not travel by cruise ship at this time.²⁶

The Federal government announced guidelines stating that the public should avoid discretionary travel; shopping trips; social visits; gatherings in groups of more than 10 people; and eating or drinking at bars, restaurants, and food courts.²⁷ Numerous states and localitieslocalitieslocalitieslocalitieslocalitieslocalitieslocalities have gone further and shut down restaurants, bars, nightclubs, and theaters. For example, 6 counties surrounding San Francisco, California have issued shelter in place orders impacting nearly 7 million residents.²⁸ Similar measures are being considered in other cities.²⁹

2. COVID-19 exists in Canada and Mexico

i. Persons from Canada and other foreign countries where COVID-19 exists cross into the United States from Canada frequently

As of March 17, 2020, Canada has reported 424 confirmed cases of COVID-19, of which the Canadian government believes 74% are travel-related with an additional 6% being close contacts of travelers.³⁰ This is a 115% increase in confirmed cases in four days.³¹ The provinces of Ontario and British Columbia have reported the most COVID-19 cases, with Ontario reporting a 29% increase in confirmed cases in a single day.³² Canada's Chief Public Health Officer stated that community transmission of COVID-19 is occurring in multiple provinces and Ottawa public

²⁵ Centers for Disease Control and Prevention, Travelers' Health, COVID – 19 and Cruise Ship Travel, Warning – Level 3, Avoid Nonessential Travel (March 17, 2020) <https://wwwnc.cdc.gov/travel/notices/warning/coronavirus-cruise-ship>.

²⁶ U.S. Dept. of State, Bureau of Consular Affairs, Current Outbreak of Coronavirus Disease 2019 (March 14, 2020) <https://travel.state.gov/content/travel/en/traveladvisories/ea/covid-19-information.html>.

²⁷ The White House & Centers for Disease Control and Prevention, 15 Days to Slow the Spread (Mar. 15, 2020), available at https://www.whitehouse.gov/wp-content/uploads/2020/03/03.16.20_coronavirus-guidance_8.5x11_315PM.pdf.

²⁸ Erin Allday, San Francisco Chronicle, Bay Area Orders 'Shelter in Place' Only Essential Businesses Open in 6 Counties (Mar. 18, 2020), available at <https://www.sfchronicle.com/local-politics/article/Bay-Area-must-shelter-in-place-Only-15135014.php>.

²⁹ Noah Higgins-Dunn & William Feuer, CNBC, New Yorkers Should be Prepared for a 'Shelter-In-Place,' Mayor Bill de Blasio says (Mar. 18, 2020), available at <https://www.cnbc.com/2020/03/17/new-yorkers-should-be-prepared-for-a-shelter-in-place-order-mayor-bill-de-blasio-says.html>.

³⁰ Government of Canada, Coronavirus disease (COVID-19): Outbreak update (Mar. 15, 2020), <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html>.

³¹ National Post, The Latest Numbers of COVID-19 Cases in Canada as of March 13, 2020 (Mar. 13, 2020), available at <https://nationalpost.com/pmnn/news-pmnn/canada-news-pmnn/the-latest-numbers-of-covid-19-cases-in-canada-as-of-march-13-2020>.

³² Ryan Rocca, Global News, Coronavirus: Ontario reports 39 new COVID-19 cases, provincial total rises to 142 (Mar. 15, 2020), https://globalnews.ca/news/6679409/ontario-coronavirus-update-march-15/?utm_source=site_banner.

health officials believe that there are at least 1,000 undiagnosed cases in the Canadian capital alone.³³ In an effort to slow the transmission and spread of the virus, the Canadian government banned foreign nationals from all countries except the United States from entering Canada and mandated that returning Canadians self-monitor for COVID-19 symptoms for 14 days following their return, effective March 18, 2020.³⁴

The United States and Canada share the longest international border in the world, spanning approximately 3,987 (largely unfenced) miles with 119 ports of entry.³⁵

In 2017, approximately 33 million individuals crossed the Canadian border into the United States.³⁶ Through February of Fiscal Year (FY) 2020, DHS has processed 20,166 inadmissible aliens at POEs at the U.S.-Canadian border, and CBP has apprehended 1,185 inadmissible aliens attempting to unlawfully enter the United States between POEs.³⁷ These aliens have included not only Canadian nationals, but also 1,062 Iranian nationals, 1,396 Chinese nationals, and 1,326 nationals of Schengen Area countries—all of which currently have COVID-19 outbreaks. Indeed, the United States government has determined that China, Iran, and the countries of the Schengen Area are experiencing sustained person-to-person transmittal of the disease.³⁸ As of March 15, 2020, the WHO reports that China has 81,048 confirmed cases and 3,204 deaths; Iran has 12,729 confirmed cases and 608 deaths³⁹; and the Schengen Area has almost 42,000 confirmed cases.⁴⁰ The total number of COVID-19 infections in these countries is impracticable to quantify due to the inherent limitations of epidemiological surveillance, but are likely higher than the reported number of confirmed cases because COVID-19 can be present in asymptomatic persons.

³³ Adam Miller, Canadian Broadcast Corporation, ‘The Time is Now to Act’: COVID-19 spreading in Canada With no Known Link to Travel, Previous Cases (Mar. 16, 2020), available at <https://www.cbc.ca/news/health/coronavirus-community-transmission-canada-1.5498804>; CBC News, Canadian Broadcast Corporation, Community Spread of COVID-19 in Ottawa Likely, Says OPH (Mar. 15, 2020), available at <https://www.cbc.ca/news/canada/ottawa/5-new-covid-cases-ottawa-1.5498489>.

³⁴ Government of Canada, Coronavirus disease (COVID-19): Canada’s Response, At Canadian Borders (Mar. 16, 2020), available at <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/canadas-reponse.html#acb>.

³⁵ Janice Cheryh Beaver, Congressional Research Service, U.S. International Borders: Brief Facts (Feb. 1, 2007), available at https://www.everycrsreport.com/files/20070201_RS21729_514d6fe01555a06aa58c33fd1d8cf34ad1dc50f8.pdf.

³⁶ Les Perreux, The Globe and Mail, Rejection Rate on the Rise for Canadians at U.S. Border (Apr. 14, 2017), available at <https://www.theglobeandmail.com/news/national/rejection-rate-on-the-rise-for-canadians-at-us-border/article34262237/>.

³⁷ Exhibits 2 and 3, attached.

³⁸ The White House, Proclamation—Suspension of Entry as Immigrants and Nonimmigrants of Certain Additional Persons Who Pose a Risk of Transmitting 2019 Novel Coronavirus (Mar. 11, 2020), available at <https://www.whitehouse.gov/presidential-actions/proclamation-suspension-entry-immigrants-nonimmigrants-certain-additional-persons-pose-risk-transmitting-2019-novel-coronavirus/>.

³⁹ World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report – 55 (Mar. 15, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200315-sitrep-55-covid-19.pdf?sfvrsn=33daa5cb_8.

⁴⁰ *Id.*

On March 18, 2020, the President announced that the United States “will be, by mutual consent, temporarily closing our Northern Border with Canada to non-essential traffic,” and DHS will be issuing guidance on the implementation of that arrangement, including exceptions for “essential travels.”

ii. Mexico expects community transmission of COVID-19 and has been slower to implement public health measures

According to WHO, as of March 17, 2020, Mexico has only 53 confirmed cases of COVID-19, all found to be travel related, and no deaths.⁴¹ Some Mexican public health experts believe the number of COVID-19 cases in the country is much higher and that Mexico will see widespread community transmission of the virus in the near future.⁴² A Deputy Health Minister in Mexico has attributed Mexico’s low number of confirmed cases to the virus having been first detected in Mexico on February 27, 2020, approximately one month after the first confirmed cases in the United States.⁴³ The same official also stated that, based on the Mexican government’s modeling, Mexico expects community transmission of COVID-19 to begin between 15 and 40 days from the first confirmed case (in other words, as early as March 13, 2020).⁴⁴

Mexico is only now undertaking some of the public health measures to mitigate the spread of the virus.⁴⁵ Schools will be closed from March 20 until April 20, and some large public events are being cancelled.⁴⁶ However, many events, such as professional soccer games, have gone

⁴¹ *Id.* World Health Organization, Coronavirus Disease 2019 (COVID-19) Situation Report – 57 (Mar. 17, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200317-sitrep-57-covid-19.pdf?sfvrsn=a26922f2_4.

⁴² Andrea Ano, Latin Post, Experts Question Mexico's Coronavirus Preparations (Mar. 15, 2020), available at <http://www.latinpost.com/articles/144156/20200315/experts-question-mexicos-coronavirus-preparations.htm>; Mexico News Daily, One Former Health Minister Critical of Coronavirus Response (Mar. 14, 2020), available at <https://mexiconewsdaily.com/news/former-health-secretary-critical-of-coronavirus-response/>.

⁴³ Mexico News Daily, Why so few Cases of Coronavirus? Deputy Minister Explains In Other Countries the Disease was Detected Earlier (Mar. 13, 2020), available at <https://mexiconewsdaily.com/news/why-so-few-cases-of-coronavirus-deputy-minister-explains/>.

⁴⁴ Mexico News Daily, Business Insider, A Widespread Outbreak of Coronavirus in Mexico is 'Inevitable,' Health Officials Say (Mar. 13, 2020), available at <https://www.businessinsider.com/widespread-outbreak-of-coronavirus-in-mexico-is-inevitable-2020-3>.

⁴⁵ Patrick J. McDonnell, Katie Linthicum, Tracy Wilkinson, L.A. Times, Mexico, Latin America Gear up for Next Phase of Coronavirus Threat (Mar. 14, 2020), available at <https://www.latimes.com/world-nation/story/2020-03-14/mexico-latin-america-gear-up-for-next-phase-of-coronavirus-threat>; cf. Dave Graham, Reuters, Mexico Government Urges Public to Keep Distance Over Coronavirus; President Embraces Crowds (Mar. 15, 2020), available at <https://www.reuters.com/article/us-health-coronavirus-mexico/mexico-government-urges-public-to-keep-distance-over-coronavirus-president-embraces-crowds-idUSKBN2130A0>.

⁴⁶ Alexis Ortiz & Karla Linares, El Universal, COVID-19: Mexico to Suspend Classes Over Coronavirus Concerns (Mar. 14, 2020), available at <https://www.eluniversal.com.mx/english/covid-19-mexico-suspend-classes-over-coronavirus-concerns>.

forward as planned.⁴⁷ Mexico has not announced any restrictions on persons entering the country from areas with sustained human-to-human transmission of the disease.⁴⁸ There are currently no COVID-19 health screenings at Mexico's international airports, although Mexican officials have announced that some additional screening measures may be implemented.⁴⁹ Medical experts believe that community transmission and spread of COVID-19 at asylum camps and shelters along the U.S. border is inevitable, once community transmission begins in Mexico.⁵⁰

Mexico has fewer health care resources than the United States. Mexico's total expenditure on health care per capita is \$1,122, compared to the United States' \$9,403 per person.⁵¹ On average, there are only 1.38 available hospital beds per every 1,000 inhabitants in Mexico, compared to 2.77 available hospital beds per every 1,000 inhabitants in the United States.⁵² Similarly, there are approximately 2.2 practicing doctors and 2.9 practicing nurses per every 1,000 inhabitants in Mexico, compared to 2.6 practicing doctors and 8.6 practicing nurses per every 1,000 inhabitants in the United States.⁵³ This raises public health concerns, given that Mexico is likely to reach community transmission soon (including in asylum camps and shelters).

While Mexico responded vigorously to the H1N1 pandemic in 2009-2010, Mexico does not appear to be approaching the COVID-19 pandemic with the same dispatch. In 2003, Mexico established the National Preparedness and Response Plan for an Influenza Pandemic, which was first tested during the 2009 outbreak of H1N1 influenza. Mexico helped contain that outbreak, primarily through early detection of the outbreak, followed by the declaration of a "sanitary emergency" that focused on raising public awareness of the need to contain the spread with proper hygiene, school closings, cancellation of large public gatherings, and aggressive surveillance through widespread testing.⁵⁴ Mexico does not appear to have undertaken equivalent measures in

⁴⁷ Kirk Semple, The N.Y. Times, 'We Call for Calm': Mexico's Restrained Response to the Coronavirus (Mar. 15, 2020), available at <https://www.nytimes.com/2020/03/15/sports/soccer/soccer-mexico-coronavirus.html>.

⁴⁸ Wendy Fry, The San Diego Union-Tribune, While Impacts of Coronavirus Remain Mild in Baja California, Mexico Begins Bracing for Outbreak (Mar. 13, 2020), available at <https://www.sandiegouniontribune.com/news/border-baja-california/story/2020-03-13/impacts-of-coronavirus-remain-mild-in-baja-california>.

⁴⁹ *Id.*

⁵⁰ Rick Jervis, USA Today, Migrants Waiting at U.S.-Mexico Border at Risk of Coronavirus, Health Experts Warn (Mar. 17, 2020), available at <https://www.usatoday.com/story/news/nation/2020/03/17/us-border-could-hit-hard-coronavirus-migrants-wait-mexico/5062446002/>; Rafael Carranza, AZ Central, New World's Largest Border Crossing, Tijuana Shelters Eye the new Coronavirus with Worry (Mar. 14, 2020), available <https://www.azcentral.com/story/news/politics/immigration/2020/03/14/tijuana-migrant-shelters-coronavirus-covid-19/5038134002/>.

⁵¹ Compare WHO, Mexico—Statistics, <https://www.who.int/countries/mex/en/>, with WHO, United States of America—Statistics, <https://www.who.int/countries/usa/en/>.

⁵² See Organization for Economic Co-operation and Development ("OECD"), Data—Hospital Beds, <https://data.oecd.org/health/hospital-beds.htm>.

⁵³ Compare The World Bank, Data—Physicians (per 1,000 people), <https://data.worldbank.org/indicator/SH.MED.PHYS.ZS>, with The World Bank, Data—Nurses and Midwives (per 1,000 people), <https://data.worldbank.org/indicator/SH.MED.PHYS.ZS>.

⁵⁴ See Jose A. Cordova-Villalobos et al., The influenza A (H1N1) epidemic in Mexico: Lessons learned, Health Research Policy & Systems 7:21 (Sept. 28, 2009); Gerardo Chowell, Characterizing the Epidemiology of the 2009

response to the COVID-19 pandemic. COVID-19 is more infectious than H1N1, and so CDC expected a more vigorous Mexican response to COVID-19, which has not occurred.

It also bears noting that Mexico struggled to mobilize its strategic stockpile of the antiviral drug Oseltamivir during the 2009-2010 H1N1 outbreak.⁵⁵ The entire strategic stockpile was centrally stored as dry bulk product, and the national pandemic preparedness plan called for the dry bulk to be distributed to and reconstituted by Mexico's 31 state-level public health laboratories.⁵⁶ After the onset of the outbreak, Mexican authorities realized that the network of labs they intended to rely on were not properly equipped or authorized to prepare the antiviral medication, leading to complications in implementing the planned response.⁵⁷ A comparative assessment of national pandemic preparedness plans found that Mexico's plan was missing key annexes regarding case management, surveillance, communication, laboratory sample and transport, public health measures, and plans for private business.⁵⁸ While no public health response is perfect, and testing for COVID-19 has presented global challenges, the experience of Mexican laboratories during the H1N1 outbreak raises concerns about their current capabilities.

The existence of COVID-19 in Mexico presents a serious danger of the introduction of COVID-19 into the United States for these reasons, and because the level of migration across the United States border with Mexico is so high. The U.S.-Mexico border runs an estimated 1,933 miles.⁵⁹ To date in fiscal year (FY) 2020, DHS has processed 34,141 inadmissible aliens at POEs along the border, and U.S. Border Patrol has apprehended 117,305 aliens attempting to unlawfully enter the United States between POEs, almost 110,000 of whom reported Mexican citizenship.⁶⁰ Over 15,000 were nationals of other countries that are now experiencing sustained human to human transmission of COVID-19, including approximately 1,500 Chinese nationals and 6,200 Brazilian nationals.⁶¹

Influenza A/H1N1 Pandemic in Mexico, PLOS Med 8(5): e1000436 (May 24, 2011).

⁵⁵ Luis Meave Gutierrez-Mendoza et al., Lessons from the Field: Oseltamivir storage, distribution and dispensing following the 2009 H1N1 influenza outbreak in Mexico, Bull World Health Organ, 90:782-787 (Aug. 17, 2012).

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ WHO, Comparative Analysis of National Pandemic Influenza Preparedness Plans (Jan. 2011), available at https://www.who.int/influenza/resources/documents/comparative_analysis_php_2011_en/en/.

⁵⁹ *Supra*, note 36.

⁶⁰ Exhibits 2 and 3, attached.

⁶¹ *Id.*

3. Land POEs and Border Patrol stations are congregate settings that present infection control challenges

CBP screens and processes millions of aliens who seek to enter the United States legally each year at POEs, as well as apprehending, screening, and processing the hundreds of thousands of aliens who attempt to unlawfully enter the United States each year by crossing between POEs. *See* Exhibits 2-3 (charts summarizing number of apprehensions and inadmissible aliens in FY 2020, as of Mar. 3, 2020). Apprehended aliens vary significantly by age and health status. At this time, the majority tend to be adults between 25 and 40 years old, and include those with chronic health problems such as diabetes and high blood pressure (which are comorbidities known to increase the health risks associated with COVID-19 infections and, thus, the likelihood of requiring medical intervention after infection).⁶²

i. Covered aliens in land POEs who CBP screens and processes for admissibility spend hours or days in congregate areas

There are 328 land POEs along the northern and southern borders operated by CBP. At land POEs, CBP screens and processes the millions of U.S. citizens, lawful permanent residents, and other aliens who seek to enter the United States from Canada and Mexico every year.

One of the CBP's critical functions at POEs is to screen and process arriving aliens to determine whether they are admissible to the United States. CDC understands from DHS that inadmissible aliens are typically those who do not have proper travel documents to enter or whose entry is otherwise contrary to law, such as those who are interdicted attempting to smuggle contraband into the United States. It takes CBP much longer to screen inadmissible aliens than U.S. citizens, lawful permanent residents, and aliens with valid travel documents, all of whom tend to move quickly into the United States after contact with CBP personnel and other travelers at POEs. This difference is due in part to the fact that inadmissible aliens tend to arrive by foot (not vehicle), and lack documentation. Inadmissible aliens in land POEs may spend hours or days in congregate areas while undergoing processing. During that time, they are in close proximity to CBP personnel and other travelers, including U.S. citizens and other aliens.

The admissibility of each alien is determined by a CBP officer. As part of the current admissibility screening, aliens are subject to an initial set of questions designed to elicit their risk factors for various contagious diseases, including COVID-19. Questions would include recent travel and any physical symptoms they are experiencing. CBP officers also use this initial questioning to visually observe arrivals for any obvious signs of illness. Those whose appearance or responses indicate possible exposure to or infection with COVID-19 are directed to don a surgical mask, and are escorted by a CBP officer (also wearing a surgical mask) for further evaluation and risk assessment by the contract medical staff, which is conducted in a designated area within the POE.

Presently, if CBP determines that an alien may be exposed to or infected with COVID-19, the alien is escorted to a separate, enclosed waiting area (usually a small holding room adjacent to

⁶² *Supra*, note 4.

normal processing areas) while CBP alerts the relevant health authorities. Specifically, CBP notifies the local health department, CDC, and CBP's Senior Medical Advisor. Local health officials and possibly CDC personnel if available, then consult with CBP to determine whether the individual should be tested for COVID-19 and where that testing should occur. CBP follows guidance from CDC and local health officials regarding transport to the testing site. If the alien is sent for testing in an ambulance, a CBP officer will accompany the individual in the ambulance. If CBP vehicles are used for transport, they are disinfected afterwards. In addition, CBP will consult with U.S. Immigration and Customs Enforcement (ICE) officials regarding the transport of the alien outside of the POE, given that the individual leaving the CBP facility does not have a preexisting legal right to enter the United States and must remain in custody while testing and treatment is carried out.

These infection control procedures are not easily scalable for large numbers of aliens. Moreover, an influx of infected, asymptomatic aliens would present significant infection control challenges for CBP, as the screening of such an aliens may not prompt testing. The aliens would remain in congregate areas in the POE while CBP finishes the screening and processing. During that time, the alien could infect CBP personnel or other aliens with COVID-19.

ii. Border Patrol stations present greater infection control challenges than POEs because they often have less space and fewer resources

In addition to the 328 POEs, CBP operates a network of Border Patrol stations to apprehend, process, and temporarily hold aliens seeking to unlawfully enter the United States *between* POEs. CBP has a total of 136 Border Patrol stations along the land and coastal borders, and many Border Patrol stations, particularly along the Southwest border, are in remote locations.

Border Patrol stations vary significantly in terms of size and layout, but generally have several congregate holding areas where covered aliens are divided based on demographic factors such as age, gender, and family status, as required by law. A typical Border Patrol station is designed to temporarily hold a maximum of 150 to 300 people standing shoulder-to-shoulder, and has between two to five separate holding areas that can be used to segregate adult males, adult females, unaccompanied children, and family units, with possible further subdivision for female- and male-led family units. The subdividing of aliens is crucial to maintaining order and safety inside the Border Patrol stations because the experience of CBP is that certain cohorts of covered aliens are antagonistic towards one another. On average, a covered alien apprehended between POEs will spend approximately 78 hours in a Border Patrol station before transfer to ICE.

Only 46 of the 136 Border Patrol stations offer any medical services. The services that are offered are administered by contract medical support and are limited to glucose, pregnancy, influenza testing, and basic emergency care. The 46 facilities are all located on the southwest border with Mexico.

As discussed more fully below, the infection control challenges in Border Patrol stations can be greater than the challenges in POEs, especially when the Border Patrol stations are at or near capacity. This is because covered aliens are in close proximity with one another and CBP

personnel, and there is typically no suitable space for quarantining, isolating, or engaging in social distancing with aliens.

iii. The United States Public Health Service (USPHS) observed infection control challenges during a site visit to El Paso del Norte POE

On March 12-13, 2020, a USPHS Scientist officer conducted an observational visit to the El Paso del Norte POE (El Paso PDN). The USPHS Scientist officer viewed directly the areas within the POE that CBP uses to screen and process aliens for admissibility. (Exhibit 1).

El Paso PDN is one of the country's busiest border crossings, with more than 10 million people entering the United States from Mexico every year. It receives a constant, heavy inflow of pedestrian and vehicular traffic, consisting of approximately 12,000 pedestrians and 6,000 vehicles per day. El Paso PDN operates 24/7, with a 3-4 person team of contract medical staff who work 12 hour shifts and provide 24/7 coverage. The medical team is typically led by a nurse practitioner or physician assistant, with the remaining team members consisting of emergency medical technicians (EMT) or registered nurses.

El Paso PDN adheres to the general process for screening and processing covered aliens described in § II.3.i above. In terms of medical capabilities, El Paso PDN performs on-site testing only for pregnancy, blood glucose levels, and Influenza A/B. Any other testing or treatment is performed by nearby medical providers. El Paso PDN is representative of other POEs in that it is heavily reliant on local and regional hospitals and EMT services to care for aliens. El Paso PDN has several small waiting rooms that are used to isolate individuals suspected of exposure to or infection with a contagious disease. Each room can fit approximately 6-7 people, and is equipped with windows to permit observation of the rooms' occupants, and locks to prevent them from leaving.

Facility staff indicated they have been fit-tested for N95 respirators, receive biannual N95 training, and that the facility has an approximately 30-day regular use supply of N95 respirators for use by CBP personnel. El Paso PDN has not encountered any suspected COVID-19 cases, but does not currently perform COVID-19 testing.

The site was selected by CBP because it is one of CBP's largest and best equipped POEs on the Southwest Border. Other POEs have fewer capabilities.

The USPHS Scientist officer observed that even at El Paso PDN, covered aliens would present infection control challenges during processing and screening in congregate areas.

III. The introduction into DHS facilities of persons from countries with COVID-19 would increase the already serious danger of COVID-19 in the facilities

1. POEs and Border Patrol stations are not structured or equipped to effectively mitigate the risks presented by COVID-19

The time required to test for COVID-19 dictates, at least in part, the infection control measures that DHS would have to implement at POEs and Border Patrol stations to effectively mitigate the public health risks presented by covered aliens suspected of harboring or being infected with COVID-19. At this time, there is no available COVID-19 test that yields results at the time of sample collection, such as the rapid testing available for certain influenza strains that yields results in as little as 15 minutes. Nor is there a COVID-19 test that has been cleared for use in a non-clinical setting such as a POE or a Border Patrol station lacking isolation capabilities. Rather, current COVID-19 testing would require the collection of samples from aliens suspected of infection and the mailing of the samples to a laboratory for analysis, with results available within 3-4 days. In theory, to mitigate public health risks, CBP would have to transport aliens in their custody suspected of COVID-19 infection to a nearby medical site for sample collection and testing, and then implement containment protocols (i.e., quarantine or isolation) in their facilities while awaiting test results. CDC would not have the resources or personnel required to house in quarantine or isolation or monitor dozens, much less hundreds or thousands of aliens. The burden would shift to state and local governments, and it seems equally unlikely to CDC that they could collectively implement such a massive public health initiative under current conditions.

POEs and Border Patrol stations are not structured or equipped to implement quarantine, isolation, or social distancing protocols on site for COVID-19 for even small numbers of aliens, much less dozens or hundreds of them together with CBP personnel. In particular, POEs and Border Patrol stations were designed for the purpose of short-term holding in a congregate setting. The vast majority of those facilities lack the areas needed to effectively quarantine or isolate aliens for COVID-19 while test results are pending. Moreover, the process for screening and ultimately quarantining or isolating aliens suspected of COVID-19 infection would require the alien to move throughout various sections of the facility, creating a risk of exposure to all nearby—including DHS personnel and other aliens.⁶³

Because POEs and Border Patrol stations are not structured or equipped for quarantine or isolation for COVID-19, DHS's alternative would be to try to conduct some type of social distancing in congregate holding areas. The numbers of aliens and the size and capacity of the congregate holding areas are not at all conducive to effective social distancing, which requires individuals to maintain a distance of at least six feet from each other, and to avoid contact with shared surfaces. The typical dimensions of the congregate areas at POEs and Border Patrol stations would not provide sufficient space if more than a handful of individuals were present in congregate areas (which is typically the situation). Such an approach would be fraught with public health risks for not only the aliens but also DHS personnel nearby.

⁶³ The use of congregate holding areas for quarantine or isolation would present a significant risk of transmitting COVID-19 for obvious reasons. Even if a congregate holding area were used to try to quarantine or isolate a single alien, it would significantly limit the facility's overall holding capacity, and potentially increase the public health risks in other congregate holding areas (if any space were left at all, after subdividing demographics).

CDC also has a public health tool called conditional release, which involves the release of potentially infected individuals from federal custody subject to conditions calculated to mitigate the risk of disease transmission, such as mandatory self-isolation and CDC monitoring at home. Conditional release is not a viable solution in this context because many aliens covered by this order may lack homes or other places in the United States where they can self-isolate, and CDC lacks the resources and personnel necessary to effectively monitor such a large number of persons. Reliance on the conditional release mechanism in this context would jeopardize, not protect, the public health.

2. POEs and Border Patrol stations are not structured or equipped to safely house or care for aliens infected with COVID-19

POEs and Border Patrol stations would lack the capacity to provide the medical monitoring and care that would be needed by covered aliens confirmed to be infected with COVID-19. Only a few facilities offer medical services directly, and the medical services that are provided are limited to care for minor ailments, basic emergency care, or the on-site administration of prophylaxis for seasonal influenza (i.e., Tamiflu). The facilities are heavily reliant on local and regional hospitals and emergency medical system (EMS) resources.

Moreover, many of the facilities are geographically remote and far from the major medical centers or hospital systems equipped to handle COVID-19 outbreaks. Infected covered aliens would either have to be transported tens or hundreds of miles to the nearest appropriately equipped medical center, or brought to smaller local providers who might lack the resources or capacity to accept COVID-19 cases involving covered aliens. Indeed, U.S. states along the border with Mexico have some of the lowest number of hospital beds per 1,000 inhabitants in the United States.⁶⁴ Arizona, California, and Texas also have some of the largest numbers of residents living in primary care shortage areas of any U.S. states or territories.⁶⁵ The shift of healthcare resources to large numbers of infected, covered aliens would divert the same resources away from the domestic population, which would undermine the Federal response to COVID-19. It would also increase the risk of exposure to COVID-19 for domestic healthcare workers. Such a scenario is not tenable given the current nationwide public health emergency.

IV. Determination and Implementation

Based on the foregoing, I find there is a serious danger of the introduction of COVID-19 into the POEs and Border Patrol stations at or nearby the United States borders with Canada and Mexico, and the interior of the country as a whole, because COVID-19 exists in Canada, Mexico,

⁶⁴ Arizona has 1.9 hospital beds per 1,000 inhabitants; California has 1.8; New Mexico has 1.8, and Texas has 2.3. Kaiser Family Foundation, State Health Facts: Hospitals Per 1,000 Population by Ownership Type (2018), available at <https://www.kff.org/other/state-indicator/beds-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Total%22,%22sort%22:%22asc%22%7D>.

⁶⁵ Kaiser Family Foundation, State Health Facts: Primary Care Health Professional Shortage Areas (HPSAs) (Sept. 30, 2019), available at <https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Percent%20of%20Need%20Met%22,%22sort%22:%22asc%22%7D>.

and the countries or places of origin of the covered aliens who migrate to the United States across the land borders with Canada and Mexico. I also find that the introduction into POEs and Border Patrol stations of covered aliens increases the seriousness of the danger to the point of requiring a temporary suspension of the introduction of covered aliens into the United States.

It is necessary for the public health to immediately suspend the introduction of covered aliens. The immediate suspension of the introduction of these aliens requires the movement of all such aliens to the country from which they entered the United States, or their country of origin, or another location as practicable, as rapidly as possible, with as little time spent in congregate settings as practicable under the circumstances. The faster a covered alien is returned to the country from which they entered the United States, to their country of origin, or another location as practicable, the lower the risk the alien poses of introducing, transmitting, or spreading COVID-19 into POEs, Border Patrol stations, other congregate settings, and the interior.

My determinations are based on information provided to CDC by DHS personnel regarding DHS border operations and facilities; the report of the observational visit to the El Paso PDN conducted by the USPHS Scientist officer; figures on the numbers of apprehensions at the United States borders with Canada and Mexico of aliens from countries where COVID-19 exists; information from the public domain; and my own personal knowledge and experience.

I consulted with DHS before I issued this order, and requested that DHS implement this order because CDC does not have the capability, resources, or personnel needed to do so. As part of the consultation, CBP developed an operational plan for implementing the order. Accordingly, DHS will, where necessary, use repatriation flights to move covered aliens on a space-available basis, as authorized by law. The plan is generally consistent with the language of this order directing that covered aliens spend as little time in congregate settings as practicable under the circumstances. In my view, it is also the only viable alternative for implementing the order; CDC's other public health tools are not viable mechanisms given CDC resource and personnel constraints, the large numbers of covered aliens involved, and the likelihood that covered aliens do not have homes in the United States.⁶⁶

This order is not a rule within the meaning of the Administrative Procedure Act (APA). In the event this order qualifies as a rule under the APA, notice and comment and a delay in effective date are not required because there is good cause to dispense with prior public notice and the opportunity to comment on this order and a delay in effective date. Given the public health emergency caused by COVID-19, it would be impracticable and contrary to the public health—and, by extension, the public interest—to delay the issuing and effective date of this order. In addition, because this order concerns the ongoing discussions with Canada and Mexico on how

⁶⁶ CDC relies on the Department of Defense, other federal agencies, and state and local governments to provide both logistical support and facilities for federal quarantines. CDC lacks the resources, manpower, and facilities to quarantine covered aliens. Similarly, DHS has informed CDC that in the near term, it is not financially or logistically practicable for DHS to build additional facilities at POEs and Border Patrol stations for use in quarantines or isolation. Certain soft-sided facilities may be inappropriate for use in quarantines or isolation. DHS would need at least 90 days (likely more) to build and start bringing hard-sided facilities online. Such an approach would not help address the current public health emergency presented to the Federal government today.

best to control COVID-19 transmission over our shared border, it directly “involve[s] . . . a . . . foreign affairs function of the United States.” 5 U.S.C. § 553(a)(1). Notice and comment and a delay in effective date would not be required for that reason as well.

This order shall remain effective for 30 days, or until I determine that the danger of further introduction of COVID-19 into the United States has ceased to be a serious danger to the public health, whichever is shorter. I may extend or modify this order as needed to protect the public health.

In testimony whereof, the Director, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, has hereunto set his hand at Atlanta, Georgia, this 20th day of March, 2020.

A handwritten signature in black ink, reading "Robert R. Redfield MD". The signature is fluid and cursive, with the letters "R", "R", and "M" being particularly prominent.

Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention

EXHIBIT 1

Date: March 14, 2020

To: RADM Sylvia Trent-Adams, Principal Deputy Assistant Secretary for Health, Office of the Assistant Secretary for Health (OASH)

RADM Erica Schwartz, Deputy Surgeon General, Office of the Surgeon General, OASH

From: CAPT Mehran S. Massoudi, Regional Health Administrator, Region VI, OASH

RE: Report of Observational Visit to the DHS El Paso *Paso del Norte* Port of Entry

Mission: Observe normal work flow process and personnel traffic at the El Paso *Paso del Norte* Port of Entry and assess possible public health risks or vulnerabilities posed by the Coronavirus Disease (COVID-19) at Department of Homeland Security (DHS) border facilities.

On March 12-13, 2020, I traveled to El Paso *Paso del Norte* (PDN) Port of Entry and met with Port Director Good, Watch Commander Alvarez, Watch Commander Gomez, and Supervisor Officer Rivas.

The site I visited was selected by the Customs and Border Patrol (CBP) Senior Medical Advisor Dr. Tarantino. It was intended to serve as an example of one of CBP's largest and best-equipped Ports of Entry (POEs) on the Southwest Border, not a representative of other POEs across the country.

The El Paso PDN is one of the country's busiest border crossings, and sees approximately 10 million people entering the United States from Mexico annually. The El Paso PDN processes a flow of approximately 12,000 pedestrians and approximately 6-8,000 vehicles per day. Field statistics for FY19 and Jan. 2020 were supplied by the Public Affairs and Community Liaison Director, El Paso Field Office and are attached to this report, as Attachments A and B, respectively. The location is staffed by CBP officers 24/7 working 8 hour shifts. In addition, the facility has 24/7 coverage by a third party contracted Medical Team comprised of 3-4 members, led by a nurse practitioner or physician assistant, with the rest of the team comprised of emergency medical technicians or Registered Nurses.

There are two points of entry into PDN: a pedestrian and vehicular mode. Both are staffed by the same CBP officers from El Paso. Each person seeking entry to the United States at PDN is asked a series of questions upon encountering the CBP officer, including the travel-related COVID-19 screening questions. Officers use visual cues as well as responses to the screening questions to determine the level of risk of COVID-19 infection. If CBP officers suspect any level of risk or signs/symptoms of illness, they put on a surgical mask (CBP officers wear gloves as a normal practice) and give a surgical mask to the individual as well. The officer would then escort the individual to an area where the officer would first inspect the individual for anything that could be used as a weapon, and then fingerprint the individual (if applicable). The individual would then be triaged to an area where they would be administered a 13-part

questionnaire, with a series of questions added about COVID-19 by the third party contract Medical Team. The questionnaire is attached as Attachment C.

If an individual is determined to be at risk of COVID-19, the individual is escorted to one of several small waiting rooms, each with a window and locked door, while the local health department, Centers for Disease Control and Prevention (CDC), and CBP's Senior Medical Advisor are notified. Local health officials and/or CDC would then be consulted to determine next steps with respect to testing and/or treatment for COVID-19.

If testing is recommended, then CBP will follow guidance from CDC and local health officials about which third party hospital to transport the individual. If the individual is sent for testing in an ambulance, a CBP officer will accompany the individual inside the ambulance. In addition, CBP will consult with Immigration and Customs Enforcement (ICE) officials if the individual leaving the CBP facility has not yet been processed and so must remain in custody.

CBP personnel informed me that the same basic process described above would be applied to those who arrived on foot or by vehicle—provided the individual provided a response to the screening questions indicative of COVID-19 exposure/infection or appeared to exhibit signs/symptoms of the disease requiring a medical consult for further evaluation and possible testing.

Key Observations:

- All CBP officers are fit-tested twice a year for N-95 respirators, but when asked and observed, only surgical masks were identified for use. I was told that the N-95 respirators would be used when there is a declaration of a pandemic or when they are told to use them. Leadership at the site said that they have approximately a 30-day supply of N-95 respirators on hand at the PDN sites. I observed that all CBP officers had a box of gloves and a box of N-95 respirators by their feet behind their workstations.
- The CDC Quarantine Station in El Paso makes routine visits to stop by and answer any questions and provide any updates as needed for the CBP officers. The CBP officers carry a small, two-sided laminated card with key evaluation criteria. The card is attached as Attachment D.
- Observed color-posters of CDC COVID-19 awareness messaging on walls throughout the facility.
- The third party contract Medical Team performs only a small number of tests on-site (rapid Influenza A/B, pregnancy, and glucose). Tests for other conditions, particularly other contagious diseases like measles, are performed off-site at a third part medical facility.
- If an individual is suspected of having an infectious disease or needs to be held for a short period of time, they are put in a small room with a window and a locked door, adjacent to the CBP officers' work-area. This is not an isolation room because the HVAC system is shared with the rest of the facility, and does not have adequate capabilities to contain COVID-19 (i.e., negative pressure, HEPA filtration). Escorting a contagious individual

to and from this room, as well as holding them there, poses a significant risk of exposing nearby CBP personnel.

- If an individual actually infected with COVID-19 were subject to the above screening processes, they would be maneuvered throughout various sections of the POE, creating a significant risk of COVID-19 exposure to other aliens and CBP officers in the POE.

[Attachment A: FY 2019 Field Statistics]

U.S. Department of Homeland Security
9400 Viscount
El Paso, TX 79925



U.S. Customs and Border Protection

January 21, 2019

To: Stakeholders and interested parties

From: Ruben Jauregui
Director, Communication Management Office
Public Affairs and Community Liaison
El Paso Field Office
El Paso, Texas

Subject: El Paso Field Office Traffic Summary Report January-December 2019

January 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	642	228,341	0	0	0	376,229
El Paso	Bridge of Americas	24,576	719	332,330	116	5,387	2,817	104,379
El Paso	Ysleta Bridge	46,518	0	238,762	0	0	0	116,175
El Paso	Stanton St DCL	0	0	119,715	0	0	0	0
El Paso	Ysleta DCL	0	0	101,452	0	0	0	0
Presidio		823	114	62,393	0	0	0	19,563
Boquillas		0	0	0	0	0	0	144
Serna/Tornillo		0	0	24,750	0	0	0	3,124
Serna/Tornillo	Ft Hancock	0	0	8,002	0	0	0	162
Columbus	Columbus	863	0	26,777	0	0	0	23,158
Columbus	Antelope Wells	0	*120	1,163	0	0	0	0
Santa Teresa		9,733	19	46,230	0	0	0	10,132

*Antelope Wells numbers are for passenger vans processed

February 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	793	208,026	0	0	0	347,742
El Paso	Bridge of Americas	22,159	539	296,190	116	6,503	2,487	93,721
El Paso	Ysleta Bridge	43,800	0	213,097	0	0	0	115,133
El Paso	Stanton St DCL	0	0	114,954	0	0	0	0
El Paso	Ysleta DCL	0	0	96,686	0	0	0	0
Presidio		707	77	53,410	0	0	0	15,362
Boquillas		0	0	0	0	0	0	2,385
Serna/Tornillo		0	0	24,503	0	0	0	3,284
Serna/Tornillo	Ft Hancock	0	0	7,792	0	0	0	143
Columbus	Columbus	418	0	24,635	0	0	0	21,340
Columbus	Antelope Wells	0	*76	793	0	0	0	0
Santa Teresa		9,116	15	42,335	0	0	0	7,413

*Antelope Wells numbers are for passenger vans processed

March 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	759	225,206	0	0	0	408,028
El Paso	Bridge of Americas	23,832	684	305,090	109	5,751	3,180	115,579
El Paso	Ysleta Bridge	45,152	0	221,472	0	0	0	136,788
El Paso	Stanton St DCL	0	0	124,712	0	0	0	0
El Paso	Ysleta DCL	0	0	106,205	0	0	0	0
Presidio		791	105	62,810	0	0	0	20,473
Boquillas		0	0	0	0	0	0	4,362
Serna/Tornillo		0	0	28,181	0	0	0	3,061
Serna/Tornillo	Ft Hancock	0	0	9,908	0	0	0	224
Columbus	Columbus	377	0	28,673	0	0	0	21,951
Columbus	Antelope Wells	0	*103	972	0	0	0	0
Santa Teresa		9,903	24	52,541	0	0	0	9,898

*Antelope Wells numbers are for passenger vans processed

April 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	750	155,983	0	0	0	380,366
El Paso	Bridge of Americas	18,973	670	200,817	112	6,932	3,211	154,135
El Paso	Ysleta Bridge	38,449	0	140,421	0	0	0	173,111
El Paso	Stanton St DCL	0	0	130,521	0	0	0	0
El Paso	Ysleta DCL	0	0	92,139	0	0	0	0
Presidio		829	123	55,708	0	0	0	35,469
Boquillas		0	0	0	0	0	0	2,875
Serna/Tornillo		0	0	28,326	0	0	0	4,361
Serna/Tornillo	Ft Hancock	0	0	11,545	0	0	0	339
Columbus	Columbus	608	0	28,117	0	0	0	24,299
Columbus	Antelope Wells	0	*127	1,302	0	0	0	0
Santa Teresa		10,187	29	45,852	0	0	0	20,355

*Antelope Wells numbers are for passenger vans processed

May 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	882	168,894	0	0	0	379,532
El Paso	Bridge of Americas	20,390	705	242,474	134	8,308	3,239	147,259
El Paso	Ysleta Bridge	47,835	0	169,580	0	0	0	168,443
El Paso	Stanton St DCL	0	0	138,374	0	0	0	0
El Paso	Ysleta DCL	0	0	108,888	0	0	0	0
Presidio		875	0	58,129	0	0	0	23,072
Boquillas		0	0	0	0	0	0	1,563
Serna/Tornillo		0	118	29,010	0	0	0	3,571
Serna/Tornillo	Ft Hancock	0	0	11,630	0	0	0	216
Columbus	Columbus	1,030	0	30,660	0	0	0	24,365
Columbus	Antelope Wells	0	*125	1,135	0	0	0	0
Santa Teresa		13,221	13	49,834	0	0	0	14,221

*Antelope Wells numbers are for passenger vans processed

June 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	934	158,621	0	0	0	372,565
El Paso	Bridge of Americas	14,620	789	224,054	121	7,820	3,116	154,368
El Paso	Ysleta Bridge	48,564	0	181,356	0	0	0	161,103
El Paso	Stanton St DCL	0	0	123,047	0	0	0	0
El Paso	Ysleta DCL	0	0	104,499	0	0	0	0
Presidio		643	117	55,964	0	0	0	29,194
Boquillas		0	0	0	0	0	0	1,007
Serna/Tornillo		0	0	26,625	0	0	0	1,506
Serna/Tornillo	Ft Hancock	0	0	9,443	0	0	0	334
Columbus	Columbus	1,204	0	29,661	0	0	0	15,392
Columbus	Antelope Wells	0	*127	992	0	0	0	0
Santa Teresa		11,843	30	50,672	0	0	0	16,847

*Antelope Wells numbers are for passenger vans processed

July 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	862	146,360	0	0	0	369,293
El Paso	Bridge of Americas	15,711	883	217,658	126	8,741	2,660	182,378
El Paso	Ysleta Bridge	51,922	0	305,414	0	0	0	178,969
El Paso	Stanton St DCL	0	0	123,123	0	0	0	0
El Paso	Ysleta DCL	0	0	107,296	0	0	0	0
Presidio		830	162	58,934	0	0	0	37,779
Boquillas		0	0	0	0	0	0	934
Serna/Tornillo		0	0	33,967	0	0	0	1,510
Serna/Tornillo	Ft Hancock	0	0	9,456	0	0	0	385
Columbus	Columbus	1,808	0	32,455	0	0	0	22,959
Columbus	Antelope Wells	0	*152	1,473	0	0	0	0
Santa Teresa		12,915	19	56,495	0	0	0	26,487

*Antelope Wells numbers are for passenger vans processed

August 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	981	163,806	0	0	0	349,842
El Paso	Bridge of Americas	16,129	812	240,369	124	10,404	4,487	152,466
El Paso	Ysleta Bridge	53,240	0	198,831	0	0	0	166,014
El Paso	Stanton St DCL	0	0	133,379	0	0	0	0
El Paso	Ysleta DCL	0	0	108,208	0	0	0	0
Presidio		806	130	56,539	0	0	0	25,946
Boquillas		0	0	0	0	0	0	709
Serna/Tornillo		0	0	28,161	0	0	0	3,093
Serna/Tornillo	Ft Hancock	0	0	9,508	0	0	0	273
Columbus	Columbus	2,138	0	31,132	0	0	0	25,529
Columbus	Antelope Wells	0	*121	950	0	0	0	0
Santa Teresa		11,922	22	49,664	0	0	0	16,532

*Antelope Wells numbers are for passenger vans processed

September 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	930	183,319	0	0	0	341,846
El Paso	Bridge of Americas	15,080	675	252,480	127	8,223	3,086	131,396
El Paso	Ysleta Bridge	50,428	0	221,684	0	0	0	156,242
El Paso	Stanton St DCL	0	0	134,221	0	0	0	0
El Paso	Ysleta DCL	0	0	107,839	0	0	0	0
Presidio		833	125	56,328	0	0	0	20,988
Boquillas		0	0	0	0	0	0	1,001
Serna/Tornillo		0	0	25,901	0	0	0	3,654
Serna/Tornillo	Ft Hancock	0	0	9,581	0	0	0	268
Columbus	Columbus	2,054	0	30,609	0	0	0	24,870
Columbus	Antelope Wells	0	*98	938	0	0	0	0
Santa Teresa		11,377	16	43,162	0	0	0	12,113

*Antelope Wells numbers are for passenger vans processed

October 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	839	191,494	0	0	0	361,221
El Paso	Bridge of Americas	16,498	697	265,834	115	7,278	2,571	147,038
El Paso	Ysleta Bridge	55,251	0	214,485	0	0	0	159,779
El Paso	Stanton St DCL	0	0	146,029	0	0	0	0
El Paso	Ysleta DCL	0	0	115,628	0	0	0	0
Presidio		1,054	142	56,209	0	0	0	19,401
Boquillas		0	0	0	0	0	0	1,700
Serna/Tornillo		0	0	27,883	0	0	0	4,021
Serna/Tornillo	Ft Hancock	0	0	9,676	0	0	0	268
Columbus	Columbus	2,890	0	30,318	0	0	0	23,592
Columbus	Antelope Wells	0	*0	931	0	0	0	0
Santa Teresa		12,672	13	42,174	0	0	0	11,661

*Antelope Wells numbers are for passenger vans processed

November 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	742	175,505	0	0	0	330,171
El Paso	Bridge of Americas	12,839	760	259,756	112	7,202	2,346	134,592
El Paso	Ysleta Bridge	52,063	0	203,584	0	0	0	149,073
El Paso	Stanton St DCL	0	0	133,865	0	0	0	0
El Paso	Ysleta DCL	0	0	105,061	0	0	0	0
Presidio		1,022	142	54,667	0	0	0	21,686
Boquillas		0	0	0	0	0	0	3,498
Serna/Tornillo		0	0	26,583	0	0	0	3,128
Serna/Tornillo	Ft Hancock	0	0	9,664	0	0	0	242
Columbus	Columbus	1,868	0	27,981	0	0	0	21,435
Columbus	Antelope Wells	0	*95	1,070	0	0	0	0
Santa Teresa		10,924	20	43,748	0	0	0	12,416

*Antelope Wells numbers are for passenger vans processed

December 2019

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	1,007	190,826	0	0	0	325,436
El Paso	Bridge of Americas	11,379	978	284,027	97	5,258	2,826	154,034
El Paso	Ysleta Bridge	46,744	0	221,027	0	0	0	161,469
El Paso	Stanton St DCL	0	0	135,170	0	0	0	0
El Paso	Ysleta DCL	0	0	108,080	0	0	0	0
Presidio		985	182	58,203	0	0	0	38,527
Boquillas		0	0	0	0	0	0	2,467
Serna/Tornillo		0	0	29,660	0	0	0	3,099
Serna/Tornillo	Ft Hancock	0	0	10,279	0	0	0	262
Columbus	Columbus	1,490	0	30,398	0	0	0	22,675
Columbus	Antelope Wells	0	*121	1,551	0	0	0	0
Santa Teresa		10,113	20	53,942	0	0	0	23,104

*Antelope Wells numbers are for passenger vans processed

[Attachment B: Jan. 2020 Field Statistics]

U.S. Department of Homeland Security
9400 Viscount
El Paso, TX 79925



U.S. Customs and Border Protection

February 25, 2020

To: Stakeholders and interested parties

From: Ruben Jauregui
Director, Communication Management Office
Public Affairs and Community Liaison
El Paso Field Office
El Paso, Texas

Subject: El Paso Field Office Traffic Summary Report January 2020

January 2020

		Trucks	Buses	POV's	Trains	Empty Rail containers	Full Rail Containers	Pedestrians
El Paso	Paso del Norte	0	1,047	186,475	0	0	0	294,921
El Paso	Bridge of Americas	13,612	810	279,016	91	4,090	1,481	127,497
El Paso	Ysleta Bridge	53,785	0	219,982	0	0	0	137,015
El Paso	Stanton St DCL	0	0	134,574	0	0	0	0
El Paso	Ysleta DCL	0	0	104,067	0	0	0	0
Presidio		967	128	56,535	0	0	0	25,047
Boquillas		0	0	0	0	0	0	2,585
Serna/Tornillo		0	0	24,937	0	0	0	2,929
Serna/Tornillo	Ft Hancock	0	0	9,246	0	0	0	169
Columbus	Columbus	1,032	0	28,629	0	0	0	24,479
Columbus	Antelope Wells	0	*118	1,254	0	0	0	0
Santa Teresa		11,886	31	46,478	0	0	0	14,731

*Antelope Wells numbers are for passenger vans processed

[Attachment C: 13-part Screening Questionnaire]

BSFAU SOP: 010
28 Oct 2019

Attachment 3

13 Scripted Questions for Detainee Intake

1. Do you have a history of current medical or mental health issues?
Tiene o ha tenido problemas medicos o condiciones de enfermedad mentales?
2. Are you taking any medications (prescription or OTC)? If yes, do you have it with you?
Esta tomando medicamento recetadas?
3. Do you have any allergies (food or medicine)?
Tiene alergias a cualquier medicamento o comida?
4. Are you a drug user?
Usa drogas?
5. (If female) Are you pregnant? If yes, how many months?
Esta embarazada? Cuantos meses/semanas?
6. (If female) Are you nursing?
Estas amamantando?
7. Are you currently injured or do you have significant pain?
Esta erido or tiene dolor en algun lugar?
8. Do you have a skin rash?
Tiene una condicion en la piel?
9. Do you have a contagious disease?
Tiene una enfermedad contagiosa?
10. Are you thinking about hurting yourself or others?
Esta pesando lastimarte a ti mismo o a alguien mas?
11. Do you feel feverish or do you feel that you have a fever?
Te sientes febril o tiene fiebre?
12. Do you have a cough or difficult breathing?
Tiene toz o problemas respirando?
13. Do you have nausea, vomiting, or diarrhea?
Tiene nausea, vomitos or diarea?

Page 6

Detainee Initial Health-Intake Requirements V2.1

Attachment 3

LoyalSource
Government Services**13 Scripted Questions for Detainee Intake**

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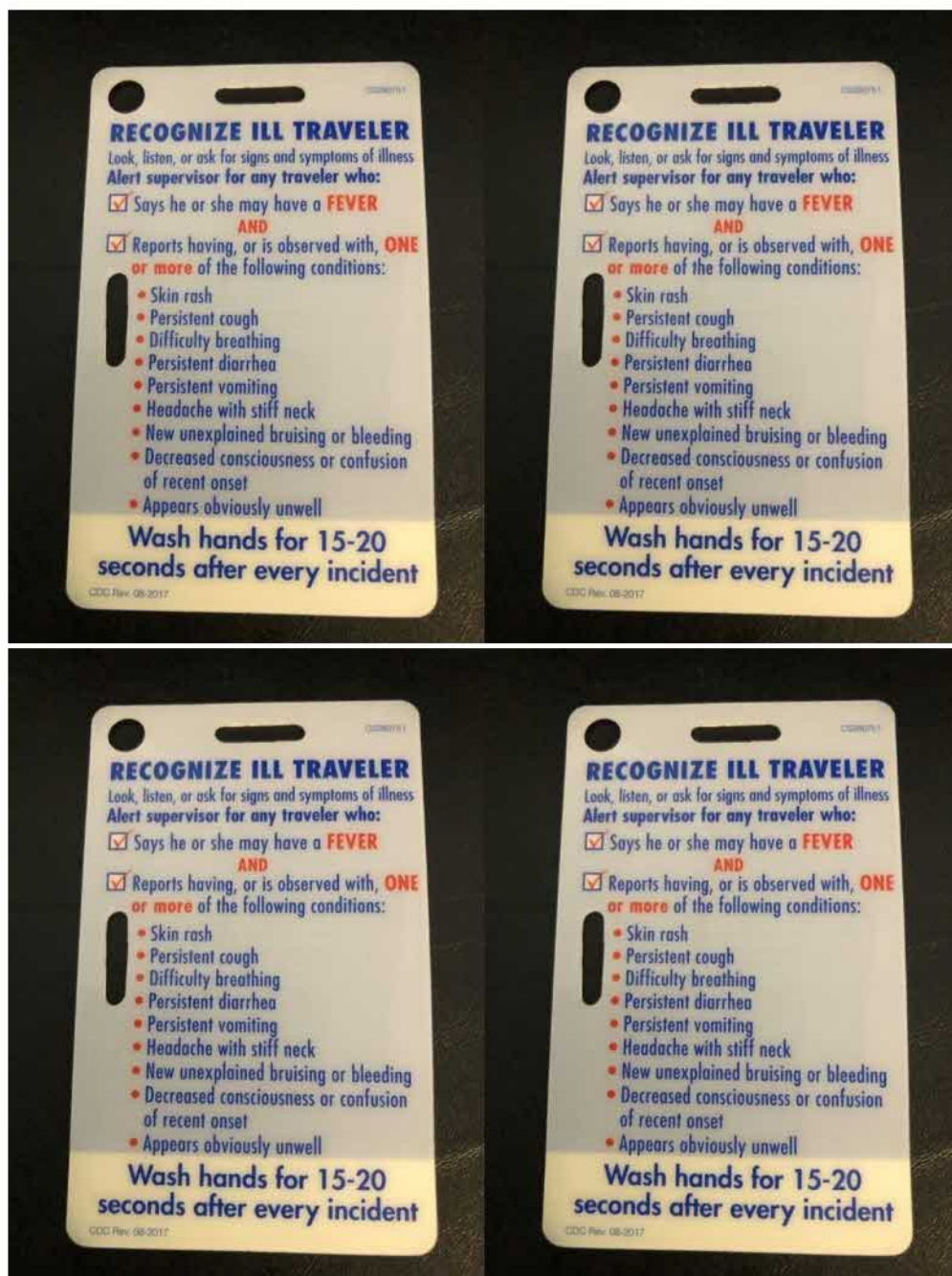
[Attachment D: RING Card]

(front)





(back)



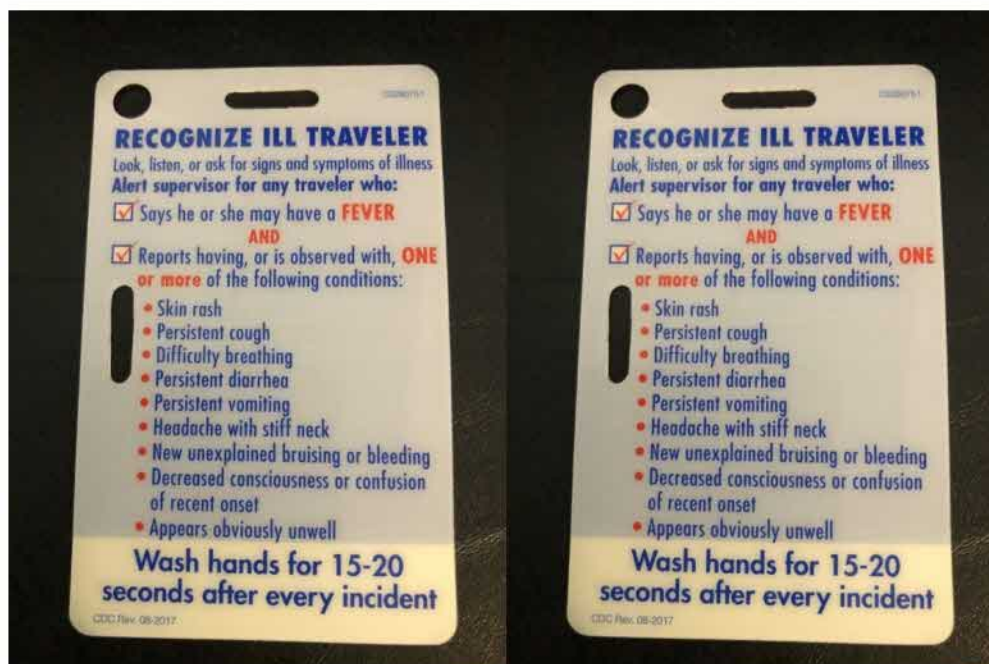


EXHIBIT 2

U.S. Border Patrol (USBP) - Apprehensions (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
ALBANIA	12	1
ALGERIA	0	1
ARGENTINA	4	2
ARMENIA	1	0
BANGLADESH	420	1
BELGIUM	0	1
BOLIVIA	10	1
BRAZIL	6,248	11
BULGARIA	1	1
BURKINA FASO	1	1
CAMBODIA	0	1
CAMEROON	20	0
CANADA	2	33
CHILE	341	0
CHINA (PEOPLE'S REPUBLIC OF)	1,157	18
COLOMBIA	204	35
COSTA RICA	21	0
DEM REP OF THE CONGO	149	0
DOMINICAN REPUBLIC	160	12
ECUADOR	7,027	35
FRENCH GUIANA	1	0
GERMANY	0	1
GUADELOUPE	2	0
HONDURAS	19,493	87
INDIA	805	111
INDONESIA	1	1
IRAN	5	1
IRAQ	1	1
IRELAND	2	0
ISRAEL	4	3
ITALY	6	1
JAMAICA	1	7
JAPAN	0	1
JORDAN	7	3
KOREA	0	1
KUWAIT	1	0
MALAYSIA	1	1

U.S. Border Patrol (USBP) - Apprehensions (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
MEXICO	80,130	707
MOLDOVA	0	1
NEPAL	77	0
NIGERIA	9	8
NORWAY	0	1
PAKISTAN	61	3
PANAMA	11	1
PARAGUAY	1	1
PERU	295	1
PHILIPPINES	0	3
POLAND	0	3
ROMANIA	151	43
RUSSIA	6	0
SENEGAL	1	1
SINGAPORE	1	0
SOUTH AFRICA	2	2
SOUTH KOREA	1	8
SPAIN	5	7
SRI LANKA	196	3
SWEDEN	1	0
THAILAND	0	1
TOGO	2	1
TUNISIA	0	1
TURKEY	46	1
UKRAINE	2	3
UNITED KINGDOM	2	10
VIETNAM	197	2
TOTAL	117,305	1,185

Source: End of Month Report

EXHIBIT 3

Office of Field Operations (OFO) - Inadmissible Aliens (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
AFGHANISTAN	0	23
ALBANIA	0	13
ALGERIA	0	349
ANDORRA	0	1
ARGENTINA	4	7
ARMENIA	108	1
AUSTRALIA	4	53
AUSTRIA	1	6
AZERBAIJAN	8	9
BANGLADESH	3	79
BELARUS	11	5
BELGIUM	15	39
BHUTAN	0	9
BOLIVIA	3	2
BOSNIA-HERZEGOVINA	0	6
BRAZIL	152	318
BULGARIA	1	14
BURKINA FASO (UPPER VOLTA)	10	20
CAMBODIA	0	3
CAMEROON	1,025	69
CANADA	25	9,693
CHILE	21	47
CHINA (PEOPLE'S REPUBLIC OF)	500	1,378
TAIWAN	0	21
COLOMBIA	83	151
COSTA RICA	8	3
CROATIA	0	10
CYPRUS	0	4
CZECH REPUBLIC	1	7
DEMOCRATIC REPUBLIC OF CONGO (ZAIRE)	171	29
DENMARK	1	16
DOMINICAN REPUBLIC	4	25
ECUADOR	156	14

Office of Field Operations (OFO) - Inadmissible Aliens (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
EGYPT	2	124
ESTONIA	0	1
FINLAND	0	5
FRANCE	6	802
GEORGIA	59	2
GERMANY	1	88
GREECE	1	19
HONDURAS	1,343	32
HONG KONG, PRC	0	8
HUNGARY	1	16
INDIA	22	2,135
INDONESIA	1	17
IRAN	3	1,061
IRAQ	2	63
IRELAND	0	27
ISRAEL	5	58
ITALY	6	50
JAMAICA	24	120
JAPAN	2	33
JORDAN	1	28
KUWAIT	3	1
LATVIA	1	1
LEBANON	2	54
LITHUANIA	2	8
LUXEMBOURG	0	2
MACAO (MACAU), PRC	0	1
MACEDONIA (SKOPJE)	0	2
MALAYSIA	0	9
MALTA AND GOZO	0	2
MEXICO	29,713	245
MOLDOVA	0	9
MOROCCO	1	350
NEPAL	0	6
NETHERLANDS	0	17

Office of Field Operations (OFO) - Inadmissible Aliens (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
NEW ZEALAND	0	20
NIGERIA	0	182
NORWAY	3	7
OMAN	1	2
PAKISTAN	5	160
PANAMA	4	1
PARAGUAY	0	2
PERU	46	15
PHILIPPINES	0	554
POLAND	1	66
PORTUGAL	0	57
REPUBLIC OF CONGO (BRAZZAVILLE)	40	9
REPUBLIC OF SOUTH AFRICA	6	21
ROMANIA	9	39
RUSSIA	340	101
SAUDI ARABIA	4	14
SENEGAL	5	56
SERBIA	0	4
SINGAPORE	0	6
SLOVAKIA	0	2
SLOVENIA	0	2
SOUTH KOREA	12	178
SPAIN	19	66
SRI LANKA	0	28
SWEDEN	0	27
SWITZERLAND	1	20
THAILAND	0	6
TOGO	6	20
TUNISIA	0	274
TURKEY	38	50
UKRAINE	70	130
UNITED ARAB EMIRATES	1	2
UNITED KINGDOM	7	148
VIETNAM	7	77

Office of Field Operations (OFO) - Inadmissible Aliens (FY20TD-Feb.)		
Country of Citizenship	Southwest Border	Northern Border
TOTAL	34,141	20166

Source: SBO Data via End of Month Report; NBO Data via CBP Data Warehouse as of
3/3/2020

BILLING CODE: 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

No Sail Order and Suspension of Further Embarkation

**AGENCY: Centers for Disease Control and Prevention (CDC),
Department of Health and Human Services (HHS).**

ACTION: Notice.

SUMMARY: The Centers for Disease Control and Prevention (CDC), a component of the Department of Health and Human Services (HHS), announces the issuance of a No Sail Order and Suspension of Further Embarkation on March 14, 2020 for all cruise ships that are not voluntarily suspending operation.

DATES: This action was effective March 14, 2020.

FOR FURTHER INFORMATION CONTACT: Jennifer Buigut, Division of Global Migration and Quarantine, Centers for Disease Control and Prevention, 1600 Clifton Road, N.E., MS V18-2,

Atlanta, GA 30329. Phone: 404-498-1600. Email:
dgmcpolicy@cdc.gov.

SUPPLEMENTARY INFORMATION:

On March 14, 2020, the Director of the Centers for Disease Control and Prevention issued the following No Sail Order and Other Measures Related to Operations. A copy of the order is provided below and a copy of the signed order can be found at

<https://www.cdc.gov/quarantine/cruise/index.html>.

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

**ORDER UNDER SECTIONS 361 & 365
OF THE PUBLIC HEALTH SERVICE ACT (42 U.S.C. §§ 264, 268)**

AND

**42 CODE OF FEDERAL REGULATIONS
PART 70 (INTERSTATE) AND PART 71 (FOREIGN):
NO SAIL ORDER AND OTHER MEASURES RELATED TO OPERATIONS**

Applicability

This Notice of No Sail Order and Other Measures Related to Operations shall apply only to the subset of carriers¹ described below and hereinafter referred to as "cruise ships," except this Order shall not apply to any cruise ship that voluntarily suspends operations for the period of this Order:

All commercial, non-cargo,² passenger-carrying vessels operating in international, interstate, or intrastate waterways and subject to the jurisdiction of the United States with the capacity to carry 250³ or more individuals (passengers and crew) with an itinerary anticipating an overnight stay onboard or a twenty-four (24) hour stay onboard for either passengers or crew.⁴

¹ Carrier is defined by 42 C.F.R. § 71.1 to mean "a ship, aircraft, train, road vehicle, or other means of transport, including military."

² Given the substantial risk of person-to-person transmission of COVID-19, as opposed to transmission via indirect contact, this Order is currently limited to passenger, non-cargo vessels.

³ Based on substantial epidemiological evidence related to congregate settings and mass gatherings, this Order suspends operation of vessels with the capacity to carry 250 individuals or more. Evidence shows that settings as small as nursing homes or movie theaters can proliferate the spread of a communicable disease. As the numbers of passengers and crew onboard a ship increases, certain recommended mitigation efforts such as social distancing become more difficult to implement. In light of the demonstrated rapid spread of this communicable disease in current cruise ship settings, application of this Order to vessels carrying 250 or more individuals is a prudent and warranted public health measure. Moreover, the management of current coronavirus cases in addition to existing seasonal care needs (e.g., influenza) has placed an extreme burden on the public health and healthcare systems and this Order will help avoid further stressing those systems.

⁴ This order shall not apply to vessels operated by a U.S. Federal or State government agency. Nor shall it apply to vessels being operated solely for purposes of the provision of essential services, such as the provision of medical care, emergency response, activities related to public health and welfare, or government services, such as food, water, and electricity.

General Background

COVID-19 is a communicable disease caused by a novel (new) coronavirus, SARS-CoV-2, that was first identified as the cause of an outbreak of respiratory illness that began in Wuhan, China. The virus is thought to spread primarily by person-to-person contact through respiratory droplets produced when an infected person coughs or sneezes; it may also spread through contact with contaminated surfaces or objects. Manifestations of severe disease have included severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure. According to the World Health Organization (WHO), approximately 3.6% of reported COVID-19 cases have resulted in death globally. This mortality rate is higher among the elderly or those with compromised immune systems. Older adults and people who have severe chronic medical conditions like heart, lung, or kidney disease are also at higher risk for more serious COVID-19 illness. Early data suggest older people are twice as likely to have serious COVID-19 illness.

On January 30, 2020, the Director General of the WHO declared that the outbreak of COVID-19 constitutes a Public

Health Emergency of International Concern under the International Health Regulations. The following day, the Secretary of the Department of Health and Human Services (HHS) declared that COVID-19 constitutes a public health emergency under the Public Health Service Act. To date, CDC has issued Level 3 Travel Health Notices recommending that travelers avoid all nonessential travel to China, Iran, South Korea, and most of Europe; the U.S. Department of State has issued a global Level 3 Health Advisory directing U.S. citizens to reconsider all travel abroad due to the global impact of COVID-19 and Level 4 Travel Advisories (Do Not Travel) for China, Iran, and certain parts of Italy. In addition, CDC has recommended that travelers, particularly those with underlying health conditions, avoid all cruise ship travel worldwide; the U.S. Department of State has similarly issued guidance that U.S. citizens should not travel by cruise ship at this time. As of March 11, 2020, the President of the United States has suspended entry to the U.S. by most foreign nationals who have recently visited China, Iran, and most of Europe due to COVID-19. On March 11, 2020, the WHO declared the COVID-19 outbreak a pandemic. As of March 13, 2020, there have been over 132,000 cases of COVID-19 globally in over 122 locations resulting in over 4,950 deaths; more than 1,620 cases have

been identified in the United States, with new cases being reported daily and over 41 deaths due to the disease. A Presidential Declaration of National Emergency concerning COVID-19 was issued on March 13, 2020.

Global efforts to slow transmission have included drastic control measures with substantial societal and economic impact. Countries such as Russia, Australia, the Philippines, Japan, Israel, and the United States have imposed stringent restrictions on travelers who have recently been in China. Similar travel restrictions have since been imposed on individuals from countries experiencing substantial outbreaks, including Iran, South Korea, and Europe. In many countries, including the United States, citizens, permanent residents, and their close relatives returning from areas known to have high rates of infection are being requested to self-quarantine for 14 days (a period estimated to encompass the incubation period for the virus) following return from countries with sustained community transmission. Despite these unprecedented global efforts at containment, cases of COVID-19 have been shown to rapidly propagate, crossing international borders with ease. For example, the Islamic Republic of Iran has seeded at least 97 COVID-19 cases in

11 other countries, as reported by the WHO, and as of March 9, 2020, the Schengen Area of Europe has exported 201 COVID-19 cases to 53 countries.

In the United States, community transmission has occurred in Washington State, California, and New York. CDC is closely monitoring COVID-19 transmission and is supporting state and local health departments in conducting contact tracing investigations of confirmed COVID-19 cases identified in the United States. These investigations are complex and resource intensive; persons identified as infected or at-risk can require observation, movement restriction (such as isolation or quarantine), clinical evaluation, and care. Public health authorities in the United States are working concurrently to contain the spread of the disease and mitigate its impact.

Risk of Transmission on Cruise Ships

Cruise ships often involve the movement of a number of people in closed and semi-closed settings. Cruises vary in size, with larger cruises involving populations of more than 4,000 passengers and crew. Like other close-contact environments, cruise ships facilitate transmission of COVID-19.

There are several features of cruise ships that increase the risk of COVID-19 transmission. A hallmark of cruise travel is the number and variety of person-to-person contacts an individual passenger may have daily. The dynamics of passenger-to-passenger, passenger-to-crew, crew-to-passenger, and crew-to-crew intermingling in a semi-closed setting are particularly conducive to SARS-CoV-2 spread, resulting in high transmission rates. Cruises include frequent events that bring passengers and crew close together, including group and buffet dining, entertainment events, and excursions. Cruise ship cabins are small, increasing the risk of transmission between cabinmates. Close quartering is a particular concern for crew, who typically eat and sleep in small, crowded spaces. Infection among crew members may lead to transmission on sequential cruises on the same vessel because crew members may continue working and living onboard the ship from one cruise to the next. Crew from one ship may in turn serve onboard multiple different ships for subsequent voyages, which also has the potential to amplify transmission.

Transmission of COVID-19 on cruise ships may also be amplified by difficulty decontaminating numerous surfaces

in common areas. Contamination of frequently touched surfaces, such as door handles and faucets in public toilet rooms, elevator buttons, handrails in stairs and passageways, and utensils/dispensing mechanisms (for beverages) in self-service buffets, etc., is also likely to be a significant factor in transmission. Less obvious examples of frequently touched surfaces, include playing cards, slot machine levers, and chips in the casino; computer keyboards in the internet café; books, puzzles, and games in the library; gym equipment; counters and surfaces in gift shops; and the cruise card used by passengers to pay/register for everything on board and exit/enter the ship in port. The high volume of people on board a cruise ship and wealth of high-touch surfaces make successful control of this method of transmission very difficult.

Moreover, the nature of cruise travel presents additional opportunities for spread of the disease to ports of calls and passengers' home communities. During a cruise, disembarkation of passengers at sequential ports of call under uncontrolled conditions may lead to disease transmission in those ports. Once a cruise concludes, passengers residing in different countries or throughout

the United States may require air transportation or other types of common carriers to return home. Return of disembarked infected passengers to their communities could lead to widespread, interstate disease transmission.

Quarantine and isolation measures are difficult to implement effectively onboard a cruise ship and only occur after an infection has already been identified onboard a cruise. If ships are at capacity, it may not be feasible to fully separate ill and well persons onboard the ship, particularly among the crew. Because crew are required to continue working to keep a ship safely operating, effective quarantine for crew is particularly challenging.

Already Observed Impact of Cruise Ship Travel in General and in the U.S.

Cruise ship travel has already been associated with a number of COVID-19 clusters and outbreaks, including on the Diamond Princess (Asia) and the Grand Princess (California to Mexico, California to Hawaii). The threat of spread is not limited to larger cruise ships. An outbreak onboard a Nile River cruise with 171 passengers and crew (29 of which were American citizens) resulted in 45 confirmed COVID-19

cases (3 of which are American citizens). Many of these passengers returned home before any notifications about COVID-19 were provided, potentially spreading the disease to their home communities. Evidence of COVID-19 transmission onboard six similar Nile River cruise ships, each carrying approximately 100 passengers, illustrates that even ships with moderate numbers of passengers and crew onboard carry a substantial risk of disease transmission and outbreak.

The initial stages of the COVID-19 epidemic were marked by the outsized role of a single cruise ship, the Diamond Princess in Yokohama, Japan, which for a period of 18 days was the setting for the largest number of cases outside the original epicenter in China. The outbreak of COVID-19 onboard the Diamond Princess demonstrates the speed and extent of disease transmission that can occur onboard cruise ships. Despite quarantine and isolation efforts, more than 700 cases of infection with the virus that causes COVID-19 were identified among Diamond Princess passengers and crew during the three weeks following the identification of one case of COVID-19 in a person who was symptomatic before leaving the ship. There are several cases of severe disease associated with the Diamond

Princess, including at least six deaths. Additionally, approximately half of the infected passengers did not report symptoms at the time their infections were diagnosed.

On March 4, 2020, Placer County, California officials reported the death of a passenger who had been onboard the Grand Princess cruise ship during a voyage from February 11-21, 2020 (Sailing A) and was a confirmed COVID-19 case. As of March 7, 2020, there were 22 presumptive positive cases of COVID-19 among persons who were onboard Sailing A. The Grand Princess left San Francisco for a second sailing on February 21 (Sailing B). Sixty-eight passengers and most of the crew from Sailing A were also on Sailing B. While testing of those who were onboard Sailing B continues, to date, 22 crew and 8 passengers have tested positive for COVID-19. As a result of the outbreak onboard the Grand Princess, the Federal government engaged in a massive effort to disembark and quarantine American passengers from the ship on four military bases to help prevent further transmission to the passengers' home communities. Passengers from Sailing A were from more than 30 U.S. states and 25 countries; Sailing B included passengers from over 50 countries. More than 70 persons from this voyage

have reported symptoms and require assessment and evaluation and additional confirmed cases in multiple states/countries are anticipated.

The Director Has Reason to Believe That Cruise Ship Travel May Continue to Introduce, Transmit, or Spread COVID-19

Cruise ship travel markedly increases the risk and impact of the COVID-19 disease outbreak within the United States. Disembarkation of passengers at sequential ports may lead to disease transmission in those ports. Return of disembarked infected passengers to their communities could lead to widespread disease transmission. Cases that have been confirmed to date may have led to secondary transmission, including in a healthcare worker. Furthermore, the passenger population of cruises often includes a substantial number of older adults, meaning there is higher risk for COVID-19 morbidity and mortality. Industry trade publications report that 51% of cruise ship passengers are over the age of 50. The median age of passengers onboard the Grand Princess Sailing B, for example, was 66 and 1,200 passengers on the ship were over age 70. Given these demographics, many cruise passengers

are at high risk for severe disease if they become infected.

Beyond the risk to these individuals, the intensive care requirements for cruise ship passengers with severe disease stresses a healthcare system already overburdened and facing a shortage of beds needed for influenza and other seasonal and critical healthcare conditions. The addition of further cruise ship cases place healthcare workers at substantial increased risk. Specifically, these cases divert medical resources away from persons with other medical problems and other COVID-19 cases, consuming precious diagnostics, therapeutics, and protective equipment. Ongoing concerns with cruise ship transmission also draw valuable resources away from the immense Federal, state, and local effort to contain and mitigate the spread of COVID-19. Safely evacuating, triaging, quarantining, and repatriating cruise ship passengers involves complex logistics, incurs financial costs at all levels of government, and diverts resources away from larger efforts to suppress or mitigate the virus.

Coordination Efforts with the Cruise Ship Industry

To address the continued and significant risks and burdens posed by ongoing cruise ship operations, CDC and other Federal agencies have engaged with representatives from Cruise Lines International Association ("CLIA"), the leading industry trade group. To that end, CLIA members and certain individual cruise lines have voluntarily taken steps to try to mitigate the impact of the spread of COVID-19. On March 13, 2020, CLIA and their associated members announced that all member cruise lines would voluntarily suspend cruise ship operations from U.S. ports of call for 30 days as public health officials and the Federal government continue to address COVID-19. The Federal government recognizes the enormity and importance of this action taken by CLIA and the commitment it demonstrates to protecting the health of both cruise ship passengers and the public at large. Following the example set by CLIA members, additional cruise lines have also voluntarily suspended operations from U.S. ports of call. Although the CLIA members and the additional cruise lines implementing a voluntary suspension of operations represent a large majority of the cruise industry, not all cruise lines or ships have announced a voluntary suspension of operations or that they will follow the important example set by CLIA members. This Order is intended to cover and specifically

apply to those cruise lines or ships that do not undertake a voluntary suspension of operations. As a result, this Order specifically excludes from applicability any cruise line or ship that voluntarily suspends operations for the period of this Order, as CLIA members have done.

Findings and Immediate Action

Accordingly, and consistent with 42 C.F.R. § 71.32(b), the Director of CDC ("Director") finds evidence to support a reasonable belief that cruise ships are or may become infected or contaminated with a quarantinable communicable disease.⁵ This reasonable belief is based on information from epidemiologic and other data regarding the nature and transmission of COVID-19 on cruise ships from the recent outbreaks onboard the Diamond Princess, Grand Princess, and other cruise ships. As a result, cruise ship passengers may be infected with or exposed to COVID-19 by virtue of having been onboard a cruise ship at a time when cases of COVID-19 are being reported in significant numbers globally and specifically on cruise ships, when testing is available.

⁵ COVID-19 is a communicable disease for which quarantine is authorized under Section 361 of the Public Health Service Act (42 U.S.C. § 264) and 42 C.F.R. §§ 70.1, 71.1, as listed in Executive Order 13295, as amended by Executive Orders 13375 and 13674.

The Director also finds that cruise ship travel may exacerbate the global spread of COVID-19. The scope of this pandemic is inherently and necessarily a problem that is international and interstate in nature, and cannot be controlled sufficiently by the cruise ship industry or individual state or local health authorities. Accordingly, under 42 C.F.R. § 70.2, the Director determines that measures taken or likely to be taken by state and local health authorities regarding COVID-19 onboard cruise ships are inadequate to prevent the further interstate spread of the disease.

The Director further determines that this Order provides public health authorities, in concert with the cruise ship industry, the necessary pause in operations to develop and implement an appropriate and robust plan to prevent and mitigate the spread of COVID-19, and acts to prevent the spread of the disease and ensure cruise ship passenger and crew health.

Therefore, in accordance with Sections 361 and 365 of the Public Health Service Act (42 U.S.C. §§ 264, 268) and 42 C.F.R. §§ 70.2, 71.32(b), for all cruise ships not

voluntarily suspending operations for the period described below, it is ORDERED:

1. Cruise ship operators shall be allowed to disembark passengers and crew members at ports or stations only as directed by the United States Coast Guard (USCG), in consultation with HHS/CDC personnel and, as appropriate, as coordinated with Federal, state, and local authorities.

2. Cruise ship operators shall not reembark any crew member, except as approved by USCG, in consultation with HHS/CDC personnel, until further notice.

3. Cruise ship operators shall not embark any new passengers or crew, except as approved by USCG, or other Federal authorities as appropriate, in consultation with HHS/CDC personnel.

4. Cruise ship operators shall not commence or continue operations (e.g., shifting berths, moving to anchor, or discharging waste), except as approved by USCG, in consultation with HHS/CDC personnel, until further notice.

5. While in port, the cruise ship operator shall observe health precautions as directed by HHS/CDC personnel.

6. The cruise ship operator shall comply with all HHS/CDC, USCG, and other Federal agency instructions to follow CDC recommendations and guidance for any public health actions relating to passengers, crew, ship, or any article or thing on board the ship, as needed, including by making ship's manifests and logs available and collecting any specimens for COVID-19 testing.

7. This order does not prevent the periodic reboarding of the ship by HHS/CDC personnel and/or USCG and/or other Federal, state, or local agencies or the taking on of ships' stores and provisions under the supervision of HHS/CDC personnel and/or USCG.

8. This order does not prevent the ship from taking actions necessary to maintain the seaworthiness or safety of the ship, or the safety of harbor conditions, such as movement to establish safe anchorage, or as otherwise directed by USCG personnel.

CDC may modify this order by an updated publication in the Federal Register or by posting an advisory to follow at www.cdc.gov.

Authority

The authority for these orders is Sections 361 and 365 of the Public Health Service Act (42 USC §§ 264, 268) and 42 CFR §§ 70.2, 71.32(b).

Dated: March 19, 2020

Robert R. Redfield, M.D.

Director,

Centers for Disease Control and Prevention

**ORDER OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION,
DEPARTMENT OF HEALTH AND HUMAN SERVICES
UNDER 42 CFR 71.31 and 71.4**

Attn: Each airline carrying a passenger who has departed from, or was otherwise present within, the People's Republic of China (excluding the special administrative regions of Hong Kong and Macau) within 14 days of the date of the passenger's entry or attempted entry into the United States via that airline's carriage.

In accordance with 42 CFR §§ 71.31(b) and 71.4(d), as authorized by 42 U.S.C. § 264:

1. Each airline is hereby ordered to collect and provide information about any passenger who has departed from, or was otherwise present within, the People's Republic of China (excluding the special administrative regions of Hong Kong and Macau) within 14 days of the date of the passenger's entry or attempted entry into the United States via that airline's carriage ("Designated Passengers").
2. Each airline must collect and provide the following information ("Designated Information") to the extent such information exists for any Designated Passenger carried by that airline:
 - a. Full name (last, first, and, if available, middle or others);
 - b. Primary contact phone number to include country code, at which a Designated Passenger can be contacted while in the United States;
 - c. Secondary contact phone number to include country code;
 - d. Address or addresses while a Designated Passenger is in the United States (number and street, city, State, and zip code), except that a U.S. citizen or a lawful permanent resident will provide address of permanent residence in the United States (number and street, city, State, and zip code); and
 - e. Email address that a Designated Passenger will use for email communications while in the United States.
3. Each airline must produce, using existing data-sharing channels, the Designated Information to the Director of the CDC's Division of Global Migration and Quarantine ("DGMQ"), or his representative. If existing data-sharing channels become unavailable, within 12 hours, the affected airline or airlines must identify an alternate means of transmitting the required data in a manner acceptable to CDC.
4. Each airline must provide Designated Information within 2 hours of the departure of the flight carrying a Designated Passenger.
5. Before or immediately upon arrival in the United States, each airline must provide to CDC (the head of the arrival airport's Quarantine Station) the name of any Designated Passenger who had refused or was otherwise unable to provide all five fields of the Designated Information prior to departure.
6. Each airline must provide Designated Information for the duration of the January 31, 2020 Proclamation on Suspension of Entry as Immigrants and Nonimmigrants of Persons who Pose a Risk of Transmitting 2019 Coronavirus. This order will

cease to be effective when the Interim Final Rule at Federal Register, Vol. 85, No. 29, ceases to be effective.

The CDC Director has determined that Designated Passengers may be at risk of exposure to COVID-19. CDC will use this information for the purposes of public health follow-up, such as health education, treatment, prophylaxis, or other appropriate public health interventions, including travel restrictions.

“Airline” as used in this order has the meaning provided at 42 CFR § 71.1(b).

Failure to comply with this order may result in the imposition of fines or other penalties as provided in 42 U.S.C. § 271 and 42 C.F.R. § 71.2, or as otherwise provided by law. CDC maintains information retrieved by personal identifier in accordance with federal law, including the Privacy Act of 1974 (5 U.S.C. § 552a). Identifiable information may be shared only for lawful purposes, including with authorized personnel of the U.S. Department of Health and Human Services, state and local public health departments, and other cooperating authorities. CDC will delete the Designated Information when no longer required for the purposes set forth above, in accordance with federal law, and request that State and local governments do the same.

CDC may modify this order by an updated publication in the Federal Register or by posting an advisory to follow at www.cdc.gov.

In testimony whereof, the Director, Centers for Disease Control and Prevention, U.S. Department for Health and Human Services, has hereunto set his hand at Atlanta, Georgia, this 18th day of February, 2020.

Handwritten signature of Robert R. Redfield in black ink.

Robert R. Redfield, M.D.

Director, Centers for Disease Control and Prevention

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

**ORDER UNDER SECTIONS 361 & 365
OF THE PUBLIC HEALTH SERVICE ACT (42 U.S.C. 264, 268) AND
42 CODE OF FEDERAL REGULATIONS
PART 70 (INTERSTATE) AND PART 71 (FOREIGN):**

**MODIFICATION AND EXTENSION OF NO SAIL ORDER
AND OTHER MEASURES RELATED TO OPERATIONS**

Previous Order and Incorporation by Reference

This Order renews the No Sail Order and Other Measures Related to Operations signed by the CDC Director on March 14, 2020—subject to the modifications and additional stipulated conditions as set forth in this Order. This Order shall continue in operation until the earliest of (1) the expiration of the Secretary of Health and Human Services’ declaration that COVID-19 constitutes a public health emergency; (2) the CDC Director rescinds or modifies the order based on specific public health or other considerations; or (3) 100 days from the date of publication in the Federal Register. The findings and other evidence relied upon in issuing the March 14, 2020 Order are incorporated herein by reference. Any ambiguity between the March 14, 2020 Order, as modified by the current Order, shall be resolved in favor of the current Order.

Statement of Intent

This Order shall be interpreted and implemented in a manner as to achieve the following paramount objectives:

- Preservation of human life;
- Preventing the further introduction, transmission, and spread of COVID-19 into and throughout the United States;
- Preserving the public health and other critical resources of Federal, State, and local governments;
- Preserving hospital, healthcare, and emergency response resources within the United States; and
- Maintaining the safety of shipping and harbor conditions, including safety of personnel.

Applicability

This Modification and Extension of No Sail Order and Other Measures Related to Operations shall apply only to the subset of carriers¹ described below and hereinafter referred to as “cruise ships.”

¹ Carrier is defined by 42 CFR § 71.1 to mean, “a ship, aircraft, train, road vehicle, or other means of transport, including military.”

All commercial, non-cargo,² passenger-carrying vessels operating in international, interstate, or intrastate waterways and subject to the jurisdiction of the United States with the capacity to carry 250³ or more individuals (passengers and crew) with an itinerary anticipating an overnight stay onboard or a twenty-four (24) hour stay onboard for either passengers or crew.⁴

This Order shall additionally apply to any cruise ship that was previously excluded from the March 14, 2020 Order, by virtue of having voluntarily suspended operations.

“Operations” for purposes of this Order means any action by a cruise ship operator to bring or cause a cruise ship to be brought into or transit in or between any international, interstate, or intrastate waterways (e.g., shifting berths, moving to anchor, discharging waste, making port, or embarking or disembarking passengers or crew) subject to the jurisdiction of the United States.

“Operator” for purposes of this Order means the Master of the vessel (cruise ship) and any other crew member responsible for cruise ship operations and navigation, as well as any person or entity (including a corporate entity) that authorizes or directs the use of a cruise ship (e.g., as owner, lessee, or otherwise). A cruise ship operator may be either the cruise ship captain or the cruise line to which the cruise ship belongs, or both. The term “Operator” as used in this Order further incorporates the terms “company,” “designated person,” and “responsible person” as defined in 33 CFR. § 96.120.

Events Since the Issuance of March 14, 2020 Order

On March 14, 2020, the CDC Director issued a No Sail Order and Other Measures Related to Operations directing cruise ships not voluntarily suspending operations to comply with measures outlined by the CDC and U.S. Coast Guard. This followed a March 13, 2020, announcement by Cruise Lines International Association (CLIA), the leading industry trade group, that its members would voluntarily suspend cruise ship operations. On March 17, 2020, CDC issued a Level 3 Travel Warning that all travelers defer cruise travel worldwide based on widespread ongoing transmission of COVID-19.⁵ The suspension of a global tourism industry, such as the

² Given the substantial risk of person-to-person transmission of COVID-19, as opposed to transmission via indirect contact, this Order is currently limited to passenger, non-cargo vessels.

³ Based on substantial epidemiological evidence related to congregate settings and mass gatherings, this Order suspends operation of vessels with the capacity to carry 250 individuals or more. Evidence shows that settings as small as nursing homes or movie theaters can proliferate the spread of a communicable disease. As the numbers of passengers and crew onboard a ship increases, certain recommended mitigation efforts such as social distancing become more difficult to implement. In light of the demonstrated rapid spread of this communicable disease in current cruise ship settings, application of this Order to vessels carrying 250 or more individuals is a prudent and warranted public health measure. Moreover, the management of current coronavirus cases in addition to existing seasonal care needs (e.g., influenza) has placed an extreme burden on the public health and healthcare systems and this Order will help avoid further stressing those systems.

⁴ This order shall not apply to vessels operated by a U.S. Federal or State government agency. Nor shall it apply to vessels being operated solely for purposes of the provision of essential services, such as the provision of medical care, emergency response, activities related to public health and welfare, or government services, such as food, water, and electricity.

⁵ CDC, Traveler’s Health, *COVID-19 and Cruise Ship Travel*, at: <https://wwwnc.cdc.gov/travel/notices/warning/coronavirus-cruise-ship> (originally posted, March 17, 2020).

cruise line industry, does not happen instantaneously or easily. During the suspense of operations, the cruise line operators worked with both Federal, State, and local governments to disembark of over 250,000 passengers from more than 120 vessels. The cruise line operators continue discussions with Federal, State and local governments regarding the 114 vessels with over 93,000 crew either in or near U.S. ports. However, COVID-19 clusters and outbreaks continue to occur on and in connection with cruise ships.

There are a number of recent incidences of reported COVID-19 spread onboard cruise ships including the *Costa Magica*, *Costa Favolosa*, *Celebrity Eclipse*, *Disney Wonder*, *Holland America Zaandam*, and *Celebrity Coral Princess*. The *Costa Magica* and the *Costa Favolosa*, reported at least 88 ill crew members on board with respiratory symptoms of COVID-19. On March 26, 2020, in coordination with U.S. Coast Guard and public health personnel, four infected crew members were evacuated off the *Magica* and seven from the *Favolosa* for life-critical care at Jackson Memorial Hospital in Miami, Florida. The *Zaandam* cruise ship reported illness consistent with COVID-19 in at least 250 persons onboard – guests and crew members; 76 of these persons remain symptomatic. Four passengers onboard the *Zaandam* have died (one for non-COVID-19 related reasons).⁶ As of April 1, 2020, four crew members onboard the *Eclipse* have tested positive for COVID-19, three of whom remain on the ship. One passenger onboard the *Eclipse* required emergency medical evacuation and is currently hospitalized in San Diego, California after having tested positive for COVID-19. The *Wonder* reported four crew members who have tested positive for COVID-19. Two of the four are now hospitalized, the two others are isolated on the ship; an additional three former passengers (from the last voyage who disembarked) are also positive. Most recently, the *Coral Princess* reported 12 persons (seven passengers and five crew members) onboard who are confirmed positive for COVID-19 and an additional 43 suspected cases in persons with influenza-like illness. As of April 3, 2020, there are four patients on oxygen in the ship's medical center.

There are approximately 50 cruise ships that remain at sea off the East Coast of the United States and in the Bahamas with an estimated 47,800 crew onboard; off the West Coast and Gulf Coast there are approximately 45 cruise ships with an estimated 32,000 crew onboard. Some of these crew are not critical to maintain the seaworthiness or basic safe operation of the cruise ships; many are part of the hotel and hospitality crew. CDC is currently aware of 15 cruise ships at port or anchorage in the United States with known or suspected COVID-19 infection among the crew who remain onboard. CDC is currently tracking two cruise ships with passengers that are expected to make port in the United States.

There are several public health concerns when crew members become ill while onboard these ships and the cruise lines seek the aid of the United States in disembarking them, as has already occurred on numerous occasions. The intensive care requirements for infected crew in need of life-critical care greatly stresses an already overburdened healthcare system facing shortages of masks, test kits, beds, and ventilators needed to respond to COVID-19. The addition of further COVID-19 cases from cruise ships places healthcare workers at substantial increased risk. Moreover, safely evacuating, triaging, and repatriating cruise ship crew involves complex

⁶ “President of Holland America cruise line pleads for compassion while Florida debates allowing ships to dock,” Fox News, March 31, 2020, available at: <https://www.foxnews.com/travel/zaandam-holland-america-cruise-president-florida-debate>.

logistics, incurs financial costs at all levels of government, and diverts resources away from larger efforts to suppress or mitigate COVID-19.

Critical Need for Further Cooperation and Response Planning

CDC and other Federal agencies engaged with CLIA representatives in early March. On March 13, 2020, CLIA and their associated members announced that all member cruise lines would voluntarily suspend cruise ship operations from U.S. ports of call for 30 days as public health officials and the Federal government continue to address COVID-19. Several cruise lines followed CLIA's example and similarly voluntarily suspended operations.

CLIA also drafted a response plan, "On Course: Cruise Industry COVID-19 Response and Protocols" (hereinafter, "On Course"). The plan proposed "industry management of suspected or confirmed cases of COVID-19 without burden on the U.S. government."⁷ CLIA stated that it could implement this plan within 7 days.⁸ In response to a suspected or confirmed case of COVID-19, "industry would be responsible for transporting the [exposed or infected] individuals in appropriate buses, cars, or ambulances."⁹ Furthermore, CLIA averred that, "contracts for predesignated facilities though Global Rescue [a firm with purported experience and expertise in mass medical incidents] [would] receive COVID-19 patients, including arrangements [that] will be executed following plan approval."¹⁰ CLIA further stated that it had planned for "multiple redundancies" in its response efforts. Specifically, "CLIA commits to making five ships available for temporary housing purposes. They would be tasked with sailing to any affected ship and taking affected guests and crew aboard for the self-isolation period."¹¹

On April 3, 2020, CLIA drafted a new response plan, "Framework: For Cruise Industry Care of Crew and other Persons on Board while Ships Remain Idle during the Global COVID-19 Pandemic" (hereinafter, "Framework"). The Framework plan must go further to reduce industry reliance on government and shoreside hospital resources. For example, while the Framework states that a ship will maintain its medical staff, it must provide further details of how the industry will provide for the acute care needs of the critically ill. The Framework must also address industry assistance to COVID-19 affected cruise ships by deploying additional ships for cohort separation of those who are exposed, infected, and in need of hospitalization. Furthermore, laboratory sampling and testing, onboard mitigation and prevention strategies, disinfection protocols, personal protective equipment, repatriation of foreign nationals, and onshore transportation, including through contract medivac helicopter, must be addressed in further detail, including how the industry proposes to acquire, staff, and operationalize this plan, with minimal burden on Federal, State, or local government entities or the healthcare system.

Findings and Immediate Action

⁷ (On Course, pages 1, 10).

⁸ *Id.* at 2.

⁹ *Id.* at 1-2.

¹⁰ *Id.* at 7.

¹¹ *Id.* at 13.

Accordingly, and consistent with 42 CFR §§ 70.2, 71.31(b) and 71.32(b), the Director of CDC (“Director”) finds that cruise ship travel exacerbates the global spread of COVID-19 and that the scope of this pandemic is inherently and necessarily a problem that is international and interstate in nature and has not been controlled sufficiently by the cruise ship industry or individual State or local health authorities. As described in the March 14, 2020 Order, cruise ship travel markedly increases the risk and impact of the COVID-19 disease outbreak within the United States. If unrestricted cruise ship passenger operations were permitted to resume, infected and exposed cruise ship cases would place healthcare workers at substantial increased risk. Specifically, these cases would divert medical resources away from persons with other medical problems and other COVID-19 cases, consuming precious diagnostics, therapeutics, and protective equipment. Ongoing concerns with cruise ship transmission would further draw valuable resources away from the immense Federal, State, and local effort to contain and mitigate the spread of COVID-19. Further, the current ongoing non-passenger operation of cruise ships has not sufficiently abated the public health concern, as ship crew become sick and require medical care drawing on otherwise engaged Federal, State, and local resources. As operators of non-U.S. flagged vessels sailing in international waters, it is imperative that the cruise ship industry and cruise lines themselves take responsibility for the care of their crew and do not further tax limited U.S. resources during a public health emergency.

The Director also finds evidence to support a reasonable belief that cruise ships are or may be infected or contaminated with a quarantinable communicable disease.¹² This reasonable belief is based on information from epidemiologic and other data regarding the nature and transmission of COVID-19 on cruise ships, including the information described in the March 14, 2020 Order and evidence from the *Costa Magica*, *Costa Favolosa*, *Eclipse*, *Wonder*, *Zaandam*, *Coral Princess*, and other cruise ships. As a result, persons onboard cruise ships may be infected with or exposed to COVID-19 by virtue of being onboard at a time when cases of COVID-19 are being reported in increasingly significant numbers globally¹³ and specifically on cruise ships, when testing is available.

Accordingly, under 42 CFR § 70.2, the Director determines that measures taken by State and local health authorities regarding COVID-19 onboard cruise ships are inadequate to prevent the further interstate spread of the disease.

This Order is not a rule within the meaning of the Administrative Procedure Act (“APA”), but rather an emergency action taken under the existing authority of 42 CFR §§ 70.2, 71.31(b) and 71.32(b). In the event that this Order qualifies as a rule under the APA, notice and comment and a delay in effective date are not required because there is good cause to dispense with prior public notice and comment and the opportunity to comment on this Order and the delay in effective date.¹⁴ Considering the public health emergency caused by COVID-19 based, among other things, on its continued spread on board cruise ships, it would be impracticable and

¹² COVID-19 is a communicable disease for which quarantine is authorized under Section 361 of the Public Health Service Act (42 U.S.C. § 264) and 42 CFR §§ 70.1, 71.1, as listed in Executive Order 13295, as amended by Executive Orders 13375 and 13674.

¹³ Since the March 14, 2020 Order, the number of global cases of COVID-19 reported by the World Health Organization (WHO) has risen from 142,534 to 1,051,635 as of April 4, 2020, with 56,985 deaths. See Situation Reports, WHO, <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports>.

¹⁴ See 5 U.S.C. §§ 553(b)(B), (d)(3).

contrary to the public health, and by extension the public interest, to delay the issuance and effective date of this Order. Similarly, if this Order qualifies as a rule per the definition in the APA, the Office of Information and Regulatory Affairs has determined that it would be a major rule, but there would not be a delay in its effectiveness as the agency has invoked the good cause provision of the APA.

If any provision in this Order, or the application of any provision to any carriers, persons, or circumstances, shall be held invalid, the remainder of the provisions, or the application of such provisions to any carriers, persons or circumstances other than those to which it is held invalid, shall remain valid and in effect.

In accordance with 42 U.S.C. § 264(e), this Order shall supersede any provision under State law (including regulations and provisions established by political subdivisions of States), that conflict with an exercise of Federal authority, including instructions by U.S. Coast Guard (USCG) or HHS/CDC personnel permitting ships to make port or disembark persons under stipulated conditions, under this Order.

This Order shall be enforceable through the provisions of 18 U.S.C. §§ 3559, 3571; 42 U.S.C. §§ 243, 268, 271; and 42 CFR §§ 70.18, 71.2.

Therefore, in accordance with Sections 361 and 365 of the Public Health Service Act (42 U.S.C. §§ 264, 268) and 42 CFR §§ 70.2, 71.31(b), 71.32(b), for all cruise ships for the period described below, it is **ORDERED**:

1. As a condition of obtaining controlled free pratique to continue to engage in any cruise ship operations in any international, interstate, or intrastate waterways subject to the jurisdiction of the United States, cruise ship operators shall immediately develop, implement, and within **seven (7) days** of the signing of this Order operationalize, an appropriate, actionable, and robust plan to prevent, mitigate, and respond to the spread of COVID-19 on board cruise ships.
2. As a condition of obtaining controlled free pratique to continue to engage in any cruise ship operations in any international, interstate, or intrastate waterways subject to the jurisdiction of the United States, the cruise ship operator shall make the plan described in paragraph 1, above, available to HHS/CDC and USCG personnel within **seven (7) days** of the signing of this Order.
3. An appropriate plan is one that adequately prevents, mitigates, and responds to the spread of COVID-19 on board cruise ships and that, at a minimum, must address the following elements:
 - a. Onboard surveillance of passengers and crew with acute respiratory illnesses, influenza-like illnesses, pneumonia, and COVID-19, including reporting to HHS/CDC on a weekly basis on overall case counts, methods of testing, and number of persons requiring hospitalization or medical evacuation;
 - b. Reports on the number of persons onboard the cruise ship and any increase in the numbers of persons with COVID-19 made to HHS/CDC and USCG on a daily

basis for as long as the cruise ship is within waters subject to the jurisdiction of the United States.

- c. Onboard monitoring of passengers and crew through temperature checks and medical screening, including addressing frequency of monitoring and screening;
- d. Training of all crew on COVID-19 prevention, mitigation, and response activities;
- e. Protocols for any COVID-19 testing, including details relating to the shore-side transport, administration, and operationalization of laboratory work if onboard laboratory work is not feasible;
- f. Onboard isolation, quarantine, and social distancing protocols to minimize the risk of transmission and spread of COVID-19;
- g. Onboard medical staffing, including number and type of staff, and equipment in sufficient quantity to provide a hospital level of care (e.g., ventilators, facemasks, personal protective equipment) for the infected without the need for hospitalization onshore;
- h. An outbreak management and response plan to provision and assist an affected cruise ship that relies on industry resources, e.g., mobilization of additional cruise ships or other vessels to act as “hospital” ship for the infected, “quarantine” ship for the exposed, and “residential” ship for those providing care and treatment, including the ability to transport individuals between ships as needed;
- i. Categorization of affected individuals into risk categories with clear stepwise approaches for care and management of each category;
- j. A medical care plan addressing onboard care versus evacuation to on-shore hospitals for critically ill individuals, specifying how availability of beds for critically ill at local hospitals will be determined in advance and how the cruise ship operator will ensure acceptance at local medical facilities to treat the critically ill in a manner that limits the burden on Federal, State, and local resources and avoids, to the greatest extent possible, medivac situations. If medical evacuation is necessary arrangements for evacuation must be made with commercial resources (e.g., ship tender, chartered standby vessel, chartered airlift) and arrangements made with a designated medical facility that has agreed to accept such evacuees. All medical evacuation plans must be coordinated with the U.S. Coast Guard;
- k. Detailed logistical planning for evacuating and repatriating, both U.S. citizens and foreign nationals, to their respective communities and home countries via foreign government or industry-chartered private transport and flights, including the steps the cruise ship operator will take to ensure those involved in the transport are not exposed; (the use of commercial flights to evacuate or repatriate individuals, both within or from the United States, is prohibited);
- l. The projected logistical and resource impact on State and local government and public health authorities and steps taken to minimize the impact and engage with these authorities; all plans must provide for industry/cruise line management of suspected or confirmed cases of COVID-19 without resource burden on Federal, State, or local governments;
- m. Plan execution in all U.S. geographical areas – all plans must be capable of being executed anywhere in international, interstate, or intrastate waterways subject to the jurisdiction of the United States; and

- n. Cleaning and disinfection protocols for affected cruise ships.
- 4. An appropriate plan shall be designed to minimize, to the greatest extent possible, any impact on U.S. government operations or the operations of any State or local government, or the U.S. healthcare system.
- 5. The cruise ship operator shall further ensure that the plan is consistent with the most current CDC recommendations and guidance for any public health actions related to COVID-19. Where appropriate, a cruise ship operator may coordinate the development, implementation, and operationalization of a plan with other cruise ship operators, including an industry trade group.

The terms and conditions of the No Sail Order and Other Measures Related to Operations signed on March 14, 2020, as modified and extended by this ORDER, **SHALL REMAIN IN EFFECT**. Consequently, it remains **ORDERED**:

- 1. Cruise ship operators shall not be allowed to disembark passengers and crew members at ports or stations, except as directed by the USCG, in consultation with HHS/CDC personnel and, as appropriate, as coordinated with Federal, State, and local authorities.
- 2. Cruise ship operators shall not reembark any crew member, except as approved by USCG, in consultation with HHS/CDC personnel, until further notice.
- 3. Cruise ship operators shall not embark any new passengers or crew, except as approved by USCG, or other Federal authorities as appropriate, in consultation with HHS/CDC personnel.
- 4. Cruise ship operators shall not commence or continue operations (e.g., shifting berths, moving to anchor, or discharging waste), except as approved by USCG, in consultation with HHS/CDC personnel, until further notice.
- 5. While in port, the cruise ship operator shall observe health precautions as directed by HHS/CDC personnel.
- 6. The cruise ship operator shall comply with all HHS/CDC, USCG, and other Federal agency instructions to follow CDC recommendations and guidance for any public health actions relating to passengers, crew, ship, or any article or thing on board the ship, as needed, including by making ship's manifests and logs available and collecting any specimens for COVID-19 testing.
- 7. This order does not prevent the periodic reboarding of the ship by HHS/CDC personnel and/or USCG and/or other Federal, State, or local agencies or the taking on of ships' stores and provisions under the supervision of HHS/CDC personnel and/or USCG.

8. This order does not prevent the ship from taking actions necessary to maintain the seaworthiness or safety of the ship, or the safety of harbor conditions, such as movement to establish safe anchorage, or as otherwise directed by USCG personnel.

This Order is effective upon publication in the Federal Register and shall continue in operation until the earliest of (1) the expiration of the Secretary of Health and Human Services' declaration that COVID-19 constitutes a public health emergency; (2) the CDC Director rescinds or modifies the order based on specific public health or other considerations; or (3) 100 days from the date of publication in the Federal Register.

In testimony whereof, the Director, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, has hereunto set his hand at Washington, D.C., this 9th day of April, 2020.

A handwritten signature in black ink, reading "Robert R. Redfield MD". The signature is fluid and cursive, with the letters "R" and "M" being particularly large and stylized.

Robert R. Redfield, MD
Director
Centers for Disease Control and Prevention