Migrant shelters’ response to COVID-19: Comparative case study in four cities close to the Mexico-United States border

Cesar Infante, Ietza Bojorquez, Isabel Vieitez-Martinez, Silvana Larrea-Schiavon, Gustavo Nápoles-Méndez, Cesar Rodriguez-Chavez

1. Introduction

In the context of a health contingency such as the current COVID-19 pandemic, some groups may remain invisible, so that their health needs go unnoticed. These groups include migrants, asylum seekers, and refugees (MAR). In Mexico there is a network of migrant shelters (casas del migrante-CM) that provide humanitarian assistance, including access to health care. Given the major role of the CM in caring for migrants, it was important to identify the main elements of their internal capacities, and of the external resources in the cities in which they are located, that contributed to their role in protecting MAR’s health during the COVID-19 pandemic. Methods: we use a comparative case study approach to understand, explain, and compare how internal capacities and external resources available to four CM in the north of Mexico, influenced the development and implementation of COVID-19 related strategies to protect MAR. The project took place during 2021 in Saltillo and Piedras Negras in Coahuila; Ciudad Juárez, Chihuahua, and in Monterrey, Nuevo Leon. A total of 18 in-depth interviews were performed with key actors from the CM, academia, health care services and international agencies.

Results: We found a range from a total closure of one CM, to the continuation of operation of three of them, with differences in the strategies developed to provide services and avoid infections within the facilities. MARs’ still face multiple barriers to exercise their right to health, and the response of local governments towards migration and health impacts the response that CM were able to implement.

Conclusion: There is a need to strengthening the preparedness and response capacities and coordination mechanisms of local, state and federal authorities to attain their responsibilities in the provision of services directed to MAR, including access to health care.

Key words: Migration, COVID-19, Mexico, Shelters

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1. Introduction

In the context of a health contingency such as the current COVID-19 pandemic, some groups may remain invisible, so that their health needs go unnoticed. These groups include migrants, asylum seekers, and refugees (MAR) (Zambrano-Barragán et al., 2021). According to Refugee International (Refugees International 2020), the main factors associated with the vulnerability and high risk of COVID-19 transmission are: (a) housing conditions, since most of them are housed in temporary shelters, or detention centers. At these sites there is little or no access to basic sanitation conditions, including clean water and soap, shared sanitary facilities and other common areas; (b) barriers to access health care, which is associated with restrictive immigration policies, resistance to using government health services due to fear of being detained and deported, and lack of knowledge about how to navigate through health care systems; and (c) limited access to culturally appropriate information on prevention measures. On the other hand, MAR are often stigmatized or discriminated against as disease-spreading agents (Infante et al., 2009; Kluge et al., 2020). This could make MAR fearful of disclosing symptoms related to COVID-19, thus increasing the risk for worst health outcomes and the potential for transmission of the virus (4). All these factors undermine MAR’s access to health care services.

* Corresponding author.
E-mail address: ietzabch@colef.mx (I. Bojorquez).

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Regarding the COVID-19 pandemic, it was not until March 27, 2020 that the Mexican government published general guidelines for the mitigation and prevention of SARS-CoV-2 in public and closed spaces. So for a month since the first case in Mexico was confirmed, the migrant shelters (casas del migrante in Spanish and from now on referred as CM) did not had an official guideline on measures to prevent and mitigate COVID-19 (Torre-Cantalapiedra, 2021).

In Mexico, MAR converge in spaces such as the CM that are located in strategic locations of the country’s Northern and Southern international borders as well as along the route through which they travel to the USA. The CM are operated by civil society organizations that in many cases are related to faith-based organizations (Torre-Cantalapiedra, 2021).

CMs emerge as a response to the growing needs of migrants, the tightening of policies that hinder migration and the intensification of control over mobility in the borders (Doering-White, 2018). The first CM was founded in Tijuana in the eighties as a space for humanitarian response to the context in which migrants are inserted that is often characterized as being highly controlled by immigration authorities, insecure and where their human rights are violated (Leyva et al., 2016; Infante et al., 2020). CMs provide limited-time assistance to accommodation, food and clothing access. However, the burden to the CMs have increased due to changes in migratory dynamics and policies that lead to an increase of MAR presence needing long-term aid while they resolve their migratory procedures before governmental authorities (Doering-White, 2018; Moreno and Contreras, 2013; Leyva R et al., 2016).

After the reforms to Mexico immigration laws from 2008 to 2011, the CM were recognized as “sanctuaries” and are off-limits of the immigration enforcement (Doering-White, 2018). Such recognition allowed some CM to transform their internal organization and evolve from being exclusively providers of humanitarian assistance to spaces where they work for the recognition and fulfillment of migrants’ rights by providing legal and migratory assistance (Leyva et al., 2016; Moreno and Contreras, 2013; Aguillerá, 2016; Bojorquez-Chapela et al., 2021; Leyva R et al., 2016). The capacity of the CMs to address MARs’ needs depends on how CMs are internally organized and the collaborative networks they establish with institutions and local governments in addition to working with other social organizations and international cooperation agencies (Leyva R et al., 2016; Candiz and Bélanger, 2018). Although not all relations between actors are positive (Desiderio, 2015), there is recognition that a collaborative network strengthens the CMs capacity to respond to the migrants’ needs (Moreno and Contreras, 2013; Leyva R et al., 2016; Doncel de la Colina and Lara, 2021).

Nevertheless, health emergencies in this case, the COVID-19 pandemic, put under enormous pressure the capacity of CM to provide services to MAR, in a context of already limited or absent coordination with health authorities, and in the absence of official guidelines CM face the need to make their own decisions on how to address this situation under a risk reduction criterion. Given the major role of the CM in caring for the basic needs of MAR, it is essential to understand which were the elements that helped them to respond during the ongoing pandemic.

The objective of this study is to identify the main elements of the migrant shelters’ internal capacities, and of the external resources in the cities in which they are located, that contributed to their role in protecting MRA’s health during the COVID-19 pandemic.

### 2. Methods

We use a comparative case study approach to understand and compare how internal capacities and external resources available to four CM in the north of Mexico, influenced the development and implementation of COVID-19 related strategies to protect MAR. In our study, we start from the assumption that strategies and other actions to mitigate the negative effects of the COVID-19 pandemic in 2020–2021 undertaken by CM, have contributed to protect the right to health of MAR. On the other hand, we assume that the possibility of implementing these actions relies on the internal capacities of the CM and the access to the external resources in the cities where they are located.

These assumptions were tested through a comparison between four cases of CM. The comparison was made according to the following categories: (1) internal capacities and (2) external resources (Wijngaarden et al., 2012). Following previous experiences and analysis of the capacities of CM to organize and respond to the growing demands, we define internal capacities as material, human and organizational resources available at the CM, and external resources as those coming from other organizations, the government, or individuals, to which the CM could have access. These external resources may or may not be related to the participation of CMs in local, state, national or international collaborative networks.

For the selection of cases, we seek to have a sample of different CM in terms of their characteristics and internal capacities, the context, and the resources available externally.

Table 1 shows the indicators of these capacities and resources that were considered. For the selection of cases, the indicators were obtained from online search and calls to CM, as well as from the experience of the research team acquired in the development of other research projects. An initial selection of cases was made based on the previous criteria, and a total of six CM were invited to participate. Due to different circumstances not all CM were able to accept the invitation. However, we were still able to work with four CM that are located in Saltillo and Piedras Negras, Coahuila, Monterrey in Nuevo León, and Ciudad Juarez in Chihuahua.

#### 2.1. Data collection

We conducted semi-structured interviews with staff members and volunteers of the CM, health service providers, authorities of local health services, and key actors from international cooperation agencies and academics that were referred to us following the snowball technique (Ghaljaie et al., 2017). To access informants, we established telephone communication and sent invitations to participate by email. The

| Table 1 | Indicators of internal capacities and external resources. |
|---------|---------------------------------------------------------|
| **Organizational** | Time of existence (proxy indicator of the experience acquired by the CSO) Information system (management capacity indicator) Activities to facilitate the social inclusion of MAR (indicator of a model developed for inclusion, beyond the temporary solution of basic needs) Belonging to a network of shelters (indicator of the possibility of accessing information and other resources, and of acting collectively) |
| **Resources** | Number of people it can accommodate (proxy indicator of economic and other material resources) Presence of paid staff in the shelter (indicator of the ability to provide services and manage activities) Presence of volunteers in the shelter (indicator of the ability to provide services and manage activities) Presence of health care facilities and provision of service in the shelter (indicator of ability to attend to health problems) Presence of psychological or mental health service in the shelter (indicator of capacity to attend to health problems) |
| **Legislation or guidelines at the local level for health care of MAR** | Presence in the city of international organizations that support MAR Presence in the city of other social organizations that support MAR Presence in the city of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission |

| **External resources** | Judicial and administrative support for migrant care (indicator of the possibility of accessing information and other resources) |

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interviews were conducted by Zoom and took place concurrently and iteratively in time. Interviews were conducted in Spanish by the project’s research team, which has extensive experience in qualitative studies. As part of the data collection strategy, it was sought that the interviews of each case were carried out by a single researcher. The audio recordings of the interviews were analyzed.

The number of interviews was defined according to convenience criteria, seeking to have informants from the previously presented categories. The work sought to deepen the identification of the experiences and practices of each of the cases (CM) given the variability of the institutions and the context.

As many interviews as possible were carried out to recover the experiences and lessons learned by the informants without seeking theoretical saturation. A total of 18 interviews were conducted: six in Ciudad Juárez, Chihuahua (Case 1); four in Piedras Negras, Coahuila (Case 2); four in Saltillo, Coahuila (Case 3); and four in Monterrey, Nuevo Leon (Case 4).

In the interviews we inquired about: (a) resources and infrastructure of the CM available previous to the pandemic, and if there had been changes during the pandemic; (b) presence or absence of local initiatives to guarantee the access to health care for migrants, before and after the pandemic; (c) changes in health needs of migrants, including illnesses and needs for preventive actions related to COVID-19 and other health issues; (d) MAR’s access to health care services previous to the pandemic and changes derived from the pandemic; (e) actions taken by the CM in response to the pandemic; (f) barriers and facilitators encountered by CM to ensure the healthcare access of MAR during the pandemic; and (g) collaboration and support from other organizations, local health care authorities and international agencies.

2.2. Data analysis

We used a thematic analysis as descriptive qualitative approach to data analysis. Based on the interview guide, we made a thematic categorization that allowed us to understand the context from the experience and organizational practices that the CM had in the face of the situation posed by the COVID-19 pandemic. The use of a descriptive qualitative approach as thematic analysis is suitable for a relatively low level of interpretation, in contrast to grounded theory or phenomenology (Braun and Clarke, 2006). We utilize it as a method for identifying, analysing and reporting patterns (themes) across a set of interviews.

The researcher responsible for conducting the interviews in each case systematized the information in a matrix for its analysis, identifying prevention and hygiene strategies implemented; actions developed for the identification of COVID-19 cases in MAR; referral mechanisms and experiences in case of having had a migrant with COVID-19 and handling inside the CM. The matrix also included the barriers the CM faced to carry out COVID-19-related activities, and to facilitate MAR’s access to healthcare for this and other health issues, as well as facilitators for these activities. The in-depth interviews with key actors from each of the CM and local health services allowed us to contextualize and understand the rationale, limitations, and the setting in which they had to make decisions on how to carry out prevention, identification of COVID-19 cases, definition of collaborative networks for the referral of migrants to local health care services.

The synthesis across cases extends beyond the comparison of similarities and differences, to using these similarities and differences to support or refute propositions as to why strategies succeeded or failed (Goodrick, 2014). We present the results along the main topics that we considered provide substantial evidence and allows us to respond to the objective of the study.

2.3. Ethical aspects

The project was registered with the Ethics Committee of El Colegio de la Frontera Norte and in this way, it is guaranteed that the protocol and the project maintain an optimal level of quality from its registration, implementation and until the presentation of the final reports and analysis. In the same way, the ethical handling of the information collected is guaranteed and the confidentiality and anonymity of the participants and institutions is safeguarded. The qualitative data collection was done voluntarily, after obtaining verbal informed consent and without the participation or not having any impact on the relations of the research team with the participating shelters, international agencies, key actors, and health institutions.

3. Results

3.1. The internal capacities of the casas del migrante, and the external resources available to them

The four CM that participate in this study are located in three states of Mexico that border the United States. Their main internal and organizational characteristics are presented in Table 2. They are all operated by civil society organizations, provide humanitarian assistance and have activities that seek to integrate migrants into the local communities. The differences in the time in which they have been providing care to migrants, their number of paid and volunteer personnel, do not impact their capacities to provide services. All four CM provide humanitarian assistance that includes temporary accommodation ranging from a few days to months (depending on the situation of each migrant or migrant family and if they are looking for asylum or are refugees), food and clothing. Additionally, they facilitate access to health care either by provision of care within the CM or by referral to local health care services (as Case 2 does), provide legal advice on refugee and asylum migration issues, and referral to government agencies to deal with issues related to violation of rights and violence. All of them have separate dormitories for men and women and sometimes for families, a dining room, sanitary facilities such as bathrooms, showers, and sinks, running water, and their facilities are formal constructions of concrete or brick (as opposed to tents or other types of accommodations).

In the same way, we can observe that, according to the indicators considered, the contexts in which CM operate are not so different, except that some states do have legislation and programs aimed at addressing migration issues and others do not.

The financial resources of the CM come from various public and private sources, as well as from international organizations. Likewise, food, clothing, and personal hygiene and cleaning products are received through donations from individuals, churches, or support from international organizations. The way in which CMs are financed provides empirical evidence about how the conformation of local, state, national and even international networks facilitate the availability of resources. These networks are present in each of the cases to a greater or lesser extent.

Regarding human resources, the CM have a permanent staff who receive financial remuneration, and volunteer staff (with the exception of case 2) who are either students from local universities or other individuals.

As for governmental support, in Case 1 the state and local governments provide discounts in public services such as electricity and water. In Case 2, the shelter building is a loan from the municipality, which also covers the cost of electricity and water.

The four CM in this study participate in collaborative networks with local, state or national governmental institutions, but differ in the formality and degree of institutionalization of the agreements, the presence of key actors from the different levels of government and the business and academic sectors. The most institutionalized network and collaboration process was observed in Case 1, where the shelter participates in a network managed by the state Government. The network emerged in 2018 in response to the presence of “migrant caravans”.

The Government (COESPO) coordinates the network. In the network there are local organizations and international agencies that collaborate...
Table 2  
Indicators of internal capacities and external resources in four migrant shelters (at the moment of the field work).

| Case 1 in Chihuahua | Internal capacities of migrant houses and shelters | External resources |
|---------------------|--------------------------------------------------|--------------------|
| Organizational      | Time of existence: 5 years                       | Organizational     |
|                     | Information system: Yes                          | Legislation or guidelines at the local level for health care for MAR: Yes |
|                     | Activities to facilitate the social inclusion of migrants: yes | Resources |
|                     | Belonging to a network of shelters: Yes          | Presence of international organizations that support MAR: Yes |
| Resources           | Number of people it can accommodate: 180        | Presence of other social organizations that support MAR: Yes |
|                     | Presence of paid staff in the shelter: 2        | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Presence of volunteers in the shelter: Yes      | Informants from the CM: 3 staff members |
|                     | Presence of health care services in the shelter: Yes | Informants outside the CM: 1 (academic) |
|                     | Presence of mental health service in the shelter: No | Presence of internal organizations that support MAR: Yes |
|                     | Informants from the CM: 1                       | Presence of other social organizations that support MAR: Yes |

| Case 2 in Coahuila  | Internal capacities of migrant houses and shelters | External resources |
|---------------------|--------------------------------------------------|--------------------|
| Organizational      | Time of existence: 15 years                      | Organizational     |
|                     | Information system: Yes                          | Legislation or guidelines at the local level for health care for MAR: Not specifically for MAR |
|                     | Activities to facilitate the social inclusion of migrants: yes | Resources |
|                     | Belonging to a network of shelters: Yes          | Presence of international organizations that support migrants: Yes |
| Resources           | Number of people it can accommodate: 130        | Presence of other social organizations that support migrants: No |
|                     | Presence of paid staff in the shelter: 3        | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Presence of volunteers in the shelter: No       | Informants outside the CM: 2 (ANHCR) |
|                     | Presence of health care service in the shelter: No | (Governmental institution that provides services to MAR; 1 (academic); 2 (IOM); 1 (governmental health care services) |
|                     | Presence of mental health service in the shelter: No | Organizational |
|                     | Informants from the CM: 1                       | Legislation or guidelines at the local level for health care for MAR: Not specifically to MAR |
|                     | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes | Resources |
|                     | Inforents outside the CM: 1 (Governmental institution that provides services to MAR; 1 (academic); 2 (IOM); 1 (governmental health care services) | Organizational |
|                     | Presence of other social organizations that support MAR: Yes | Legislation or guidelines at the local level for health care for MAR: No |
|                     | Presence of paid staff in the shelter: No       | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Presence of volunteers in the shelter: Yes      | Presence of other social organizations that support MAR: No |
|                     | Presence of health care service in the shelter: Yes | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Presence of mental health service in the shelter: Yes | Human Rights Commission: Yes |

| Case 3 in Coahuila  | Internal capacities of migrant houses and shelters | External resources |
|---------------------|--------------------------------------------------|--------------------|
| Organizational      | Time of existence: 19 years                      | Organizational     |
|                     | Information system: Yes                          | Legislation or guidelines at the local level for health care for MAR: Not specifically to MAR |
|                     | Activities to facilitate the social inclusion of migrants: Yes | Resources |
|                     | Belonging to a network of shelters: Yes          | Presence of international organizations that support MAR: Yes |
| Resources           | Number of people it can accommodate: 300        | Presence of other social organizations that support MAR: No |
|                     | Presence of paid staff in the shelter: 15       | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Presence of volunteers in the shelter: Yes      | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Presence of health care service in the shelter: Yes | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Presence of mental health service in the shelter: Yes | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Informants from the CM: 4 staff members         | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                     | Informants outside the CM: 1 (ANHCR)            | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |

| Case 4 in Nuevo Leon| Internal capacities of migrant houses and shelters | External resources |
|-------------------|--------------------------------------------------|--------------------|
| Organizational    | Time of existence: 13 years                      | Organizational     |
|                   | Information system: Yes                          | Legislation or guidelines at the local level for health care for MAR: Yes |
|                   | Activities to facilitate the                     | Resources |
|                   | Belonging to a network of shelters: Yes          | Presence of international organizations that support MAR: Yes |
|                   | Resources                                        | Presence of other social organizations that support MAR: Yes |
|                   | Number of people it can accommodate:             | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                   | Presence of paid staff in the shelter:           | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                   | Presence of volunteers in the shelter:           | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                   | Presence of health care service in the shelter:  | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                   | Presence of mental health service in the shelter: | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                   | Informants from the CM: 1                        | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |
|                   | Informants outside the CM: 1 (ANHCR)             | Presence of offices of the National Institute of Migration, Grupo Beta, Human Rights Commission: Yes |

not only in health related issues. At the beginning (2017) there was no access to health services, and they began to see how to manage these services. What was done was to give migrants and identification number so that they could have access to health care. Currently they receive care at the primary healthcare unit “Todos Somos Mexicanos”. They receive consultations and medicines. Several organizations approached the network since the migrant “crisis” in 2018–2019.

“The state supports us with the consumption of water and with food and infrastructure, the municipality provides public security, public lighting, and garbage collection”. (Testimony from staff at C1 in Chihuahua)

This network lead by the state government, has made it possible to generate a consensual mechanism for the provision of health services for MAR, with representation of the local level health authorities, the CM, and other relevant actors. In Case 1 there is also a local private initiative, led by businessmen and in which the CM participates. This network provides other types of support such as a job bank, in addition to constituting another place for dialog. Similarly, in Case 4 the shelter is part of the Network for Humanitarian Strengthening of Migrants (REFUMI), which arises from an initiative of the Secretariat of Social Development of the State of Nuevo Leon.

In Case 3, in contrast, there is not a governmental office, program, or person responsible for responding to MAR, and it is from the effort led by the CM itself that it has been possible the creation of inter-institutional initiatives on issues such as childhood, alternatives to detention, crimes against migrants or gender violence. Nevertheless, participants mentioned that there is not yet been established an interinstitutional health agenda.

The State Government defined different groups such as children, women, victims of violence as especially vulnerable. They included migrants within this category. A group of key actors study all the regulations and protocols regarding the rights of these populations. They realized that the regulations violated human rights. Regulations and guidelines were reviewed and adapted so that people had access to services and there were no differentiated regulations. This began in 2015. However, this does not replace the existence of offices dedicated to the migrant population. Testimony from CM staff at C3 in Coahuila

Finally, in Case 2 there is no governmental sponsored network, and the CM usually interacts on a “case by case” basis with the different governmental agencies.

3.2. Access to health services for MAR: before and after the COVID-19 pandemic

MARs seek for health and psychology services mainly in shelters and clinics adjacent to private pharmacies. According to participants, the
main source of healthcare for MAR are the services available within the shelters. Three of the four CM (except Case 2) have basic care available within the shelter: a volunteer doctor in Case 1, and medical and psychology services provided by permanent staff and volunteers in Cases 3 and 4. Before the pandemic, in all cases, doctors and nurses were periodically sent by the local Health Jurisdictions (the local level of the Ministry of Health) to provide health care and preventive interventions. MAR also make use of the low-cost private services in pharmacy-adjacent medical offices. For the most serious situations, the main source of care are the emergency rooms of the general hospitals of the Ministry of Health.

“The shelter has a consultation room. In this place, migrants who report a health problem are cared for. This is endowed with medicines that do not require a prescription and treatment is given to people with hypertension, diabetes, and other chronic health problems. Treatment is supervised and pillboxes are given to them. When a migrant person requests care, the nurse or a trained volunteer takes the medical history and if required, consultations are made via telephone with volunteer doctors. If a person has a condition that requires attention is detected because it is more complex, she/he is referred to the two health centers that receive migrants, the general hospital, children’s hospital, and international red cross” (Testimony from CM staff C3 in Coahuila).

In all four cases there are governmental health care facilities nearby the CM where MARs are entitled to receive care without cost. However, in practice there is a major administrative barrier, the request of identity the CM where MARS must be provided, that this link is based on interpersonal relationships.

“In practice there is a major administrative barrier, the request of identity the CM where MARS are verified, that this link is based on interpersonal relationships. Therefore, in order for MAR to access the public health care system, staff from the CM generally must accompany them to facilitate access by convincing the staff to accept them. In all cases, access to health care services depends on the relationships established between the CM and the directors of the governmental health care facilities. Participants reported, that this link is based on interpersonal relationships.

“Health issues are resolved with the legal department of the state and local health care services. There is no state public policy related to attend health needs of migrants. The shelter has many things resolved for health care, however there is no state policy. The shelter has very standardised procedures to access health care for MAR, but the shelter is an exception. This does not mean that a migrant person has access to services.” (Testimony from CM staff C3 in Coahuila).

An exception is Case 1, where the state government led network has reached formal agreements with public health institutions to identify access routes to the General Hospital and recently a primary care center was defined as the reference site for MRA.

A second important barrier to MAR health care access is the need for out-of-pocket expenses. According to participants, the lack of money to cover expenses was a major reason for not seeking care among MAR. In all case studies, services in the CM, and public services once accessed, are offered free of charge. However, public services do not always provide medicines and other supplies, so shelters must find out the way to provide those to MAR.

“We have challenges related to the scarce information health care providers have on migrant’s right to health and health care. Another of the challenges we have is the financial one. We do not have sufficient financial resources to be able to support the number of people who require a health intervention and follow-up of treatments. This is another great challenge and I think it will be a challenge for all the shelters”. (Testimony form male staff C4 in Nuevo Leon).

The effect of the pandemic on access to health services has been different in each case. At the beginning of the pandemic, the visits of doctors and nurses sent by the Health Jurisdictions were interrupted. Testimony from CM staff C1 in Chihuahua

“Yes, before the pandemic they came to the shelter every monday, wednesday and Fridays. Some doctors came from the health services. There were three of them, so the office became a doctor’s office, so yes, we did give them medical attention”. (Testimony from CM staff C2 in Coahuila).

The same happened with the volunteers who provided medical or mental health services. In all four cities, general hospitals were reoriented to the care of COVID-19, decreasing their ability to respond to other health needs. Something to highlight is that health jurisdictions facilitated the detection and care of COVID cases in all cases, as will be described in more detail below.

3.3. The response of casos del migrante to the COVID-19 pandemic

The internal activities and organization of the CM were transformed and faced challenges due to the need to receive MAR while avoiding the risk of infection by SARS-CoV-2. The main challenge was to have adequate spaces to maintain physical distance and achieve the isolation of suspected and confirmed cases.

In Case 1, this challenge was solved thanks to the implementation of a strategy designed by the previously mentioned network of state and local government and health authorities, the CM and international organizations, consisting of the opening of “filter shelters” at the beginning of the pandemic. These shelters that were designated to receive MAR for a quarantine period before moving to the other CM. Later on, the International Organization for Migration (IOM) sponsored a “filter hotel” for the same purpose. This strategy also made it possible to strengthen the local economy, at least in the hotel sector, and participants mentioned that this was promoted by various local networks of entrepreneurs.

“The organizations brought canvases with information and indications (symptoms, care that we should have). If someone started with a cough, we asked them to wear a mask, separate him from the others, and send him to the doctor at the filter hotel. At moments of increase of COVID-19 cases no new people arrived, and when cases diminished, they could enter the shelter after they spent some time at the filter hotel, show no symptoms and have a negative COVID-19 test.” (Testimony from CM staff C1 in Chihuahua).

In case 3, the United Nations High Commissioner for Refugees (UNHCR), together with other organizations, financed the adaptation of CM, providing tents for isolation and other resources such as portable hand washing stations.

The pandemic raised the need for resources to maintain the hygiene of MAR and shelters staff, as well as the urgency of having face masks, alcohol gel, and other items available for the prevention of contagions. This was a challenge for all CM, which mainly received donations from international organizations, social organizations, or individuals.

At the same time, the flow of financial and human resources decreased to different degrees from the start of the pandemic. In Case 1, the economic resources from individuals and social organizations in the USA were limited, on the one hand because the resources were redirected to the needs of vulnerable groups in that country, and on the other because of the closure of the border crossing. In all CM, the volunteer staff decreased since they had to limit their activities to avoid contagion, either because they were people at risk due to their age or health status. In cases 3 and 4, universities withdrew students from internships and professional practices.

The four Cases took measures to reduce the risk of contagion that included the use of personal protective equipment for sheltered people, volunteers, and staff, as well as the installation of filters at the entrance of the shelter with questionnaires of symptoms and temperature measurements. A common measure was to promote hygiene by washing hands, facilitating access to alcohol gel for residents, and practicing frequent cleaning of spaces. Informants mentioned that at the beginning,
the measures were very strict, almost at a hospital level, where masks, gowns, and gloves were used.

“At first, we defined the activities according to theoretical information and developed protocols. We went through the phases defined by the Federal Government but there was not much information regarding people in mobility. We developed protocols according to our reality and permanent needs, dealing with fear and stress. We currently have flowcharts and action protocols for the attention of cases and to define the actions that are developed daily (cleaning, food, dining room, among others). We received multiple trainings from different actors from whom they received certain guidelines that they adapted to reality. The first recommendations received from PAHO led us to close the shelter, because we had to duplicate a hospital filter system and they were so harsh (the guidelines that they had to close). (Testimony from CM staff C3 in Coahuila).

This measures created a lot of stress on the shelter staff and the MARs and eventually led to the closure of new admissions given the impossibility of maintaining those conditions. The total closure of the shelter occurred in Case 2, while in Cases 3 and 4 the entry of new MARs was limited for some time. In Case 1, MARs that had passed through the “filter hotel” were able to entry the shelter after completing the quarantine. Information (posters and triptychs) was posted in the shelters on prevention measures and on the signs and symptoms of the disease. Another measure installed in Cases 3 and 4 was to limit the mobility of sheltered migrants, so working and going out of the shelters other than for emergency reasons were prohibited.

The measures of physical distancing and the isolation of cases were the most difficult to implement, due to the lack of spaces for it. Case 4 and Case 1 implemented isolation zones, and Case 3 increased the separation of people in the bedrooms and placed partitions between beds. In Case 1, the IOM donated isolation tents that facilitated these actions. All the CM sought to have the greatest number activities outdoors to avoid crowding in closed spaces. Meals and other activities were re-scheduled for the same purpose.

Other actions implemented had to do with psychosocial support aimed to “deal with stress problems” or “make the situation lighter”. Some examples were the virtual or face-to-face psychological care and recreational activities.

“With the pandemic, our work tripled or quadrupled in all senses. We had more cases related to psychosocial issues because of anxiety, job losses, depression, and as result of violence. Care was provided virtually and just a few cases required personal accompaniment to undertake laboratory tests, medical internments, or psychiatric treatment”. (Testimony from CM staff C4 in Nuevo Leon).

The shelters also distributed food and supplies to MARs who were not sheltered and who stayed either in temporary camps or by renting rooms nearby.

3.4. Relationship between shelter capacities, context, and response to the COVID-19 pandemic

The responses of CM went from a total closure, to not receiving new MARs, but allowing those that were already sheltered to stay indefinitely.

“The closure of the shelter was from March 21 to October 25 and we only stay with those who were already at the shelter and with the freedom to leave according to their interests. In May we began to provide food, water, and allow the use of toilets and showers to migrants that were not housed. In June, we allow the entry of people or groups that are especially vulnerable or at greater risk such as women, pregnant women, families, older adults, and LGBTI population although there was little demand since people preferred to continue their journey to the border since they thought that the “migras” would not stop them for fear of contagion. At the end of June, we began to provide legal assistance and advice, including immigration regularization issues with restricted hours from 10 a.m. to 1 p.m. In October we reopened with a limited capacity of 70 people, but we adapted the capacity according to the implementation of protocols and prevention measures and currently we have capacity for up to 130 people”. (Testimony from CM staff C3 in Coahuila).

The informants considered the closure of the CM to new arrivals could have been avoided, but the decision was taken in the absence of clear information and recommendations from the Ministry of Health, or assurances from the Health Jurisdiction that preventive supplies and COVID-19 case management would be provided. According to the informants in Case 3, there was a “vacuum” in terms of leadership to respond to the health crisis.

“We received very contradictory information on some topics such as the use of face masks and outdoor activities, ways of transmission of the virus and others. The state is relegated on issues of leadership or responsibility in emergency situations. When we spoke with the staff form the Health Jurisdiction about the federal level guidelines (where they link the responsibility of the Health Jurisdictions) in the care of migrants, they told us that they were not aware of such guidelines and did not have the resources to provide care as indicated in the guidelines”. (Testimony from staff CM C3 in Coahuila).

In October 2020, they decided to reopen, although receiving only a small number of people in order to maintain adequate physical distancing. By that time, they had already received support from international cooperation agencies such as UNHCR and Doctors Without Borders (MSF) for the adequation of bedrooms and dining rooms, to install portable sinks, and training for the installation of filters to detect cases and handle suspected cases. The Health Jurisdiction had also responded by then, providing rapid tests and keeping in touch with the shelter for rapid reference of COVID-19 cases. Unfortunately there is still the perception on both staff from the CM and local health care providers that the response from the government came from a perspective of risk control rather than recognition of the vulnerability of MAR.

“Migrants are being considered within public policy as risk factors. Is as saying: ‘migrants are going to infect us because they come walking and see many people.’ Be afraid of them because they come to infect us, and will worse the conditions of the pandemic. This idea permeates society”. (Testimony from health care provider C2 in Coahuila).

Case 4 experienced a similar situation to Case 3, where the managers also made the decision to stop receiving MARs and to modify the shelter’s space and generate prevention strategies. This allowed them to begin to receive new MAR in December 2020, after a negative COVID-19 test applied at public primary health care facilities near the shelter.

“Basic hygiene measures were implemented, such as the use of gel, use gloves, face masks and taking a temperature. Staff stopped using public transportation. Disposable plates and cutlery were used. It was decided that the students that provided social service should stop attending the shelter and the shelter was closed to new incomes until we had a
4. Discussion

The distinctive feature of this work is the emphasis on examining the extent to which the context, characteristics of the shelter, networks of support, presence of international agencies and the role of local health care authorities caused the results, particularly outcomes and impacts of the implementation of COVID-19 related strategies. We recovered the experience developed in four houses of migrants from the north of Mexico, which is useful to know the barriers, limitations and mechanisms that facilitated the response to the initial moment of the COVID-19 pandemic. It was developed at a time when there was already an apprenticeship in relation to the pandemic and the possibility of carrying out preventive measures. This made it possible to have an informed reflection on the response and its impact. It collects the own experience of the CMs that continue to be the first line of attention to the needs of migrants in Mexico.

Our analysis shows that the implementation of health care policies related to MARs and those specific to the COVID-19 pandemic still imply a series of barriers to the exercise of the right to health. Also, the response of local governments impacts the response that CM develop and implement in the face of a health crisis such as the one we are currently experiencing with the COVID-19 pandemic. We found different responses, from a total closure of one of the shelters, to the continuation of operation of three of them, with differences in the strategies developed to provide services and avoid infections within the facilities.

The four cases show the importance of CM in promoting MAR’s right to health. The particular case in which the total closure occurred was not due to the inability of the CM to operate, but rather to the local authorities’ decision. Even in this case, the organization continued to support MAR with activities outside of the shelter.

Collaboration networks between local governments, international agencies and civil society gained relevance to respond more rapidly to MAR’s health needs during the critical phase of the pandemic in 2020. The importance of governmental leadership was reflected in the fact that in Case 1 it helped to provide the shelter with additional support.

It is important to highlight the experience of Case 1 in the way they responded to the pandemic. The existence of a previous and functional network and the close coordination of different actors allowed for a more efficient response. Another point to take into account is that international cooperation agencies played a major role in supporting the CM. It is also important to consider and reflect on the need for their actions to coordinate with other agents, so as not to duplicate efforts and allow the resources to be invested in such a way that existing capacities are strengthened. In order for this to happen, the actions and strategies should be defined in a consensual manner between the different actors involved in the response. It is desirable, that the collaborative networks between shelters, international agencies, academia and government, become institutionalized (Moreno and Contreras, 2013; Leyva R et al., 2016).

The guideline to prevent contagion and operate with less risk in closed spaces (Gobierno de, 2020), such as the CM, was issued by the Federal government a month after the identification of the first case in Mexico. It arrived later than other recommendations issued by international organizations, making hard for the shelters to align as some of the indications were contradictory between documents. In addition, the operationalization of these guidelines at the local level took longer and was not linked to resources making it hard for the cases de migrants to comply. Also, the CM faced barriers to apply the indicated measures with their available funding, personnel, and infrastructure, as the guidelines did not take into account the context on which they operate. Likewise, there is evidence that this information did not reach the jurisdictional health care services where the response to the COVID-19 pandemic should have been operationalized and from where the actions directed at shelters (including CM) should have been given. This shows us the importance and relevance of sharing information within the network because it can help achieve important benefits such as an increase in productivity, improve policy-making, and integrate services. Information sharing, however, is often limited by technical, organizational, and political barriers that should be identified to be avoided (Dawes, 1996). It also highlights the guiding role (rectory) that the health sector should have from the federal, state and local levels (Salinas et al., 2021).

The Health Jurisdictions and local health services responded according to their capacities and the challenge posed by the initial response to the pandemic in Mexico. Although at the beginning there were no preventive supplies and human resources to support CM, the health care authorities were able to improve the provision of services once the initial shock had passed. So, they provided the CM with rapid tests and access to PCR tests, as well as to identify focal points for the referral and attention of COVID-19 cases in MARs. This form of response in crisis situations allows organizations to provide the assistance for which they are intended, however the collaboration also resizes the role and impact of both actors ‘actions to guarantee the right to health care for migrants [9,11,12].

This study shows that migrants still face significant barriers to access health care services. These barriers range from the requests for documents to access health services, failures in the flow of information regarding the responsibility and procedures to resolve MAR’s health needs by health services at their different levels, and finally problems in coordination of care networks. Full recognition of the rights of migrants in transit is required to guarantee access and resolution of their health needs. In order to do so it is imperative to provide visibility in public policies, define mechanisms and procedures to guarantee access to health care focusing on the person (migrant) rather than on their immigration status. Finally it will be important to strengthen local networks that provide care to MAR.

4.1. Importance of the self-management capacity of shelters

The adecuación and reorganization of internal arrangements at the CM allowed them to respond even with limited collaboration from other agents. An example is particularly given in C3 and C4, which are the CM with a significant development of their capacities in both the specialization of their human resources and the available infrastructure. These shelters’ characteristics made it easier for them to define and implement adequate strategies. In the same way, the adaptation capacity of these CM allowed them to look for alternatives to address the different needs that arose during the pandemic.

During the pandemic development and response from the CM it is important to recognize the relevance of local networks of support and the role international agencies, not only because its capacity of mobilizing resources but for establishing a constant dialog with all the actors involved in the response to migration. The lessons learned should be
documented in order to reflect on them and establish algorithms or protocols to define roles, activities and responsibilities to the different actors involved in the response to health crisis. However, there are criticisms of the role of international agencies and their impact on the creation of closed models of political management of migration and having a homogeneous control of borders (Desidério, 2015). There is also evidence that suggests that the line between mutual collaboration and subordination between government and civil society is thin and difficult to define (Dawes, 1996; Agranoff, 2007; Greenaway et al., 2020). Nevertheless, according to what we present in this work, the development of these forms of collaboration, additionally allow to empower the CMs and constitute as spaces that seek to guarantee the rights of the MAR.

5. Conclusion

Globally, MAR faced exposure to Sars-Cov-2 without appropriate means to protect themselves, while public health measures did not always reach them (Hillyard, 2006). This has intensified preexisting inequities in access and utilization of health services, which exacerbates MAR social vulnerability and increases health risks related to migration (Klugé et al., 2020; Shadmi E et al., 2020; P.Rigginazzi and Cintra, 2020; Fernández-Niño et al., 2020). In Mexico, CM continue to be the main place where MAR receive humanitarian assistance and where they manage to satisfy their basic needs. This highlights the relevance of the response of civil society and non-governmental organizations and possibly the absence or neglect of the State to provide adequate services to MAR.

Laws, regulations and health care guides particularly in relation to the COVID-19 pandemic are not applied homogeneously in Mexico and important differences are observed at the local level with direct implications in the way in which MAR access health services. In the same way, the information regarding the guidelines for attention to a health crisis such as the COVID-19 pandemic did not reach those responsible for its implementation locally. These aspects relate to political, legal and regulatory issues that have a direct impact on the way in which CM were able to respond to the needs of MAR in the context of the pandemic. In this study we have identified that there is a lack of resources to cover the COVID-19 related needs for those who provide services such as staff of CM and the MARs themselves. However, there has been a response to prevent and provide care for MARs in the context of the COVID-19 pandemic in these four CM at the Mexican-US border. This has been possible due to the financial and resources provided by international agencies, the existence of networks that support a series of health care services provided to MARs, and the internal capacities of the migrant houses to adapt to the realities imposed by the pandemic. These changes in the form of organization of the CM have been extensively documented in other studies and demonstrate not only the flexibility of the CM to adapt to change, but also the relevance they have as organizations that seek to guarantee the rights of migrants (Torre-Cantaliapiedra, 2021). In the case of the COVID-19 pandemic, this study highlights the role that the CM have as guarantors of the right to health.

Although it is not the intention of this work to evaluate the response on who did it better or worse, it is clear that there is a need to establish evidence-based standard procedures that could shed light on the decisions CM must make in order to reduce risks and maintain a response in order to guarantee humanitarian assistance to MARs.

There is a need to strengthening the preparedness and response capacities and coordination mechanisms of local, state and federal authorities to attain their responsibilities in the provision of services directed o MARs, including access to health care. In the case of the CMs, we find organizations that intend to go beyond humanitarian assistance and propose structural changes that seek to guarantee the rights of MARs. Evidence shows the potential of MCs to contribute to health care programs. However, the available evidence presented in this paper indicates that the favorable conditions for CMs to participate in political decision-making at the federal level and in the states do not always exist (Moreno and Contreras, 2013).

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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