

## SITUATIONAL BRIEF: TRANSIT MIGRATION IN MEXICO DURING THE COVID-19 PANDEMIC

**Authors:** Ana Cristina Sedas MD, MMCs(c)<sup>1</sup>; Mercedes Aguerreberere MD, MMCs<sup>2</sup>; Luis Alberto Martinez Juarez MD, MPH, DrPH(c)<sup>3</sup>; Luis Eduardo Zavala-deAlba, PhD<sup>4</sup>; Itzel Eguiluz, MSc, PhD<sup>5</sup>; \*Jacqueline Bhabha, LLM, MSc<sup>6</sup>

### CONTEXT: TRANSIT MIGRATION FROM CENTRAL AMERICA

Aligned to the Lancet Migration Global Statement to include migrants and refugees in countries' response to COVID-19, this update focuses on Mexico's challenges and opportunities to build an inclusive response that is based on a contextualized adaptation of the recommendations published by the Lancet Migration<sup>1,2</sup>. A critical component for this analysis is the recognition of migration as a social determinant of health, which acts as a major risk factor for populations subjected to violence, trauma and forced exile<sup>3</sup> while in the face of a global pandemic.

- 1.1 Since 2018, unprecedented numbers of Central American migrants from three northern triangle countries of Guatemala, Honduras and El Salvador, have transited through Mexico. In 2019, increasing poverty, extreme violence, gender-based violence, state failure and climate change drove around 400,000 distressed Latin Americans to flee north. A distinctive recent feature of this large-scale have been the Central American Caravans<sup>4,5</sup>—a form of collectively organized migration<sup>6,7</sup> comprised of large groups that number between 3,000 and 6,000 migrants travelling together as a moving cohort. The demographic membership of these groups include family units, unaccompanied minors, elderly migrants, and people with disabilities and chronic health conditions<sup>8</sup>. Both the number of people traveling together, and the demographic diversity have increased the complexity of humanitarian assistance as the already under-resourced and fragile systems and infrastructures are overburdened. This situation further hinders access to services critical for health and well-being (food, water, shelter, hygiene, medical and psychological care) which are usually provided by migrant shelters<sup>9</sup>. At the same time, people in the caravans may experience predatory violence, sexual assault, rape, trafficking, food insecurity, discrimination and social exclusion<sup>10</sup>. Moreover, asylum seekers waiting times exceed months or years during which migrants remain in dangerous and high-risk border cities<sup>11</sup>; due to the "Migrant Protection Protocol" (in place since 2019) 62,000 migrants have been sent back to northern cities<sup>12</sup>.
- 1.2 Over the last three years, numerous policies have been implemented in response to the surge in US-bound Central American migration through Mexico. The binational response to COVID-19 complicates this already challenging policy terrain, further limiting distress migration to the US despite the unchanging home country situation. The deterrent impact of these policies is evidenced by a 45% decrease in apprehensions at the U.S Mexico border in 2020 compared to the same period the previous year, and a 33% increase in asylum claims in Mexico during the first three months of 2020<sup>13–15</sup>. US anti-migration rhetoric and rapidly escalating barriers to asylum have been widely criticized by human rights experts and international humanitarian agencies<sup>11,16</sup>. They point to the importance of safeguarding the livelihood, human rights and physical and mental health of thousands of migrants trapped in overcrowded shelters, camps and detention centers where humanitarian assistance falls below minimum standards<sup>17</sup>.
- 1.3 Several measures with severe exclusionary impact have been justified by reference to migrants' (unsubstantiated) national security impact in relation to the spread of COVID-19. On March 24<sup>th</sup>, the Mexican Secretary of Foreign Affairs agreed to receive 1,250 returned Central American asylum seekers per day from U.S. detention centers<sup>18,19</sup>. At the same time, Mexico is deporting large numbers of asylum seekers to Central America. As of mid-April, at least 13,100 people including families, single adults and unaccompanied minors have been returned from Mexico and the U.S. to their home countries<sup>20</sup>. International humanitarian agencies have demanded a halt to these deportation practices, not only because they deprived forced migrants of protection, but also because they increase the risk of COVID-19 transmission into countries with fragile health systems and limited capacity to follow international COVID-19 preparedness and response guidelines<sup>20,21</sup>.

<sup>1</sup> Harvard Medical School, Global Health and Social Medicine, [ana\\_sedas@hms.harvard.edu](mailto:ana_sedas@hms.harvard.edu)

<sup>2</sup> National Institute of Psychiatry (Mexico), Universidad Nacional Autónoma de México, Partners in Health-Mexico, [meraguerreberere@gmail.com](mailto:meraguerreberere@gmail.com)

<sup>3</sup> London School Hygiene and Tropical Medicine, Mexican Society of Public Health, [luis.martinez@lshtm.ac.uk](mailto:luis.martinez@lshtm.ac.uk)

<sup>4</sup> Director of Casa Monarca. Humanitarian Aid for Migrants, [direccion@casamonarca.org.mx](mailto:direccion@casamonarca.org.mx)

<sup>5</sup> Tecnológico de Monterrey, [eguiluz@tec.mx](mailto:eguiluz@tec.mx)

<sup>6</sup> FBX Center for Health and Human Rights, Harvard T.H Chan School of Public Health, Harvard Law School, Harvard Kennedy School of Government, [jacqueline\\_bhabha@harvard.edu](mailto:jacqueline_bhabha@harvard.edu)

## MEXICAN PREPAREDNESS FOR COVID-19 IN MIGRANT POPULATIONS

- 2.1 According to the *Colegio de la Frontera Norte* (COLEF), 32.5% of Central American migrants travelling as caravan members in 2018 and 41.9% in 2019 expressed a health need, mostly relating to upper respiratory tract infections, fever and diarrhea. An additional 5.4% of caravan members reported diabetes, 19.3% hypertension, 3% physical trauma and 25.2% mentioned other concerns, including reproductive health and mental disorders<sup>6,7,11</sup>. While it is difficult to estimate the true number of migrants in transit through Mexico that need or might need medical care, the International Rescue Committee (IRC) reports that 36% of migrants experience difficulties accessing healthcare<sup>22</sup>. These barriers are likely to increase as the Mexican National Guard implements an increase in militarized checkpoints to regulate migration flow.
- 2.2 Like other countries across the globe, Mexico faces unprecedented pressures to uphold its international legal obligations to protect the health not only of its citizens, but also of the thousands of distressed migrants in the country<sup>9</sup>. To that end, on March 27, 2020, the government of Mexico published public health guidelines to prevent the transmission of COVID-19, mandating immediate suspension of non-essential activities within the public, private and social sectors as well as “social distancing” recommendations<sup>23</sup>.
- 2.3 Internationally accepted guidelines highlight the importance of testing and isolating individuals who are COVID-19 positive or who have been exposed to people who have tested positive<sup>24,25</sup>. However, Mexican efforts to track and limit the spread of the disease, to strengthen national laboratories’ productive capacity and to enhance prevention control have so far attracted limited funding<sup>26</sup>.
- 2.4 Mexico’s National Commission for Human Rights expressed concern over the number of migrants held in government run migrant detention centers and asked the Mexican Foreign Affairs Ministry to initiate negotiations to secure the immediate release and safety of the detainees<sup>27</sup>. Similarly, *Médecins Sans Frontières* (MSF) has appealed to the Mexican authorities to end migrant detention following a riots ignited by the unsanitary conditions and absence of COVID-19 medical preparedness in two facilities in Tabasco and Chiapas<sup>28</sup>. On April 26, 2020 the National Institute of Migration, in response to international criticism of the country’s migrant detention policies, released and returned home 3,653 migrants who had been held without due process in 65 different facilities across the country<sup>29</sup>.
- 2.5 While the Mexican government’s efforts to include refugees in the national COVID-19 response<sup>25</sup> have been acknowledged by the United Nations High Commissioner for Refugees (UNHCR), such efforts have not included or reached all distress migrants equally. Those living in overcrowded and unsanitary conditions, as so many are, struggle to abide by physical distancing or sanitary self-protection strategies. Popular fear and suspicion exacerbate already latent xenophobic tendencies, which further distance this population from equitable and high-quality access to healthcare and social support. Local actors have noted the absence of necessary staff, “stuff” (personal protection equipment), space (for shelter, quarantine and isolation), systems (coordination and rapid response by the local health governance) and social support—the so-called “five Ss” described by the prominent public health expert Paul Farmer<sup>30</sup>. Moreover, there has been no surveillance strategy for migrant populations and to date, only 14 cases of migrants positive to COVID-19 have been reported in the large and densely populated settlement at Tamaulipas<sup>31</sup>.

## POTENTIAL RISKS AND IMPACTS OF COVID-19 FOR MIGRANT HEALTH IN MEXICO

- 3.1 The COVID-19 pandemic has exacerbated an already dire health outlook for forced migrants in Mexico. When the Mexican health system becomes overwhelmed by the COVID-19 health crisis, the health of migrant populations risks being further jeopardized<sup>32</sup>. COVID-19 has exposed for all to see the shared responsibilities of a closely interconnected global polity<sup>33</sup>. The consequences of current and previous political efforts by the U.S and Mexico to deter migration and force vulnerable populations to remain in unsatisfactory settings will become more evident as a growing number of migrants develop severe respiratory illness due to COVID-19 and require attention from already saturated and insufficient health systems<sup>34</sup>.
- 3.2 Mexico is in a particularly compromised position when it comes to facing the onslaught of COVID-19 due to the country’s high prevalence of chronic disease and inequitable access to healthcare<sup>35</sup>. Well before the outbreak of the COVID-19 pandemic, the country had been attempting to cope with significant challenges in the national health system. In January 2020 the *Seguro Popular*—a publicly funded, decentralized insurance program, which covered primary care and 66 high cost specialized health services for 50 million Mexicans<sup>36</sup>—was replaced by the newly centralized National Institute of Health and Well-being (*INSABI*)<sup>37</sup>.

INSABI was designed to provide free comprehensive primary care for all Mexicans. However according to Julio Frenk, a public health expert and previous Mexican Health Minister, the current guidelines and implementation protocols, recurrent budget and personnel cuts, and limited capacity to provide high-quality care for millions of people have been an ongoing cause of public concern<sup>38</sup>. Specialized hospital care has been particularly affected by recent budget cuts<sup>39</sup>, a process that compromises the health system's capacity to respond in a timely and efficient way to the acute emergency posed by COVID-19<sup>40</sup>.

- 3.3 Despite the fact that migrant populations are covered by the 2019-2024 Health Sector Program and the Comprehensive Health Care Plan for the Migrant Population (which describes health services that migrants are entitled to receive<sup>41,42</sup>), “stuff, space and systems” to assure access to these services are lacking. For instance, while *Seguro Popular* provided migrants in transit with health coverage for 90 days<sup>43</sup>, specific guidelines for migrant access to INSABI health care services are not yet publicly available. Moreover, INSABI requires that individuals seeking medical assistance present government-issued identity documentation, a requirement that is likely to prevent many migrants from getting the health care they need<sup>37</sup>.
- 3.4 Considering the demographic profile of the Central American migrant population in Mexico, health vulnerabilities might increase COVID-19 morbidity and mortality. While recent estimates indicate that most migrants are under 45 years of age<sup>6</sup>, there have been growing numbers of elderly, young children and pregnant women transiting Mexico<sup>6</sup>. Likewise, the prevalence of diabetes, hypertension, obesity and tobacco use among the migrant population is likely similar to that of their home countries, which is similar to Mexico<sup>44</sup>. In Mexico, more than half of individuals requiring critical care, as well as more than half of deaths from COVID-19 have to date been in people under 65 years, largely because of the comorbidities previously mentioned<sup>45</sup>.

#### MIGRANT RELATED COVID-19 RESPONSES TO DATE BY GOVERNMENT AND HUMANITARIAN ORGANIZATIONS

- 4.1 In Mexico, as of May 12, 2020, 142,204 tests have been administered, 38,324 positive cases have been confirmed and 3,926 deaths have been reported<sup>46</sup>. National and international commentators suggest the actual figures far exceed those reported<sup>47</sup>. The Government of Mexico has launched several coordinated efforts in order to increase the capacity to respond to COVID-19 across all sectors. On April 4<sup>th</sup> 2020, it initiated a nation-wide recruitment and hiring drive and accelerated the procurement of needed equipment. As of May 12, 2020 over 44,300 health professionals have been temporarily hired and 610 hospitals have been adapted for the COVID-19 response<sup>45</sup>. Approximately 3,000 ventilators have been purchased of which half are estimated to arrive in August or September<sup>48</sup>.
- 4.2 Historically, civil society organizations, including religious bodies and humanitarian non-profits have been the primary providers of migrant health care in Mexico, with a small minority accessing governmental health institutions (1.8%), hospitals or clinics (2.5%)<sup>49</sup>. This complex tapestry of actors provide the health care that local government entities are mandated to ensure<sup>50</sup>. But these actors lack the capacity to respond to the current pandemic. Moreover, in 2019, the Mexican Government modified its humanitarian assistance approach, promoting a more centralized form of migrant care. It instituted federal funding for very large migrant shelters, and at the same time withdrew government funding from all NGOs that provide services to the migrant population and operate smaller shelters<sup>51</sup>. As a result of this policy change, the systems previously built by civil society and migrant shelters have been largely unable to maintain their prior assistance operations<sup>52</sup>.
- 4.3 Most migrant shelters are located in states with high prevalence of COVID-19 transmission. Because of their limiting capacity to implement the national and international health and safety recommendations, many have restricted their regular operations, some temporarily canceled the reception of new migrants<sup>53-55</sup>. These limitations have increased the number of migrants living in homelessness or informal settlements, heightening their risk of physical, gender-based violence and mental illness<sup>56</sup>. Migrants forcefully returned from the U.S. are barely receiving medical care and those who used to receive humanitarian assistance in shelters are now unable to access such services<sup>27,57</sup>. According to the lead coordinator for MSF Mexico, Sergio Martín, the response in migrant shelters has been limited to temperature recordings<sup>58</sup>. Moreover, as the health system's operations narrow to essential services and the COVID-19 response, migrants will be at increased risk of illness and death from all causes, including but not limited to COVID-19<sup>9</sup>.
- 4.4 International humanitarian agencies have tried to mitigate the harm of migrant exclusion, providing “social support” as well as resources through comprehensive delivery strategies. For instance, UNHCR has been collaborating with local actors to strengthen the Water, Sanitation and Hygiene (WaSH) provision in the shelters in Tijuana and Mexicali, and to provide other essential protective services for refugees<sup>59</sup>. The IOM launched a program (*Hotel Filtro*) to avoid migrant virus transmission<sup>60</sup> in

Ciudad Juarez, by providing 14 days of quarantined shelter, food and access to primary care before allowing access to the migrant shelter. IOM is also working with the Mexican government on repatriation assistance and the provision tents and other forms of shelter to migrants in need. In collaboration with local actors, it has also participated in social media anti-discrimination campaigns targeting COVID-19 related anti-migrant xenophobia. Other organizations have also increased their operations to address the new needs generated by the pandemic. MSF is collaborating in the COVID-19 response with local actors and the Ministry of Health (MoH) in both northern and southern states<sup>61</sup>. UNICEF has sent a shipment of medical and personal protection equipment, has supported the local governments by providing access to mental health and psychosocial educational videos. It has strengthened migrant resilience through recreational activities activated via virtual engagement, and distributed violence-prevention and emotional support media and materials<sup>62,63</sup>.

- 4.5 Local actors and non-religious migrant shelters have been coordinating “social support” for migrant populations, mediating between the migrant and the health system when needed, and advocating for the inclusion of this population in the local and national response. Some shelters have started to collaborate with authorities as well as international agencies to assure food provision and support the production of hand-made facemasks by migrants, a gesture that increases solidarity with the host communities<sup>64</sup>, and contribute to the local migration governance.
- 4.6 The Mexican Commission in charge of refugee assistance (COMAR) continues to receive asylum claims, but it has suspended all resolutions, appeals, family reunification and transfer requests until further notice<sup>65</sup>.

### PROPOSED SOLUTIONS TO URGENT HEALTH & HUMANITARIAN NEEDS IN RESPONSE TO COVID-19:

To conclude, Mexico faces unprecedented challenges in addressing the health needs of its large migrant population in the context of the COVID-19 pandemic. The country is likely to continue receiving significant numbers of returned migrants over the following months. In terms of Mexico’s obligations towards its migrant population, international treaties and actors establish a clear set of guiding norms. International agreements mandate non-discriminatory access to care for refugees, asylum seekers and irregular migrants<sup>66–69</sup>. If the Mexican government does not include migrant populations in the evolving decision-making and planning directed at limiting the spread of COVID-19, the chances of controlling transmission will be severely reduced. The following recommendations are aligned to Lancet Migration Global Statement in adaptation of the UCL-*Lancet* Commission of Migration and Health and UNHCR COVID-19 recommendations<sup>70,71</sup> under the “Five S Framework”<sup>30</sup>:

#### Personnel:

- R1. Support the rich array of local actors engaged in efforts to strengthen community response capacity<sup>34</sup>.** They play a critical role by reaching communities in a culturally, and linguistically sensitive manner, building trust and contributing to development of the nuanced forms of intervention, accompaniment and partnership essential for success in vulnerable communities<sup>72</sup>.
- R2. Provide national support and training:** A public health corps trained by the Ministry of Health (MoH) should be available for on-site medical assistance if needed. National Guard agents should receive human-rights training to ensure non-discrimination respect for migrants’ rights to protect free transit, access to health and freedom from torture.

#### Material resources:

- R1. Establish a coordinated response by the MOH, UNHCR and the national body in charge of public health and disease control (CENAPRESE)** to monitor migrant shelter administration and activity, to ensure provision of adequate WaSH and protective equipment and to supervise the establishment of hygiene routines that reduce the risk of infection exposure for staff shelter residents<sup>73</sup>.
- R2. Conduct recommended amounts of testing and contact tracing in accordance with applicable MOH and UNHCR guidelines<sup>74,75</sup>.** As the number of positive cases and reported deaths increase, the deep fissures generated by socio-economic inequalities, including disparities of race, class, gender and health status, will influence the virus’s deadly toll. Mitigate the challenges of maintaining social distancing in migrant shelters and camps by supported isolation of any infected residents.
- R3. Provide culturally and linguistically appropriate information material** to educate and build trust within the migrant community.
- R4. Suspend all fees for health services** and essential services and provisions within migrant shelters.

**Infrastructure:**

- R1. Convene local health authorities, civil society and the national response team to develop clear guidelines** on the COVID-19 pathway to care for migrant populations.
- R2. Identify individuals with special vulnerabilities** and ensure regular provision of their medication requirements.
- R3. Strengthen the infrastructure of migrant shelters** to ensure compliance with minimum standards, including for quarantine and isolation areas.
- R4. Provide free access to the national health system, including to mental health services, without proof of eligibility for asylum seekers, refugees and other distress migrants.**

**Systems:**

- R1. Suspend all policies that prevent migrants from accessing medical, legal, child welfare, social protection, education, immunization and other protective services. Ensure birth registration and access to legal identity and nationality for all migrant children at risk of statelessness following birth in Mexico.**
- R2. Build a migration governance process that complies with Mexico's international human rights obligations and includes the active participation of migrant representatives, other members of civil society, media, local authorities, national and international migration leaders. Ensure that the best interests and views of children and young people inform the governance process.**

**Social support:**

- R1. Encourage all actors involved in the social support of migrants, refugees and internally displaced people (IDP) to engage in sustainable and scalable approaches** that include migrant populations into actions that benefit the entire community. International actors ought to respond in collaboration with community-leaders as they are more knowledgeable about the local needs. Encourage the engagement of beneficiaries in the preparedness and response planning, dissemination and implementation of national strategies.
- R2. Media reporting must support the efforts to include migrants, refugees, and IDPs by combating misinformation and providing well-informed and contextualized facts. Open communication networks must be available through diverse channels to assure timely and accurate information is accessible for this community.**



## Organisations and acknowledgements

*This situational brief was authored by Ana Cristina Sedas MD, MMCs(c)<sup>7</sup>; Mercedes Aguerrebere MD, MMCs<sup>8</sup>; Luis Alberto Martinez Juarez MD, MPH, DrPH(c)<sup>9</sup>; Luis Eduardo Zavala-deAlba, PhD<sup>10</sup>; Itzel Eguiluz, MSc, PhD<sup>11</sup>; Jacqueline Bhabha, LLM, MSc<sup>12</sup>; and expert reviewed by Pia Riggiozzi<sup>13</sup>. Overall direction and review on behalf of the Lancet Migration collaboration was provided by Miriam Orcutt and editorial review by Elspeth Carruthers. This brief represents the views of the authors. Many thanks to the Lancet Migration team, and particularly Miriam Orcutt, for all the time and inputs into the editing and formatting of this briefing.*

*This series of situational and policy briefs summarises key aspects of the COVID-19 response in relation to migrants and refugees at country or regional level. They include public health and policy recommendations and perspectives and build on the [Lancet Migration Global Statement](#) recommendations to ensure migrants and refugees: have access to healthcare; are included in prevention, preparedness and response; and are part of responsible and transparent public information strategies, during the COVID-19 pandemic. Policy and situational briefs have been authored by experts working in academia, operational, or clinical areas of migration and COVID-19, and are hosted on the Lancet Migration website ([www.migrationandhealth.org](http://www.migrationandhealth.org)). Lancet Migration is a global collaboration between The Lancet and researchers, implementers, and others in the field of migration and health that aims to address evidence gaps and drive policy change building on the recommendations of the UCL-Lancet Commission on Migration and Health published in December 2018.*

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<sup>7</sup> Harvard Medical School, Global Health and Social Medicine, [ana\\_sedas@hms.harvard.edu](mailto:ana_sedas@hms.harvard.edu)

<sup>8</sup> National Institute of Psychiatry (Mexico), Universidad Nacional Autónoma de México, Partners in Health-Mexico, [meraquerrebere@gmail.com](mailto:meraquerrebere@gmail.com)

<sup>9</sup> London School Hygiene and Tropical Medicine, Mexican Society of Public Health, [luis.martinez@lshtm.ac.uk](mailto:luis.martinez@lshtm.ac.uk)

<sup>10</sup> Director of Casa Monarca. Humanitarian Aid for Migrants, [direccion@casamonarca.org.mx](mailto:direccion@casamonarca.org.mx)

<sup>11</sup> Tecnológico de Monterrey, [equiluz@tec.mx](mailto:equiluz@tec.mx)

<sup>12</sup> FBX Center for Health and Human Rights, Harvard T.H Chan School of Public Health, Harvard Law School, Harvard Kennedy School of Government, [jacqueline\\_bhabha@harvard.edu](mailto:jacqueline_bhabha@harvard.edu)

<sup>13</sup> Professor of Global Politics, Head of Department, Politics and International Relations University of Southampton, UK

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