

ANALYSIS OF HEALTH SYSTEMS RESPONSIVENESS AND ACCESS FOR MIGRANTS, ASYLUM SEEKERS, AND REFUGEES DURING THE COVID-19 PANDEMIC

CASE STUDIES FROM MEXICO, COLOMBIA, AND PERU



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EXECUTIVE SUMMARY

This report explores the health system responsiveness and access to healthcare for migrants, asylum seekers and refugees during the COVID-19 pandemic as experienced by three Latin American countries, both in theory and in practice, by contextualizing health policy analysis within health and migration frameworks. The overall goal of this report is to understand how human mobility embedded within the current and historical political, economic, and social dimensions of the Latin American context has impacted health system responses during the COVID-19 pandemic in Mexico, Colombia and Perú.

Researchers from El Colegio de la Frontera Norte (Mexico), Instituto de Salud Pública—Pontificia Universidad Javeriana (Colombia) and Pontificia Universidad Católica del Perú (Perú), the Johns Hopkins Center for Humanitarian Health, and *Lancet* Migration conducted a multi-phased mixed-methods study between May 2021 and January 2022. Each study phase brought forward an additional level of analysis and context rooted in an in-depth policy assessment tailored to the Latin American context while analyzing access to healthcare and the health systems' resiliency towards migrants, asylum seekers and refugees. The policy analysis was then deepened with a focused grey and peer-review literature review aimed at exploring the impact of policies from various evidence-based, humanitarian and field perspectives. This novel approach to understanding both the migration and health context, content and processes at country level allowed for an assessment of preparedness, response, and implementation strategies during the COVID-19 pandemic in three countries in Latin America between March 1, 2020, and May 31, 2021.

The primary barriers to care for migrant populations throughout the pandemic in **MEXICO** included cost,

language barriers, and specific requirements around legal documents for identification. The national pandemic response primarily focused on epidemiological surveillance and transmission control, and failed to meet the broader health and socio-economic needs of migrant populations. However, the research also highlighted the critical role played by civil society organizations in filling gaps in the national pandemic response for migrant populations and reaching last mile communities. Finally, findings highlighted a major lack of data pertaining to migrant health. Recommendations to improve health system response to migrant needs in the context of the COVID-19 pandemic include addressing the barriers to health services to advance health system equity; strengthening health system capacity through improved coordination between local, regional, national, and international actors; and improving data collection and health information systems for migration populations to improve continuity of care, health equity, and the ability to identify health risks in vulnerable groups.

The primary barriers to access of care for migrant populations in **COLOMBIA** during the pandemic included regulatory barriers barring participation in the health system, and high costs that could affect the access of migrant populations to health services. However, migrants had access to emergency services in general, even for COVID-19 illness. Colombia's national pandemic response focused on gathering together epidemiological and socio-demographic information to ensure representation of migrant populations and ensuring access to health care for migrant populations through linking the health system to the migrant population; a coordinated response with international cooperation to guarantee access to social services

and facilitate the settlement and integration of the migrant population; policy guidelines focused on health care and the regularization and formalization of this population in the Colombian context; and cultural sensitivity amongst health professionals to ensure an appropriate intersectional response. Recommendations to improve the health system's response to the needs of migrant populations include an emphasis on the collection of data on migrant populations. The difficulty in collecting this information has been noted as detrimentally impacting the tracking and monitoring of the Colombian health system response.

The primary barriers to accessing health care for migrant populations throughout the pandemic in **PERU** included economic barriers, access to information, language, discrimination, and specific requirements around legal documents for identification. Furthermore, the border closures resulted in increased irregular routes of immigration and exacerbated the many health needs of migrant populations. The research demonstrates that Peruvian policy efforts to improve conditions focused too heavily on short term solutions and lacked a long-term vision to address the needs of migrant populations, resulting in unsustainable programs and policies. Recommendations to improve the health system response to migrants' needs in the context of the pandemic include addressing barriers to health system services to advance health system equity, particularly as it pertains to eliminating discrimination against migrant populations and expanding health insurance coverage for migrant populations; and enhancing coordination of key stakeholders between local, regional, national, and international levels to improve the availability and quality of care.

This study demonstrated commonalities and differences in the health and migration context and response for Mexico, Colombia and Perú regarding the inclusion of migrants and refugees in their health systems during the COVID-19 pandemic.

All three countries have recently experienced major changes in their migration landscape, with an increase in the arrival of foreigners as part of mixed migration flows of economic migrants and those displaced by violence, economic crises, or natural disasters in their countries of origin. These were composed mainly of Central Americans for Mexico, and Venezuelans for Colombia and Perú. Health care provision for migrants and refugees has been integrated into the context of three countries' health systems in varying degrees, and with different characteristics in terms of their organization, financing, governance, among other elements. Normatively, access to the public health system in Mexico and Perú is independent of migratory status, while in Colombia irregular migrants are entitled to only some health care services compared to nationals, but all have access to emergency services. In practice, however, administrative, and economic barriers persist in all three countries, making migrants' access to health care limited compared to that of the local population.

During the COVID-19 pandemic, the health systems of Mexico and Perú had in common a response towards the migrant population that focused on health system response due to the health emergency created by the pandemic, the development of contingency plans, and a focus on the reduction in transmission of COVID-19. There was less attention on the longer term sustainable health system responses and on the right to health of migrants in their strategies. In contrast, Colombia's pandemic response did not come only from the health system, but also included migration policy action, such as the implementation of the Temporary Protection Statute to regularize the stay of Venezuelan migrants in the country. In all three countries there were relatively few health policies issued in response to the pandemic specifically aimed at migrant populations. Rather, many of the COVID-19-related policies issued were more general in nature, and could indirectly benefit migrants.

ABBREVIATIONS

IOM	International Organization for Migration
WHO	World Health Organization
PAHO	Pan American Health Organization
UNHCR	United Nations High Commissioner for Refugees
MSF	Doctors without Borders
UNICEF	United Nations International Children's Emergency Fund
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
IACHR	Inter-American Commission on Human Rights
ICRC	International Committee of the Red Cross
GIFMM	Interagency Group of Mixed Migratory Flows
R4V	Response for Venezuelans
HIAS	Hebrew Immigrant Aid Society
AAAQ	Availability, Accessibility, Acceptability and Quality
GBV	Gender-Based Violence

MPP	Migrant Protection Protocol
RMRP	2020 Migrant and Refugee Response Plan
MSPS	Ministerio de Salud y Protección Social
CURP	Unique Population Registration Certificate
PRASS	Program of Tests, Tracking and Sustainable Selective Isolation
SERUM	Rural and Urban Marginal Service
SISFOH	Household Targeting System
CSO	Community Service Organization
COMAR	Mexican Commission for Refugee Aid
GTRM	Working Groups for Refugees and Migrants
MIRPS	Comprehensive Regional Framework for Protection and Solutions
MINSA	Ministry of Health of Perú
SIS	Comprehensive Health Insurance
SGSSS	Social Security System in Health
INSABI	The Institute of Health for Well-being
PRASS	Program of Test, Tracking and Sustainable Selective Isolation

INTRODUCTION

At the beginning of 2021, Johns Hopkins Center for Humanitarian Health (CHH) at Johns Hopkins Bloomberg School of Public Health and *Lancet* Migration were commissioned by the International Organization of Migration (IOM) to conduct a research project to explore and document how health systems in the Americas have responded to migrants, asylum seekers, refugees and other displaced populations (henceforth, called migrants and refugees) in their COVID-19 public health responses; specifically, by assessing the challenges encountered by both the public health system and context-specific humanitarian issues.

The research focused on exploring the impact of public health policies on access to health services for migrants and refugees by evaluating those that had been developed and implemented in response to the pandemic within Latin America. Country research teams undertook a multi-phased mixed-methods study in Mexico, Colombia and Perú between May 2021 and January 2022, focusing on public health and migration policies issued between March 1, 2020, and May 31, 2021.

The mixed methods research study focused on health system responsiveness and adaptation towards migrants, refugees, asylum seekers, and internally displaced individuals. Within each country, an in-depth policy analysis was conducted to capture country preparedness, response, and implementation of public health measures. The policy analysis was then deepened with a focused grey and peer-review literature review aimed at exploring the impact of policies from various evidence-based, humanitarian and field perspectives. The literature

review included publications between March 1, 2020 when COVID-19 was declared an emergency of public health concern within Latin America until May 31, 2021.

To deepen our analysis and complement the literature review, research teams interviewed stakeholders and key informants directly or indirectly involved in the provision of care, the protection of vulnerable populations, and the formulation and implementation of public health policies designed in response to the COVID-19 pandemic. The full results by country are presented in the report. Finally, a comparative analysis was made by merging high-level findings from each country; general yet contextualized conclusions are offered based on findings from each category.

The overall goal of this report is to shed light on the regional situation and understand how the mobility framework embedded within the current historical, political, economic, and social dimensions of the Latin American context has impacted health system response during the COVID-19 pandemic. In addition to the individual country sections that will include the same axes of analysis, a cross-sectional comparison in the discussion and conclusion allows us to identify divergence and convergence of health system response. Consequently, we can identify theoretical and practical implications within governmental and non-governmental responses as to how to improve the health system responses to the health needs of migrants and refugees and their right to access health services. We are, therefore, able to utilize COVID-19 as a regional case study to discuss findings in the Latin American region and promote the universal right to health.

BACKGROUND

Within the context of the COVID-19 pandemic, a crucial issue is the health system responsiveness for the most vulnerable populations, including migrants and refugees. People on the move are a population at high risk. Their risk for negative health outcomes expands beyond COVID-19 infection and mortality, and may exacerbate already unmet health, social and economic burdens. The need to document, systematize and analyze the global impact of COVID-19 in migrant populations is not only of public health concern, but a collective global need to advance the migration and health agenda.

A study was undertaken to assess how the health system and national policies in Latin America included migrants and refugees in the COVID-19 pandemic. Case studies were undertaken in Mexico, Colombia, and Perú. All three countries have historically had significant emigration. In more recent years, they have become recipients of a large number of migrants, either in transit, permanent or temporary resettlement and return. This massive movement of individuals has increasingly challenged the countries' overwhelmed and underfunded health systems, especially since the beginning of the COVID-19 pandemic in 2020.

A study by the World Health Organization (WHO) on migrant and refugee health found that this population suffers from specific challenges that arise from increasing diversity in their determinants of health, unique expressed and unexpressed needs, as well as their health seeking experiences that challenge their health seeking behaviors.¹ Many migrants and refugees' health become even more vulnerable due to dire working, living, and traveling conditions, often with inadequate access to water, sanitation, housing, and basic services. In addition to the acute and chronic exposures that threaten their health

status, this population often lacks adequate access to preventative and curative health services. In this context, a migrant-sensitive approach is critical to promoting the health and well-being of migrants and refugees during the COVID-19 pandemic.¹

Understanding the health needs of people on the move within a pandemic is crucial for a proper management and resilient response. This understanding will aid in the formulation of inclusive, equitable and human rights-based government mechanisms explicitly designed to include the health needs and rights of mobile populations. Assessing the specificities of this situation in middle-income countries within Latin America will support contextualized solutions for the inclusion of migrants into health systems within this region. The Pan American Health Organization (PAHO) published a report in 2019 on migrants' access to health services that showed barriers related to their migratory status and absence of economic agency. Similar barriers have been noted amongst Venezuelan migrant populations in Colombia. Researchers found similar existing complexities within the migration journey of Venezuelans.²

Within the framework of the COVID-19 pandemic, several studies have indicated that the health conditions of migrant populations have been negatively affected by different non-pharmaceutical intervention (NPI) strategies designed towards 'healthy distancing' and border closures, mainly associated with the increase in domestic violence, gender-based violence (GBV) and conditions of social precariousness. In this context, it is critical to establish health strategies to protect and care for migrant and refugee populations. These strategies should be based on the limited but increasing evidence-base focusing on mobile populations.

THEORETICAL FRAMEWORK

According to Abubakar et al (2018)³ migration is a fundamental determinant of health and a global priority. Davies, Basten y Frattini (2009), illustrate that during the migration cycle, such populations are exposed to social conditions associated with mobility that affect their physical and mental health. The IOM (2012) highlights that across all the migration phases, mobile populations will experience determinants that affect access to and demand of health services (Fig 1). At the beginning, during the pre-migration stage, individuals (soon to become migrants) and their families are influenced by determinants within their country's community. During transit, these

conditions threaten the health of migrant individuals, making them significantly more vulnerable due to their migration status. Finally, within destination countries, migrant populations are exposed to determinants associated to their new environment, characterized by inequities, marginalization, xenophobia, and discrimination.

This report presents an analysis of the comprehensive response by Mexico, Colombia and Perú within the framework of access to health services and migration as a social determinant of health during the COVID-19 pandemic (Fig 2). This figure outlines the basis for

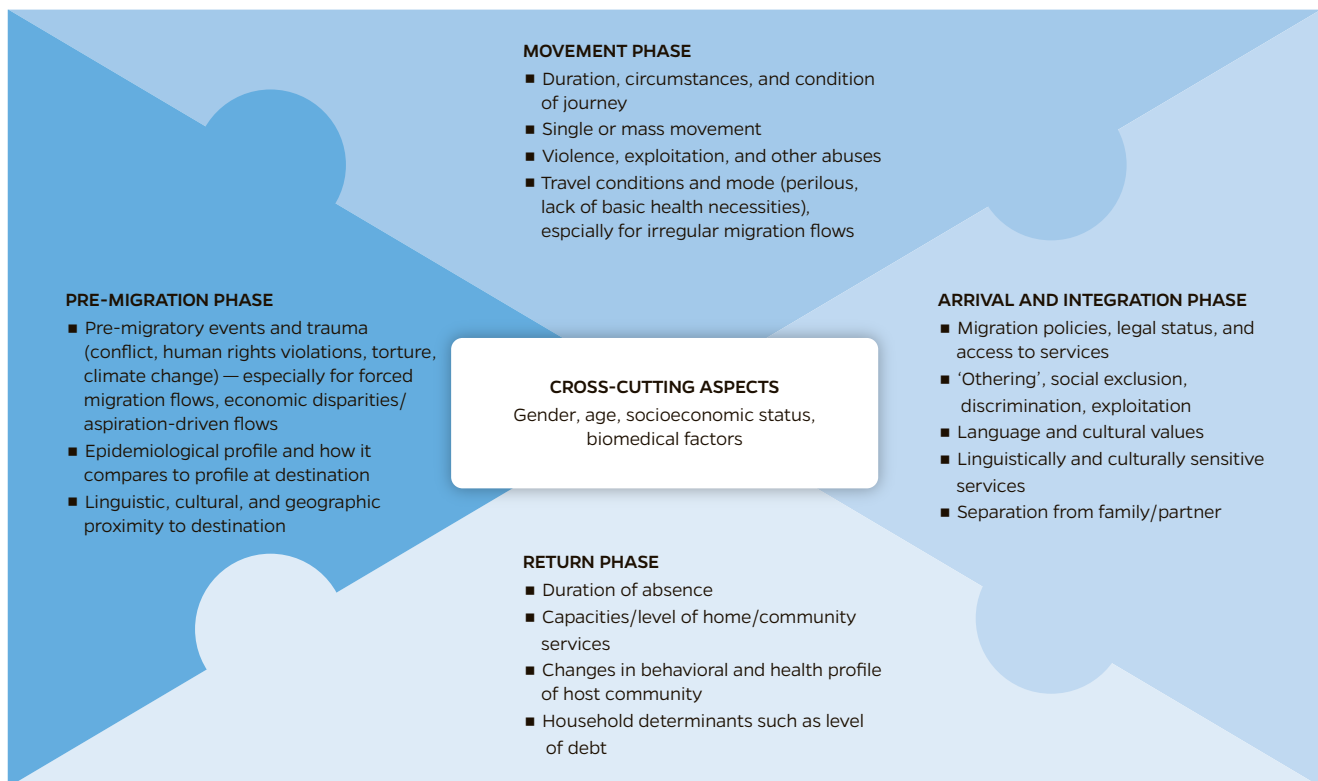


Fig 1 — Health and migration phases adapted from Migration Data Portal.⁴

this analysis, which considers that access depends on both supply and demand elements.

Responsiveness is defined as the way in which individuals are treated and the environment in which they are treated, containing the notion of an individual's experience of contact with the health system.⁵ The most commonly used framework for understanding health systems responsiveness was proposed by the WHO. It contains aspects of respect of human rights, as well as interpersonal aspects of care.⁶ This research will mainly build on the health system responsiveness conceptual framework by Mirzoev and Kane.⁷ Responsiveness is affected by both demand and supply-side (ie, individuals' social context and system factors).⁸

Fig 2 demonstrates how human rights an equal access to healthcare is affected by both supply and demand sides of the health system. The framework outlined aspects of the supply side affecting accessibility to accessing health care, and also the demand side of how people were able to access the health system. The broader context of access to

the health system was the geographical, economic, and institutional factors, including legal and policy factors. All these factors must be considered to achieve a migrant-sensitive health system, which actually provides access to migrants in terms of implementation.

The framework was used as a basis for this study by considering the following questions:

1. How have governance factors facilitated and limited equity of access to the health system during COVID-19?
2. Supply side: how has accessibility to health determinants and health services been affected during COVID-19?
3. Demand side: how has the ability to access services by migrant communities during COVID-19 been affected?

Whilst much has been done to advance policy integration measurements such as the Migrant Integration Policy Index (MIPEX), those indicators are primarily rooted in European policy, governance,

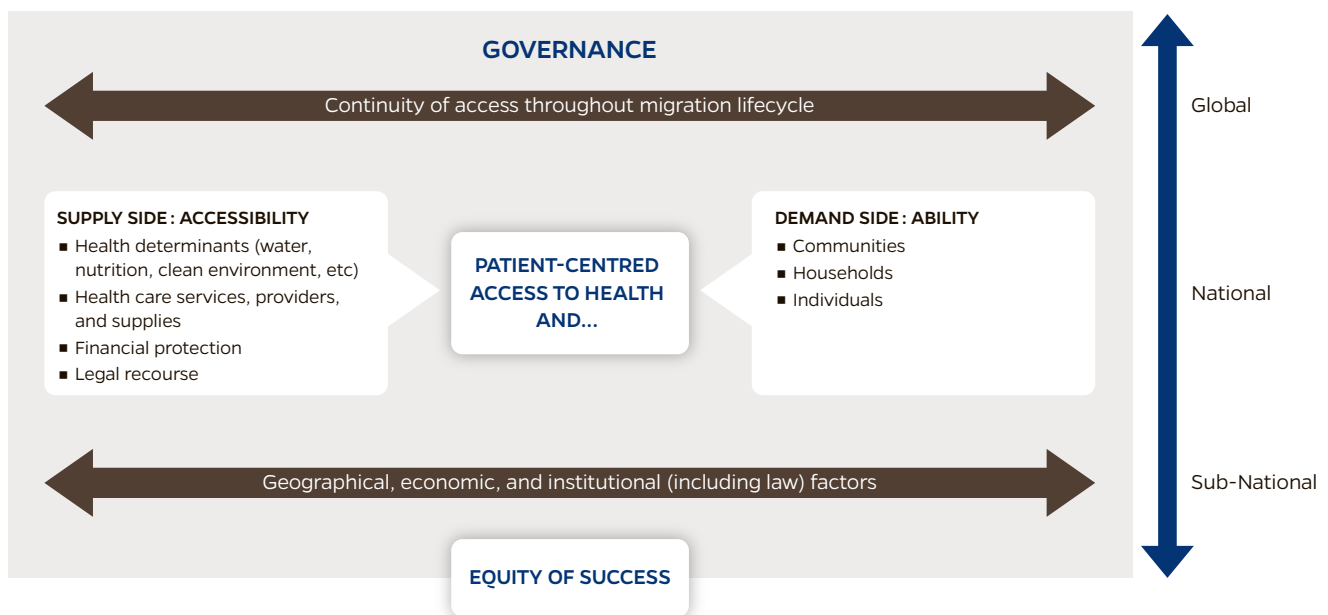


Fig 2— Theoretical framework for health systems access to health and protection services for migrants, adapted from Abubakar et al (2018).³



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and financing schemes. Therefore, the research teams identified key variables within MIPEX, adapted to the unique Latin American health system, governance and policy-making context, and incorporated new variables rooted in both the UCL-Lancet Commission on Migration and Health Framework,³ the AAAQ

framework (Availability, Accessibility, Acceptability and Quality) by WHO within the General Comment 14, people-centered care brought forward by Levesque and colleagues and health system responsiveness; both demand and supply-side all within the context of COVID-19.⁸⁻¹⁰

STUDY OBJECTIVES

This study aims to explore how health systems within Latin America have responded to the inclusion of migrants and refugees within their COVID-19 responses.

The specific objectives of the study are:

To explore and document how health systems in Perú, Colombia and Mexico have responded to the inclusion of migrants, asylum seekers/ refugees and other displaced populations in their COVID-19 responses, specifically by assessing the challenges encountered by both the public, private and humanitarian components of their health systems.

To assess how the short, medium, and long-term policies and strategies adopted in the Americas to cope with the evolving needs of health systems during the COVID-19 pandemic have affected the responsiveness of and accessibility to the health system for people on the move.

To offer specific recommendations for health policy and humanitarian response that are informed by the findings.

To share and promote discussion with policy-makers, humanitarian actors and academics throughout the region.

Each country selected for inclusion the most vulnerable groups, considering the forced migration context within the region. For Mexico, it explored the response to the needs of non-Mexicans that transit through the country with the intention of reaching the United States of America (US), internally displaced Mexicans with the intention to apply for asylum in the US, and Mexicans deported from the US.

METHODOLOGY

The information gathered for each country included:

- Public policy document analysis.
- Literature review (peer-review and grey literature).
- Stakeholder interviews.

This information was triangulated to obtain individual country results with further comparative analysis of Colombia, Mexico and Perú based on final conclusions.

PHASE 1 PUBLIC POLICY DOCUMENT ANALYSIS

Policy analysis

Research teams from each country conducted a policy review on national health systems and responses to COVID-19 within health and migration public policies using the well-known policy framework for analysis of context, process, and content. **Fig 3** illustrates the policy analysis framework utilized for the policy-analysis framework adapted from Buse and colleagues.¹¹

All retrieved documents were individually assessed and were included if they were related to each country's health system response to COVID-19 and migrants within the proposed time frame. However, documents that did not explicitly mention migrant populations within their response were included if they discussed the impact of access to health care for migrant populations, such as social programmes.

Please see **Box 1** for more details.



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Countries independently searched central governmental databases by reviewing information issued by the Ministry of Health (MOH) and other relevant governmental agencies working with migrant populations at a national level within each country.

Documents included for initial assessment were those related to laws, regulations, standards, decrees, agreements, projects, resolutions, guidelines, plans (eg, strategic, sectoral), recommendations, manuals and protocols issued in line with



the preparedness and response national plans for COVID-19, which were published between March 1, 2020 and May 31, 2021 (**Box 1**).

The approach to document retrieval consisted of three stages:

1. Directly extracting information from official government and MOH online pages in addition to agencies known to be responsible for migrant-related issues.
2. An online search using a combination of MeSH terms using contextualized lexicons per country and in Spanish.
3. Relevant documents noted by research or recommended by experienced colleagues that indirectly included access to health services for migrants and refugees.

Researchers analyzed public policy documents considering eight thematic areas as listed in **Table 1**.

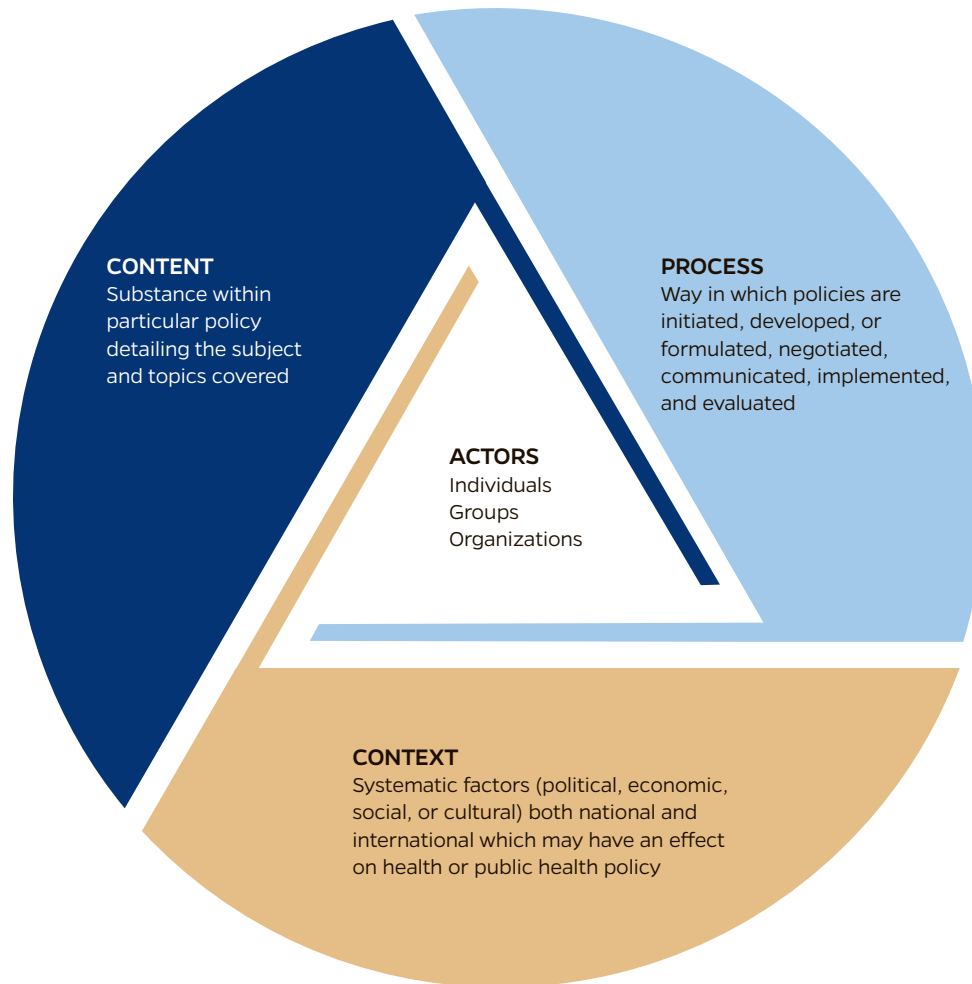


Fig 3— Health policy triangle, adapted from Buse K, Mays N, Walt G (2005).¹¹

PHASE 2 LITERATURE REVIEW

Grey literature

Country teams searched for published literature that was not peer-reviewed, including government reports, conference proceedings, research reports, survey analysis, newsletters and bulletins, fact sheets, infographics, situational updates, thesis and dissertations and manuals.

All countries followed a combined three step approach to systematically collect the data that included searching within: (i) websites

of government and other agencies working on migrant health issues or responsible for migration policy: (eg, relevant non-governmental organizations [NGOs], IOM, WHO, United Nations High Commissioner for Refugees [UNHCR], United Nations International Children’s Emergency Fund [UNICEF]) and national and multilateral organizations; (ii) internet searches using the following search strategy illustrated in **Table 2**; and (iii) documents found through research team networks. Snowball document search was also employed to identify other relevant documents.

Please see **Box 2** for more details.

Box 1 — Public policy methodology**Instrument development (jointly)**

Public policy instrument development and piloting

Public policy review (by country)**Database**

1. Federal health ministry, government, government agencies
2. Online search limited to fifth page using contextualized MeSH terms in Spanish per country's lexicon and agency acronyms:
Example of Mexico's MeSH terms: (Health OR Medical OR health services OR health system OR public health) AND ("Health Secretariat" OR "Health Institute" OR INSABI OR government OR "national migration institute" OR "COMAR") AND (mitigation OR containment OR response OR emergency) AND (COVID-19 OR pandemic OR SARS-CoV-2 OR contingency OR "health distance") AND ("Mexico")
3. Complementary documents known by the research team or recommended by experienced colleagues (snowball) that indirectly includes access to health services for migrants and refugees within the time frame

Documents

Laws, regulations, standards, decrees, agreements, projects, resolutions, guidelines, plans (strategic, sectorial, etc), recommendations, manuals, protocols in line with preparedness and response plans for COVID-19

Documents eligibility

Related to country's national health system response to COVID-19 and migration to include either:

- Policies on health service delivery and other social determinants of health, public actions, health system organization, financing for health care and public actions, epidemiological surveillance, outbreak control and mitigation efforts
- Migration policies issued in response to COVID-19 pandemic including: policies related to restrictions of movement, regularization, document issuing and processing, detention centres, return, migrant centres and overall mobility, particularly pendular mobility across borders

Peer-reviewed literature

For peer-reviewed literature, researchers utilized academic servers including Medline, PubMed, Embase, EBSCO, Science Direct, Web of Science, Redalyc, Google Scholar in both English and Spanish, Biblioteca Virtual en Salud and BIREME.

Inclusion of documents consisted of all published peer-reviewed documents between January 1, 2020, to May 31, 2021 in English, Spanish and Portuguese.

The search included terms in both English and Spanish: (migra* OR refugee* OR asylum seeker* OR detainee*) AND (health* OR medic* OR health services OR health system OR public health) AND (COVID OR coronavirus OR COVID-19 OR SARS-CoV-2) AND [country].

Please see [Box 3](#) for more details.

Researchers analyzed grey and peer-reviewed literature considering seven thematic areas as listed in [Table 2](#).

**PHASE 3
SEMI-STRUCTURED INTERVIEWS WITH
KEY INFORMANTS**

Through an exploratory sequential design, researchers developed an interview guide based on variables identified within the preliminary findings of the literature review. Semi-structured interviews were tailored to each interview group.

THEME	VARIABLES
Migration	<ul style="list-style-type: none"> ■ Type of population covered — irregular, circular, economic, asylum seeker, returned, deported, unaccompanied, specific nationality (eg, Venezuelan), refugee, unaccompanied minor ■ Focus on specific mobility pattern to address within migration journey — formal, closed or contained, informal, integrated ■ Mobility patterns considered to address specific health issues — pendular, returned, transit, destination, deported, awaiting resolution, interception
Coverage within national system	<ul style="list-style-type: none"> ■ Does the document/policy consider migrants within the national system, policy, programme, system, service provision, guideline? Are there any administrative or legal barriers to access such service? ■ Which health services are covered? ■ Is coverage the same for migrants (irregular, regular) as for non-migrants?
Ease of access/inclusion	<ul style="list-style-type: none"> ■ Does the document/policy describe strategies to inform migrants about access to health services? ■ Does the document/policy describe health and staff workers cultural competencies training? ■ Does the document/policy describe measures to mitigate racism, discrimination, xenophobia while seeking or receiving health services? ■ Does the document/policy consider cultural and language aspects? ■ Does the document/policy describe ways in which migrants with health professional backgrounds are supported to work?
Collection of information	<ul style="list-style-type: none"> ■ Does the document/policy suggest collecting data, if so — what type of data and how will it be used to improve service delivery? ■ Describe what information, methods, to which groups
Population and issues considered/covered	<ul style="list-style-type: none"> ■ Is the document/policy aimed at a special group of migrant individuals (eg, women, children, people with disabilities, people living with HIV/AIDS, chronic or acute conditions)? ■ Which health issues does the document/policy focus on? ■ Does the document/policy address any other social or political determinants of health (eg, access to food, water, hygiene, education, shelter, government issued identities)?
Supply and demand	<ul style="list-style-type: none"> ■ Does the document/policy address demand aspects (eg, informing migrants about access mechanisms and rights)? ■ Does the document/policy address supply-side aspects (eg, defining services to which migrants have access, implementing specialized services for migrants, promoting cultural competencies in staff)?

(Table 1 continues on next page)

(Continued from previous page)

THEME	VARIABLES
COVID-19 specific efforts	<ul style="list-style-type: none"> ■ What does the document/policy focus on concerning COVID-19 efforts (eg, preventing transmission, improving standards of living, ensuring minimum standards, health service provision, health system financing, governance, protection mechanisms)? ■ Describe the type and service
Implementation	<ul style="list-style-type: none"> ■ Is the document/policy implementation nationwide or is it restricted to certain geographical areas? ■ Is the implementation of the policy/document permanent or restricted to a time limit (which one)? ■ How will the activities within the document be financed? ■ Does the document/policy include evaluation indicators? ■ Who are the actors involved in implementing document/policy and what are the coordinating mechanisms between actors?

Table 1 — Thematic approach and variables for public policy documents.**Box 2** — Grey literature methodology**Instrument development (jointly)**

Grey literature and peer-reviewed instrument adaptation from public policy

Grey literature (by country)**Database**

1. Search within government and other agencies working on migrant health issues such as NGOs, UN System (IOM, UNHCR, WHO, UNICEF) and national multilateral organizations
2. Google online search limited to the eighth page using contextualized MeSH terms in Spanish: migrant OR refugee OR asylum seeker OR detained) AND (health OR medic OR medical services OR health services OR health system Or public health) AND (COVID OR coronavirus OR COVID-19 OR SARS-CoV-2) AND [Country]
3. Complementary documents known by the research team or recommended by experienced colleagues (snowball) that indirectly includes access to health services for migrants and refugees within the time frame

Documents

Reports, conference proceedings, research reports, survey analyses, newsletters and bulletins, fact sheets, infographics, situational updates

Documents eligibility

Related to country's national health system response to COVID-19 and migration to include either:

- Policies on health service delivery and other social determinants of health, public actions, health system organization, financing for health care and public actions, epidemiological surveillance, outbreak control and mitigation efforts
- Migration policies issued in response to COVID-19 pandemic including: policies related to restrictions of movement, regularization, document issuing and processing, detention centres, return, migrant centres and overall mobility

Box 3 — Peer review methodology**Instrument development (jointly)**

Grey literature and peer-reviewed instrument adaptation from public policy

Peer-review (by country)**Database**

1. Medline, PubMed, Embase (Perú has no access to this server), EBSCO (Mexico, Colombia), Science Direct (Mexico) Web of Science, Google Scholar (English and Spanish limited to page 8), Biblioteca Virtual en Salud (Mexico), BIREME (Mexico, Colombia)

Search 1: (migra* OR refugee* OR asylum seeker* OR detainee*)

Search 2: (migra* OR refugee* OR asylum seeker* OR detainee*) AND (health* OR medic* OR health services OR health system OR public health)

Search 3: (migra* OR refugee* OR asylum seeker* OR detainee*) AND (health* OR medic* OR health services OR health system OR public health) AND (COVID OR coronavirus OR COVID-19 OR SARS-CoV-2)

Search 4: (migra* OR refugee* OR asylum seeker* OR detainee*) AND (health* OR medic* OR health services OR health system OR public health) AND (COVID OR coronavirus OR COVID-19 OR SARS-CoV-2) AND [Country];

*Text was in English, Spanish, and Portuguese; Perú was limited to Searches 1 and 2

Documents

Abstracts, free full text, full text, articles, reviews

Documents eligibility

Mention or contemplate migrant populations within their writing and include within their text COVID-19 and:

- Access to healthcare
- Preventing transmission
- Improving standards of living
- Health service provision
- Health system financing
- Social or political determinants of health
- Special considerations for health delivery
- Governance
- Impact of health or migration policies
- Strategies to inform migrants about health services

The migrant groups in forced mobility among relatively new flows in the region were considered most vulnerable and were selected for each country. For Mexico, the response to the needs of non-Mexicans transiting through the country with the intention of reaching the US, internally displaced Mexicans with the intention of seeking asylum in the US, as well as Mexicans deported from the US to Mexico. For Colombia and Perú, the response to the needs of displaced Venezuelans was analyzed.

Semi-structured individual interviews were conducted with key informants to explore the response capacity of the country's health system and the policies, plans, or strategies that were formulated and implemented for COVID-19 care within the migrant population.

Each country conducted between 15–20 interviews as a minimum sample size divided into four groups within the context of COVID-19:

THEME	VARIABLES
Data concerning migrant information captured	<ul style="list-style-type: none"> ■ What data is included? Qualitative, quantitative or both? ■ Research methodologies to collect information about migrants' health ■ Collection description. What information, methods, which groups does the document describe?
Migration	<ul style="list-style-type: none"> ■ Type of population covered — irregular, circular, economic, asylum seeker, returned, deported, unaccompanied, specific nationality (eg, Venezuelan), refugee, unaccompanied minor ■ Focus on specific mobility pattern to address within migration journey — formal, closed or contained, informal, integrated ■ Mobility patterns considered to address specific health issues: pendular, returned, transit, destination, deported, awaiting resolution, interception
Population and issues considered/covered	<ul style="list-style-type: none"> ■ Is the document aimed at a special group of migrant individuals (eg, women, children, people with disabilities, people living with HIV/AIDS, chronic or acute conditions)? ■ What health issues are mentioned? ■ Does the document address any other social or political determinants of health (eg, access to food, water, hygiene, education, shelter, government issued identities)?
Coverage	<ul style="list-style-type: none"> ■ What does the document mention about health coverage or health delivery towards migrant populations? ■ Describe the main data published on health services provided for migrant populations
Access/inclusion	<ul style="list-style-type: none"> ■ What does the document mention about strategies designed to inform migrant individuals about how to access health services? ■ What does the document mention about strategies aimed to mitigate racism, discrimination, xenophobia while seeking or receiving health services?
Supply and demand	<ul style="list-style-type: none"> ■ Does the document/policy address demand aspects (eg, informing migrants about access mechanisms and rights)? ■ Does the document/policy address supply-side aspects (eg, defining services to which migrants have access, implementing specialized services for migrants, promoting cultural competencies in staff)?
COVID-19 specific efforts	<ul style="list-style-type: none"> ■ What does the document focus on concerning COVID-19 efforts (eg, preventing transmission, improving standards of living, ensuring minimum standards, health service provision, health system financing, governance, protection mechanisms)? ■ Describe the type and service
Main conclusions	<ul style="list-style-type: none"> ■ Describe the main document conclusions

Table 2 — Thematic approach and variables for grey literature and peer-review documents.

- Direct provider and health system managers—hospital and clinic case managers, frontline workers including nurse, triage personnel, physician residents and senior doctors.
- Mediators for access to healthcare, advocates, and academia—migrant shelter staff, local NGOs and members of the civil society, UN System staff, international NGOs, and academia.
- Local and international governmental and non-governmental policy implementers and policymakers involved in the coordination of migrant health.
- Individuals who identify themselves as either migrants or refugees.

ANNEXES 1–3 show the interviews conducted in Mexico, Colombia, and Perú.

Following the instrument guide and using a life-course perspective, migrants were asked about prior experiences in their country of origin, their migration experience and trajectory, experiences accessing health services in each of the participating countries, as well as the impact of the pandemic on their health, access to health services and other indirect aspects that may influence their health and well-being.

Participants from groups 1–3 were asked about their experiences involved within the activities across their agency or institution related to migrant

care and protection, in line with the national public health and migration policies within the context of COVID-19, access to healthcare for migrants during the pandemic, as well as the impact of the pandemic in access to health and social services for migrants.

The interviews were conducted online or in person, most with a duration of 30–90 minutes. Prior verbal consent was obtained. Ethical review boards at JHSPH/CHH and all participating universities in the three countries were obtained. Interviews were transcribed and coded following a common codebook.

Comparative analysis

The sequential integration of each country's analyzed data obtained from the previous phases was merged into a comparative cross-thematic analysis with sub-category construction based on significant findings in Colombia, Mexico, and Perú. The joint analysis considered the following three aspects: migration and health system context, rights to access health services, and accessibility of health services.

Methodological challenges and limitations

In terms of methodology there were some limitations in the literature review in terms of ensuring comparative search terms, for example using the same keywords in Google Scholar retrieved from different documents depending on the country from which the search was made.

CHAPTER 1

THE CASE OF MEXICO

SUMMARY

In recent decades, an emerging feature of Mexico's migration scape has been the increasing number of migrants from Central America, South America, and Caribbean nations entering the country with the aim of reaching the US. The resulting challenge for the nation's health system, was further exacerbated by the COVID-19 pandemic. This section of the report evaluates the Mexican health system's response to the needs of migrants in the COVID-19 pandemic and provides recommendations for key stakeholders and decision-makers moving forward.

The findings of this research suggest that the main barriers migrants faced in accessing health care throughout the pandemic in Mexico included the need for out of pocket expenditures, language barriers, and administrative requirements around legal documents for identification. Furthermore, the national pandemic response primarily focused on epidemiological surveillance and transmission control and failed to meet the broader health and socioeconomic needs of migrant populations. The research also highlights the critical role played by civil society organizations and multilateral agencies in filling gaps in the national pandemic



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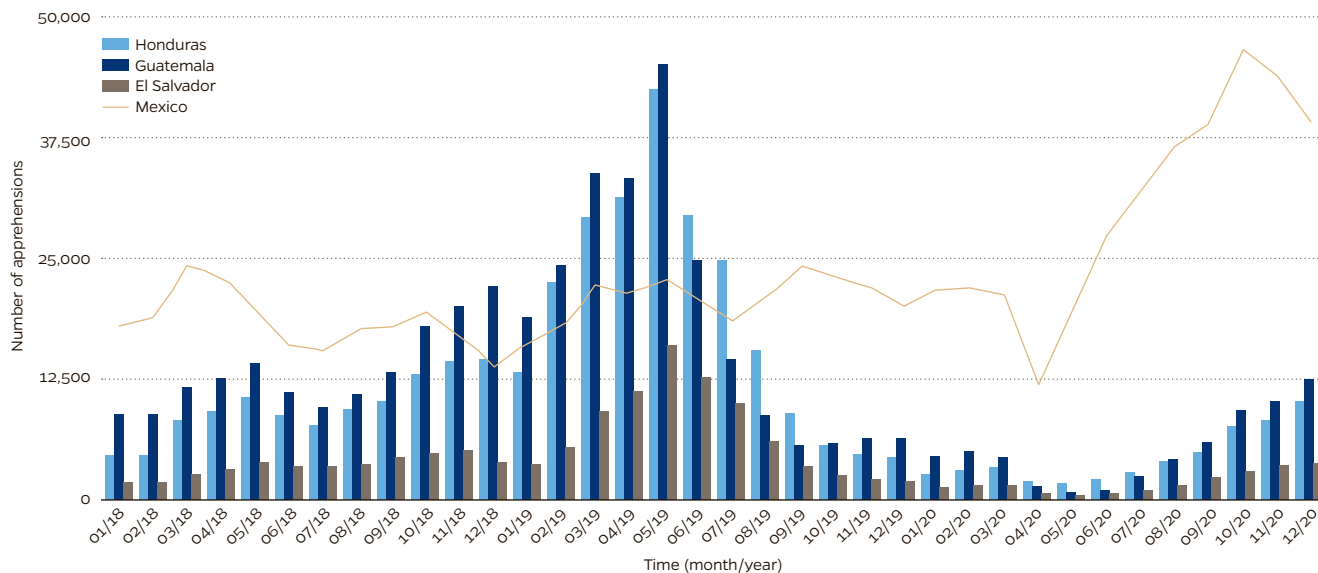


Fig 4 — Apprehensions at the US–Mexico border since January 2018–December 2020.¹⁶

response for migrant populations. Finally, findings highlight the scarcity of data pertaining to migrant health. Recommendations to improve health system response to migrant needs in the context of the COVID-19 pandemic include addressing the barriers to health services to advance health system equity; strengthening health system capacity through improved coordination between local, regional, national, and international actors; and improving data collection and health information.

MIGRATION CONTEXT

Historically the main migration flow in Mexico has been the emigration of Mexicans to the US. Mexico is the second-largest emigration country in the world after India,³ and Mexicans account for almost 24% of the US' foreign-born population.¹² Mexico has functioned as an important, yet dangerous, travel path connecting Latin American Countries with North America. The sum of these flows makes Mexico one of the leading migration corridors globally, together with the Syrian–Turkey, and India–United Arab Emirate corridors.¹³ Another main component of migration is the return of Mexicans from

the US. Although there is no official figure for the total number of Mexicans voluntarily returning from the US to Mexico each year, Mexico's 2020 census reported a total of 178,072 individuals claiming to have lived abroad in the past five years (2015–2021), with 71.2% having returned from the US to Mexico.¹⁷ The return, on the other hand, can either be voluntary, or forced by removal or deportation from the US. Whilst voluntary return poses an important challenge for many families, the challenges of being forcefully returned have been shown to significantly impact the livelihoods of those depending on remittances, as well as the increased likelihood of health, economic and social disparities due to a variety of factors. Separation from social networks and support systems, unemployment, the challenges of returning to unfamiliar or dangerous cities, and lack of proper integration mechanisms into health and social protection systems increases the risk of having their needs unseen or unaddressed.^{18–20}

However whilst Mexico has been mostly has been mostly a country of origin and transit, rather than of destination and resettlement,¹⁴ the COVID-19 pandemic highlighted the relevance of other forms of mobility. Since March 2020, the beginning of the

COVID-19 pandemic, binational agreements between Mexico and the US led to border closures between both countries, the suspension of current asylum claims, the return of asylum seekers, as well as the mounting return of migrants under the Migrant Protection Protocols (MPP), a bilateral US–Mexican agreement for the return of asylum seekers to remain in Mexico until their petitions are resolved by US courts.¹⁵ Whilst cross-border movement was in theory halted, US border apprehensions continued, as people resumed attempts to cross the border early in the pandemic (Fig 4).

While it is challenging to obtain accurate figures for populations heading northwards through Mexico due to a variety of complex factors, an estimate based on the number of arrests by immigration authorities in Mexico and the United States suggests that the number of people passing through the country each year may be in the hundreds of thousands.²¹

In recent years, the number of Central American, Caribbean, and transcontinental migrants transitioning through Mexico has dramatically changed the already challenging scenario Mexico was facing when attempting to uphold international treaties and commitments. In 2019, increasing levels of extreme violence, including gender-based, gang-related and political violence, as well as poverty and climate change, drove at least 400,000 migrants from Latin American Countries to flee north.²² This figure included people travelling in small groups and the so-called ‘migrant caravans’, and there were more than 458,000 apprehensions at the US–Mexico border during 2020, and more than 1.7 million apprehensions in 2021.

The increasing number of asylum seekers arriving at the southern US border has been widely documented, however, this situation has also resulted in a substantial increase in the number of asylum or refugee applications in Mexico. Over the course of ten years (2011–2021), the number of asylum and refugee applications in Mexico has increased from 680 applications in 2009 to 70,609 in 2019.¹⁷ Furthermore, between January and October 2021, the number of

applications increased by 73.3% relative to the same ten-month period in 2019.²³ Most of the asylum claims in 2021 were by migrants from Haiti, Honduras, Cuba, El Salvador, and Chile; many of whom were children from Haitian parents who were born in Chile and arrived in Mexico. Despite the increased number of Central American and Caribbean migrants, most refugee resolutions were granted to Venezuelan migrants between 2013–2020, (98.1%), while only 51.2% of Honduran requests were approved.²⁴

The return of non-Mexicans to Mexico ‘justified’ under bilateral agreements either as part of the MPP as well as the Title 42 expulsion—a national security policy imposed by the Centers for Disease Control and Prevention in the US,¹⁷ under the rationale of preventing disease transmission by halting all non-essential travel left a highly vulnerable group in the Mexican side of the border during the pandemic; these included children, pregnant women, and people living with chronic health conditions and disabilities, many on the brink of marginalization and destitution. As of October 2021, there had been more than 70,000 people returned under the MPP program, and at least 1.2 million expulsions under the Biden administration.²⁵ Rather than being suspended, MPP and Title 42 expulsions have been expanded by the current US administration.^{26,27}

HEALTH AND MIGRATION IN MEXICO

The conditions in which migrants transit or are returned to Mexico define important risks, such as violence, sexual assault, rape, trafficking, food insecurity, discrimination, or social exclusion. Ultimately, these risks have an immense negative impact on their individual and collective physical and emotional health as well as their well-being. In addition to the increasingly diverse countries of origin, reasons for leaving the countries of origin have diversified, with people moving for reasons of forced displacement, as opposed to the previous mostly economic migrants. This has resulted in a change in demographics, with a higher percentage of women, unaccompanied children, and families.²⁸

Previous reports issued by El Colegio de la Frontera Norte (COLEF) highlight the mounting health needs of migrants trapped at the US–Mexico border. In 2018, three of ten individuals traveling in a migrant caravan had a health need at the time of the survey.²⁹ At the same time, their options for accessing health care in Mexico remain limited. In a 2015 study conducted alongside the migration route, migrants expressed receiving care mostly from local and international NGOs, while only a small minority accessed health services through government institutions (1.8%).³⁰ An International Rescue Committee (IRC) needs assessment conducted in 2019 revealed that the main reasons discouraging migrants to try to access public health services included feeling unsafe to travel outside of shelters where they were staying, limited economic resources, indirect and direct costs of accessing and continuing care, lack of knowledge of where to seek care and no medications available in the health facilities. Moreover, migrants most often resorted to irregular means of travel, often-times involving the interaction with members of the organized crime or exerted violence from Mexican immigration and police authorities,^{31,32} further distancing from accessing timely health, social and protection programs.

MIGRATION POLICY ANALYSIS

While Mexico upholds various international conventions on migration and human rights (eg, 1951 Refugee Convention, UN Convention on the Rights of the Child, Covenant for Economic, Social and Cultural Rights, UN Convention on the Rights of the Child, Global Compact for Refugees, Global Compact for Safe Regular and Orderly Migration), and its own legislation on migrants and refugees emphasizes respect for and the protection of human rights,^{34,35} in practice, immense political and administrative barriers exist for individuals seeking protection.²⁸

On the other hand, while previously Mexico’s health and migration policies were mostly focused on responding to the needs of Mexican nationals residing in the US and returned Mexican migrants,³⁶ given the shifting migration trends and epidemiology, Mexico has begun to develop policies aimed at foreign origin migrants. One example are the 2014 amendments to the Migration Law and the Law on Refugees, Complementary Protection, and Political Asylum (Table 3), both recognizing the right to health irrespective of the individual’s immigration status. In 2019, the General Health Law specified

1983	2014	2019
The Right to Health is included in the Political Constitution of the United Mexican States (Article 4: “Everyone has the right to the protection of health”)	The Migration Law (Article 27) states that care must be provided to foreigners, regardless of their immigration status “in accordance with the applicable legal provisions” The Law on Refugees, Complementary Protection and Political Asylum (Article 44) states that refugees have the right to receive health services; government agencies (including the MOH) must implement the corresponding actions with their own resources approved for resources (Article 4)	The modifications to the General Health Law indicate that all people in Mexico who do not have social security have the right to receive health services free of charge (Article 77bis1); the only requirements to receive this care is that one must be in the national territory, not have social security, and have a form of identity document (Unique Population Registry Code, birth certificate or certificate, “or the documents established in the provisions regulations”) (Article 77bis7)

Table 3— History of healthcare for migrant populations in Mexico.

that all individuals in the country have the right to receive public health services free of charge regardless of social security status. In this framework, regular and irregular migrants, asylum seekers, and refugees have the same rights to health care as the national population.

ANALYSIS OF HEALTH SYSTEM RESPONSE TO MIGRATION

Despite the positive changes over time that aim to improve the rights of migrant populations, many barriers regarding access to health care for migrant populations in Mexico remain.³⁷ Before the COVID-19 pandemic, Mexico faced substantial challenges to ensure the right to health for citizens and non-citizens alike. The analysis of this section takes into consideration the barriers within the context of Mexico's fragmented and chronically under-resourced health system.³⁸

While Mexico's health system is divided into several public and private institutions, we will focus on public health service provision. The public health system includes services for persons in formal employment and their families, which are provided by social security institutions (eg, IMSS, ISSSTE), and services provided by the federal and state level Health Secretariats to persons not covered by social security. This fragmentation of health service delivery further perpetuates inequities in access to health care, as the quality-of-service provision and financial protection is better in social security services.³⁹

Given that very few migrants have regular employment in Mexico, they are covered by the second type of public health services. However, those services face immense challenges. Despite being free of charge according to the Mexican law, users must often pay out of pocket for direct and indirect costs to cover transportation, diagnostic testing, surgical equipment, medications, and rehabilitation.³⁹ In this context, migrants right to becomes mainly aspirational, and in many cases their health care falls to local and international

NGOs.⁴⁰ As described above, despite immigration status by itself not being a legal barrier to access health care in Mexico, migrants have expressed many challenges and complexities within the system that directly or indirectly hinder their access to health services. One clear example of this is the lack of policies protecting migrant's legal stay in Mexico, thus limiting the ability to obtain formal employment, consequently limiting their possibility to obtain social security health services (eg, IMSS, ISSSTE). Another example is the exigency of proof of identity or address by public health care providers, documents which migrants often do not possess.

FINDINGS FROM POLICY ANALYSIS, LITERATURE REVIEWS AND STAKEHOLDER INTERVIEWS

Public policy response to health needs of migrants during the pandemic

Based on the search criteria for public policy documents, the team identified and included for review a total of 23 documents related to Mexico's response to COVID-19 and migration. **Table 4** shows the main themes within the public policy review (for full list of policy documents, please see **ANNEX 4**). In contrast to previously issued health and migration policies in Mexico that focused primarily on guidelines and recommendations directed towards Mexican migrants, these policies were centered on the flow of migrants transiting through Mexico towards the US.

The first of these documents, titled *General Guidelines for Mitigation and Prevention of COVID-19 in Closed Public Spaces* [8] was issued by the Government of Mexico on March 27, 2020. It provided recommendations to prevent transmission of COVID-19 in places including shelters hosting migrant populations. The Ministry of the Interior issued a second document on April 19, 2020, titled *Action Protocol for the Prevention and Care of Suspected and Confirmed Cases of COVID-19 in Immigration Stations and Provisional Stays of the National Institute of Migration* [14] in response to the risk of transmission within formal detention

THEMES WITHIN POLICY DOCUMENTS	REFERENCE TO POLICY DOCUMENT (SEE ANNEX 4)
COVID-19 response documents not focused on migration	[2-4, 7, 9-11, 13, 15, 17, 20-23]
COVID-19 response documents not focused on health	[5, 6, 19]
COVID-19 response document related to travelers arriving from high-risk cities within China	[1]
COVID-19 document issued by cooperation initiative between the Government of Mexico and Central America limited to general recommendations for displaced populations	[12]
COVID-19 documents explicitly addressing migrant populations	[8, 14, 17, 18]

Table 4—Themes identified within Mexico’s public policies.

centers, also known as ‘migration stations’. A month later, on May 11, 2020, the Federal MOH issued the *Operational Plan for the Care of the Migrant Population in the Face of COVID-19* [17], primarily focused on migrant shelters in “states with [high] migrant population mobility, with emphasis on border areas of the north and south of the country”. The final document issued on May 20, 2020 by the MOH, titled *Sanitary Recommendations for Temporary Shelters* [18] focused on shelters run by CSOs.

These documents outlined measures for identification of individuals at risk of complications from COVID-19, the implementation of hygiene and physical distancing measures, the development of reporting mechanisms for epidemiological surveillance systems, and the identification of hospitals for COVID-19 cases referrals. However, they assumed that the resources to implement the measures would be provided by the CSOs themselves, with aid from the local-level public health system. In addition, despite the operational plan [17] mentioning general health and wellbeing, there were very few measures for mental health services, drug prevention, or to outline any specific measures to promote access to health care beyond the COVID-19 response. Neither did they discuss strategies to improve the overall health, economic, and social well-being of migrants.

Main findings from literature review and stakeholder interviews

The above-mentioned verticalization of the response to COVID-19 within these settings was viewed by study participants in charge of putting the guideline in practice as a major limitation of the current Mexican health system’s response to the pandemic:

“So, it goes beyond having a doctor. They are perhaps thinking of an urgency...immediate. But...the needs go far beyond a medical consultation.”
— Government official, federal level, September 2021

From triangulation amongst the findings from the literature review and stakeholder interviews, it is apparent that the COVID-19 pandemic aggravated the existing chronic barriers in accessing services. The pandemic limited even more the ability of migrants to gain access to hospitals within Mexico’s health system, led to reduced employment opportunities, and consequently ability to cover health-related costs.⁴¹

Furthermore, the public policy documents that were issued failed to address the rich and complex array of social and political determinants of health, such as access to food, employment, housing, and essential immigration procedures. Evidence has

shown that during the study period, the limited attainment of such essential determinants had a profound impact on the health of migrant populations throughout the pandemic.⁴¹ However, this was not an exclusive consequence of policies aimed towards migrant populations; the public health response impacted the performance of many public health institutions as they did not consider factors that went beyond the prevention of COVID-19 transmission within their response. This limited approach resulted in a failure to provide proper resources during COVID-19 towards broader determinants of health, such as nutrition, physical activity, general health care, GBV, and employment for populations working informal jobs; the latter is approximately half of the employed population in Mexico.⁴²

Population inclusion and access to healthcare

The operational plan [17] as well as the protocol issued for migrant stations [14] both include “vulnerable groups”; a term that includes women, children, adolescents, and individuals at risk of health complications from COVID-19. However, by focusing so narrowly on migrant shelters and migration stations, migrants, refugees, and asylum seekers living in communities, informal camps, or on the streets are implicitly excluded from the guidelines. Although populations “without a fixed address” are mentioned in the context of detention centers [18], they are listed solely for the purpose of recommending their admission to shelters without defining a strategy to address their health and wellbeing.

Furthermore, although both Mexican legislation and protocols issued for immigration stations mention the inclusion of all individuals when referring to the right to free health services regardless of an individual’s immigration status, the documents do not explain the process to ensure and fulfill such rights beyond explaining that the state and local MOHs have the responsibility to provide such services. Similarly, the public policy documents assume health service provision for COVID-19 and other health needs will be covered by the MOH; however, it is unclear which health services are to be covered

by the government, resulting in another barrier to implementation and care.³⁷ This lack of operationalization and clear guidelines for implementation resulted in significant barriers to access to care for migrant populations, as mentioned with the following illustrative quote.

“You know that now the CURP [Unique Population Registration Certificate] is the key to economic, social, and cultural rights, right? In other words, although they tell you that health is universal, they ask you for a CURP or an INE [identification card] in order to access it...And this is where the challenge lies.”

— Government official, Federal Level, September 2021

A thorough exploration of both literature and interviews with key stakeholders and key informants enabled a deeper knowledge of key actions implemented by the MOH to address migrant health, which was not evident within the policy documents reviewed. One example of this was the MOH’s installation of health modules, following an approach previously implemented in Mexican migration offices receiving Mexican migrants returned by the US authorities. Those modules, staffed by doctors, nurses and psychologists, supported COVID-19 testing, and conducted health promotion activities centered on safety and prevention measures. While some of these efforts may have been successful in reaching specific migrant populations, such as deported Mexican individuals who were originally excluded from public policy documents, their response continues to focus heavily on the acute emergency response for COVID-19, rather than a more holistic approach to migrant health. Consequently, important aspects that could positively improve their health and well-being were missed.

Overall, the policy documents issued in response to the COVID-19 pandemic in Mexico were primarily aimed at strategies designed to control the transmission of COVID-19, with a strong focus on the locations with the highest risk of transmission. Although Mexico’s public health approach could be

justified within the context of an acute public health emergency, the policies lacked a comprehensive vision that captures both the migration and health nexus and vulnerable migrant populations and failed to properly address access to health care for these populations.

AREAS OF PUBLIC POLICY ANALYSIS

Adequacy of health services

The reviewed public policy documents did not sufficiently consider the adequacy of health services provided, or the need to adjust services to better serve migrant populations in the context of the pandemic. According to interviewees, the absence of two key aspects resulted in critical barriers in access to health services. First, the public policy documents did not address language barriers and other key elements of cultural adaptation that could limit access to health services. Although CSOs had taken some measures to address this issue, the policy documents issued by the government don't consider it.

INTERVIEWER: “And you [community service organization] CSO that provides health services to migrants], what have you done...? Do they have, for example, translators or...how do you handle this [challenge]...of populations that don't speak Spanish, for example?”

INTERVIEWEE: “When they speak English, there are several of us who speak English, but, for example...when the population of Haitians first arrived, Mrs [NAME OF THE DIRECTOR OF THE ORGANIZATION] helped us with the translation to Portuguese [REFERS TO HAITIANS WHO HAD LEARNED PORTUGUESE IN BRAZIL]...with the others, it was quite complicated for us...sometimes, for example, the [CSO that provides various services to migrants], a translator comes that works with them and he translates for us.”

— OSC worker, July 2021

Second, the public policy documents did not address current barriers to care resulting from the

requirements of presenting identity documents in order to receive care in the public health services. Although a birth certificate (from any country) is recognized by the General Health Law⁴³ as admissible to obtain care, key informants stated that, in practice, Mexican health services only accept Mexican identity documents. Furthermore, health services frequently asked for proof of residence, a requirement nearly impossible for most migrants. While according to the interviewees a positive and unintended consequence of the pandemic has been a decline in this barrier to enable for a more effective pandemic response, none of the policy documents directly address this issue, and there is great variation in this practice between different sites and services.

“So...that I think is one, the interpretation of what the law says, and that, at the end of the day, each state and each institution interprets it...well...at their convenience, right?”

— Government official, federal level, September 2021

The operational plan lists the only apparent adjustment to the policy regarding the care of migrant populations throughout the pandemic by delineating improvements to epidemiological surveillance measures in shelters and detention sites, and by identifying hospitals for COVID-19 referrals [17]. However, once again, no actions are proposed to account for the challenges related to language differences, cultural diversity, or adapting services to better meet the needs of migrant populations.

Data on the health of migrants in Mexico is scarce. Some public health registries include place of birth as a variable, which could be used as a proxy for the identification of migrants. However, this variable is not collected on all cases, and is not publicly available. Thus, insufficient data and information is another critical limitation in the health system's response to the pandemic.

The public policy documents issued in response to the pandemic [8, 14, 17, 18] state migrant data

should be collected to enable improved prevention of COVID-19 cases in shelters and migratory stations, as well as for improved epidemiological surveillance. To address COVID-19 prevention, the operational plan [17] states that shelters should gather data on individuals at risk of complications from COVID-19. However, in the reviewed documents, there is no mention of collecting other forms of data. Regarding surveillance, the same plan of operation specifies that shelters are responsible for informing the health jurisdictions of suspected cases, as well as leading the corresponding epidemiological studies. The data collected goes to the National Epidemiological Surveillance System where it is made available to the public through both the database as well as periodic epidemiological reports. For a limited period of the pandemic, the MOH also published bulletins to provide further information on COVID-19 cases amongst migrant populations.

Findings from key stakeholders involved in the response

The public policy documents designate two main agencies responsible for leading the response to migrant health during the pandemic: the MOH and the Ministry of the Interior (from the local to national levels). The guidelines issued by the Ministry of the Interior [14] mention migrant populations' right to health and outline actions pertaining to pandemic response within the purview of its role. The same guidelines state that COVID-19 cases will be managed by doctors assigned to immigration stations, and that the stations must also be prepared with a list of referral hospitals for more severe cases. Within the framework of the Mexican health system, these referral hospitals correspond primarily to the MOH, or other public institutions defined as 'COVID hospitals'.

The MOH operational plan [17] states that health jurisdictions at the local level bear responsibility for COVID-19 response efforts while also suggesting that the CSOs operating migrant shelters are responsible for obtaining resources for care, reporting suspected cases, and complying with MOH instructions for transmission prevention. In accordance with this, the interviews and literature both suggest that the

health jurisdictions (local level of the MOH) effectively addressed the pandemic in shelters by maintaining communication with those in charge of the shelters, responding to outbreaks with proper epidemiological control measures, and at some sites by providing materials for personal protective equipment (PPE) and sanitation.⁴⁴ However, the implementation of this response was slow at the beginning of the pandemic, and was frequently interrupted due to lack of resources and other issues. For example, in some places MOH doctors withdrew from migrant camps during the most critical stages of the pandemic and only pressure from CSOs made them respond again.

"...and particularly, I will tell you, I am infinitely grateful for the support of the State Government, but mainly of these, the officials of my health region and particularly of the [COVID] testing center of my health region, because the Director of the testing center...has not left me and has been super empathetic with the cases."

— OSC Worker, September 2021

Hernández-Hernández (2021) emphasizes the significant role of politics throughout the COVID-19 pandemic.⁴⁴ The response of state level actors in a country governed by the opposing party often resulted in conflict between state and federal level actors. Although states ultimately adhered to the federal guidelines, state level actors initially aimed to use the situation for political gain. For example, at times migrants were presented as a vulnerable population that required attention, while in other moments migrants were presented as a risk to the local population and a national security problem. Similarly, the National Institute of Migration constructed a fence around an informal migrant camp of 2,000 residents as a strategy that they presented as intended to control transmission while migrants and CSO members alike perceived it as a means to control migration, rather than a constructive response to the health crisis.⁴⁴

According to interviews and literature review findings, health care to migrants throughout the pandemic was provided primarily by CSOs and volunteer

organizations that visited shelters, offered remote consultations, or maintained community clinics. These organizations successfully implemented measures to prevent transmission in residence spaces, improved access to hygiene products, provided masks and sanitation products, and shared trustworthy education about COVID-19, as well as creating their own quarantine spaces.^{23,41,44}

Although the reviewed public policy documents do not discuss international agencies as key players involved in pandemic response, the interviews and the literature suggested that the presence of international agencies and organizations increased at the start of the pandemic, including groups such as IOM, UNHCR, Doctors of the World, Hebrew Immigrant Aid Society (HIAS), Doctors without Borders (MSF), and the International Committee of the Red Cross (ICRC). These groups provided essential resources, such as hygiene supplies, PPE, and COVID-19 educational materials. The IOM also donated tents for quarantine and isolation, and, in some cities, it

contracted with hotels for quarantine and isolation (the 'filter hotels'). Additionally, these organizations offered face-to-face and remote medical and psychological consultations for migrant populations.^{23,41,44,45} These efforts occurred independent of those executed by the Secretary of Health, with international organizations operating in direct coordination with the CSOs.

Thus, the primary stakeholders involved in providing health services to migrant populations throughout the pandemic have primarily consisted of international and national CSOs, international organizations, and the MOH. The interviews and the literature acknowledge that the local Ministries of Health responded sufficiently to address needs related directly to the COVID-19 pandemic. However, both sources acknowledge that the government agencies in Mexico failed to consider other general healthcare needs of migrant populations throughout the pandemic, and non-governmental agencies attempted to fill this gap.

CHAPTER 2

THE CASE OF COLOMBIA

SUMMARY

Migratory flows in Colombia have undergone a transition in recent decades, with Colombia shifting from primarily being a ‘sender country’ to receiving an increasing number of migrants emigrating from Venezuela and the return of Colombians residing in other nations. This research evaluates the response of the Colombian health system to the COVID-19 pandemic and its impact on migrant populations and provides suggestions for further improvements.

This research indicates that the barriers to access of care for migrant populations in Colombia during the pandemic include regulatory barriers barring

participation in the health system and high costs that could affect the access of migrant populations to health services. Colombia’s national pandemic response focused on gathering together epidemiological and sociodemographic information to ensure representation of migrant populations and ensuring access to health care for migrant populations through linking the health system to the migrant population; a coordinated response to guarantee access to social services and facilitate the settlement and integration of the migrant population; policy guidelines focused on health care and the regularization and formalization of this population in the Colombian context; and training in cultural sensitivity by health personnel. The country has



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TIMEFRAME	MIGRATION CONTEXT
1960s	The end of the ‘period of violence’ (<i>época de La Violencia</i>) generated high flows of emigration, primarily to the United States and Spain
1980s–mid-1990s	Another key migratory flow developed, which involved high rates of migration from Colombia to Venezuela
1995–2005	The exodus continued and Colombian populations emigrated to Venezuela, the United States, Spain, and Ecuador; these four countries hosted 77.3% of the migrant Colombian population abroad
2010	Populations begin to migrate to Colombia; these groups primarily consist of Colombians returning to their home country due to the economic crisis in Europe, the United States, and Venezuela
2015	<p>Migration remained stable until 2015 until the rate of migration from Venezuela to Colombia rapidly increased due to an order resulting in the expulsion of Colombians by the government of Nicolás Maduro</p> <p>The migrant populations entering Colombia consisted of returned Colombians, regular migrants, irregular migrants, transnational indigenous populations, binational families, and commuting populations⁴⁶</p> <p>The migration of Venezuelans to Colombia was on the rise as well</p>
2018	The highest peak of Venezuelans entering Colombia occurred in 2018, with a total of 1,174,743 migrants within the country
2020–2021	<p>As of October 2021, there were approximately 1,842,390 Venezuelans in Colombia</p> <p>Primary destinations include Bogota, Medellin, and San Jose de Cucuta; all three destinations account for 45% of the total Venezuelan population within the country</p> <p>Most of the Venezuelans located in the national territory are irregular migrants (56%); however, with the implementation of the Temporary Protection Statute, approximately 1,182,059 Venezuelans are in the process of obtaining permanent status</p> <p>Approximately 4 million migrants wait with uncertainty at the border between Colombia and Venezuela (2,219 km)</p> <p>Demographics: 51% men, 49% women, and approximately 1,006,349 migrants are between 18 and 39 years old</p> <p>The main reasons for migration from Venezuela to Colombia include access to health services, nutrition, quality of life, and the deterioration of social and economic conditions in Venezuela^{47,48}</p>

Table 5—Timeline of main Colombian migration situations.

strengthened the collection of information of migrant populations, which is a very important aspect in order to establish health care strategies for these populations.

For this reason, it is extremely important to have traceability of the information, which allows knowing the procedures carried out in the migratory transfer, in order to maintain a robust information record that

allows understanding the procedures carried out on these populations on the migratory routes.

HEALTH AND MIGRATION IN COLOMBIA

Colombia has been characterized primarily as a ‘sender country’ and the flows of entry and exit have presented themselves in a series of migratory waves through different periods of its history (Table 5).

However, according to the studies analyzed, it is evident that the pandemic exacerbated pre-existing vulnerable conditions in migrant populations, due to the lack of access to health services and other social services, aspects that were subject to the conditions of the regularity of this population.⁴⁹

During the COVID-19 pandemic, although there were attempts to return Venezuelans to their country, ranging from 1,809,872 in March 2020 to 1,715,831 in September 2020, which showed for the first time a decrease in the number of Venezuelan migrants in Colombia. This return was not significant after the pandemic, these migratory flows continue to be directed towards Colombia and this figure continues to increase. This shows that the pandemic did not have a significant effect on the entry movements of Venezuelan populations towards Colombia.

“As a border region we had several aspects that changed for us when the largest cities in the country (with the permission of Migration Colombia and others) put migrants on buses to come to the border...[where they came from]...more than 130,000 migrants, [which generated]...the migratory bottleneck at the stop because Venezuela did not allow daily entry, but only a very small number. We had 1,200 people living on the streets, in the midst of a pandemic...”

— Multilateral Organization Official, September 2021

Regarding the border, and specifically the decision to close it, the analysis carried out by Fernández-Niño et al (2020)³⁶ points out that this strategy has

been counter-productive in containing the spread of COVID-19 in migrant populations and those receiving them at border points. The establishment of specific entry and exit points at formally established and recognized border crossings where the passage and tracking of migrants could be recorded, would have been preferable. This would have avoided the further spread of the virus through unregulated access.

The NGO, MSF, pointed out that:

“We are also seeing an increase in xenophobia and discrimination against this population, which is falsely accused of the spread of COVID-19 in border areas.”

— Rymshaw E, cited by Daniels JP, 2020: 1

The increased xenophobia towards the Venezuelan community further hampered access to essential medical services, affecting public health indicators in the context of the pandemic. Although this study focuses on the political response to providing health care for the Venezuelan migrant population, other migrant populations also entered Colombia, mainly from Africa, the Caribbean, Oceania, and Asia; their reason for entry was to continue their migratory routes to the north of the continent, with Colombia being a strategic corridor to enter the Americas.² This factor undoubtedly exacerbated the capacity of the health system to respond to the migrant populations.

MIGRATION POLICY AND HEALTH SERVICE PROVISION ANALYSIS

A study by Murillo-Pedrozo et al found that the main barrier to access to health services by the migrant population was due to their lack of legal status in the host country and their poverty which limited their ability to pay for health services.⁵¹ Although in Colombia access to the system is given in many cases as a priority via emergency services, as a gateway, the continuity of treatments is limited

due to reasons associated with affiliation and direct health care costs, as well as additional out-of-pocket expenses related to seeking care.⁵²

In Colombia, the Social Security System in Health (Sistema de Seguridad Social en Salud, also known as SGSSS) is divided into public and private care so that workers with the ability to pay do so and the vulnerable and those in a condition of poverty are subsidized; this also applies to the migrant population. Healthcare from the SGSSS has been fragmented, resulting in health system overload and producing inequities both at territorial and population levels, thus adding to problems related to the centralization of politics and decision-making (Law 2136 of 2021). In this regard, the challenges related to financial sustainability, the generation of trust and the promotion of transparency among the agents involved. In the framework of care for migrant populations, the challenge is to achieve an improved provision of service based on the supply capacities of the Instituciones Prestadoras de Servicios de Salud (IPS), avoiding more significant access barriers in the face of the broad demand for health care.

According to the report given by Circular 029, in the period from March 2017 to January 2021 there was an increase in health care provision for the migrant population. In 2019 and 2020, the approximate number of services provided was 3,900,000, aimed at more than 500 thousand migrants. In the reporting period (2017 to 2021), a total of 10,125,863 instances of health care assistance were carried out, of which 78% related to people not affiliated with the SGSSS, 8.1% of the population served in this period were affiliated to the subsidized regime while only 7.8% were affiliated to the contributory regime; 6% of the payments were covered by the migrant population.⁵³ Regarding the distribution by type of consultation and hospitalization (emergency room-outpatient consultation-emergency consultation and hospitalization) of the total number of visits (2,945,242), 52% were provided through external consultation, followed by 32% in emergency consultation. 20% of the care was given in Bogota followed by Antioquia (15%) and Norte de Santander 11%.⁵³

With respect to access barriers it is primarily immigration status that affects accessibility and continuity of care in health services. According to Profamilia (2020), there are administrative barriers to address health needs of migrant populations that are still present, this is why it is important to think about care strategies in the health system for migrant populations that overcome these barriers. There is a perception of economic barriers to payment by migrants for emergency services.⁵⁴ It is necessary to strengthen primary health care strategies, to generate better results in the promotion of care in the framework of COVID-19 and in a post-pandemic scenario.

FINDINGS FROM POLICY ANALYSIS, LITERATURE REVIEWS AND STAKEHOLDER INTERVIEWS

Political response of health care to migrant populations

Health care policies for migrant populations in Colombia were divided into two moments. At first (in 2015) they were aimed at the massive expulsion of Colombian populations by the Venezuelan government. Therefore, many of the attention policies were oriented to the attention of the returnees. Subsequently, Colombia began a process of formulating and executing health policies aimed at migrant populations, for which the country has worked constantly and arduously during this response period.

Population inclusion and access to health-care during the pandemic

The response of the health sector was based on the following: health care for the migrant and returned population to Colombia; the affiliation to the health system of the migrant population; the coordinated response to guarantee access to social services to facilitate the settlement and integration of the migrant population; policy guidelines oriented towards health care; the regularization and formalization of the residence of this population in the Colombian context; improved access to health care; health care strategies with a differential approach;

raising awareness and capacity building strategies; responses to mental health needs; the prevention of discrimination and xenophobia; the establishment of shelters and passage houses; intersectoral coordination; actions to promote the empowerment of migrant women and girls; and assistance strategies for the migrant population with binational support.

Concerning the health response towards the migrant population in the context of the pandemic, international organizations provided support to States to adapt containment measures, establish channels of cooperation and coordination between countries of origin, transit, and destination of migrant populations, to protect the rights of all people in situations of human mobility in the face of the pandemic. The Inter-American Commission on Human Rights (IACHR) called for implementing the strategies suggested in Resolution N° 1/2020 Pandemic and Human Rights in the Americas (Adopted by the IACHR on April 10, 2020). This document provides specific guidelines to strengthen care for these populations in the region, establishing strategies for the protection of economic, social, cultural, and environmental rights (DESCA).

Of the documents issued by the health authorities that indicate actions aimed at the migrant populations, a health emergency framework emerges, where the Government has decreed regulations in different areas to face the health, economic and social crisis caused by the COVID-19 pandemic. Although the services contemplated in the Colombian health system are indicated, the mechanisms for the migrant population to effectively access the services need to be strengthened. It is, therefore, important to achieve coordination at the different levels of government, both at the national and territorial levels. At present, population strategies to mitigate and prevent the spread of the disease are divided into the following groupings:

- Prevention, detection, and risk mitigation in suspected or confirmed cases.
- Management, treatment, and follow-up of cases.

The support of international cooperation has been fundamental to implement the strategies and provide continuity outside the institutional scope within the framework of the health system.

As part of the Colombian Government's response strategy, guidelines for the prevention, detection and management of COVID-19 cases in the migrant population were designed to "guide territorial entities and institutions that support prevention, detection and management of suspected cases and infection caused by the coronavirus in migrant population".

The Colombian Government has made different contributions towards a comprehensive response to the migrant population, for which six key strategies were established within the framework of this response:

1. Responsible and humanitarian political management of the border.
2. Guarantee of access to health services according to immigration status.
3. Strengthening and reorientation of actions carried out by international cooperation to respond to the pandemic in migrant populations.
4. Strengthening of strategies aimed at mental health care for migrants in vulnerable conditions.
5. A focus on the resources for the response in high-impact municipalities, mainly in border areas.
6. Strengthening of information management by the MOH.

In addition to the above, the implementation of Decree 1109 of 2020 is highlighted, through which the Program of Tests, Tracking and Sustainable Selective Isolation (PRASS) was established "to slow down the contagion of COVID-19 and interrupt the transmission chains".

The national Government of Colombia has included response strategies that have been implemented at the national and local levels to improve the health outcomes among migrant populations and to mitigate the pandemic.

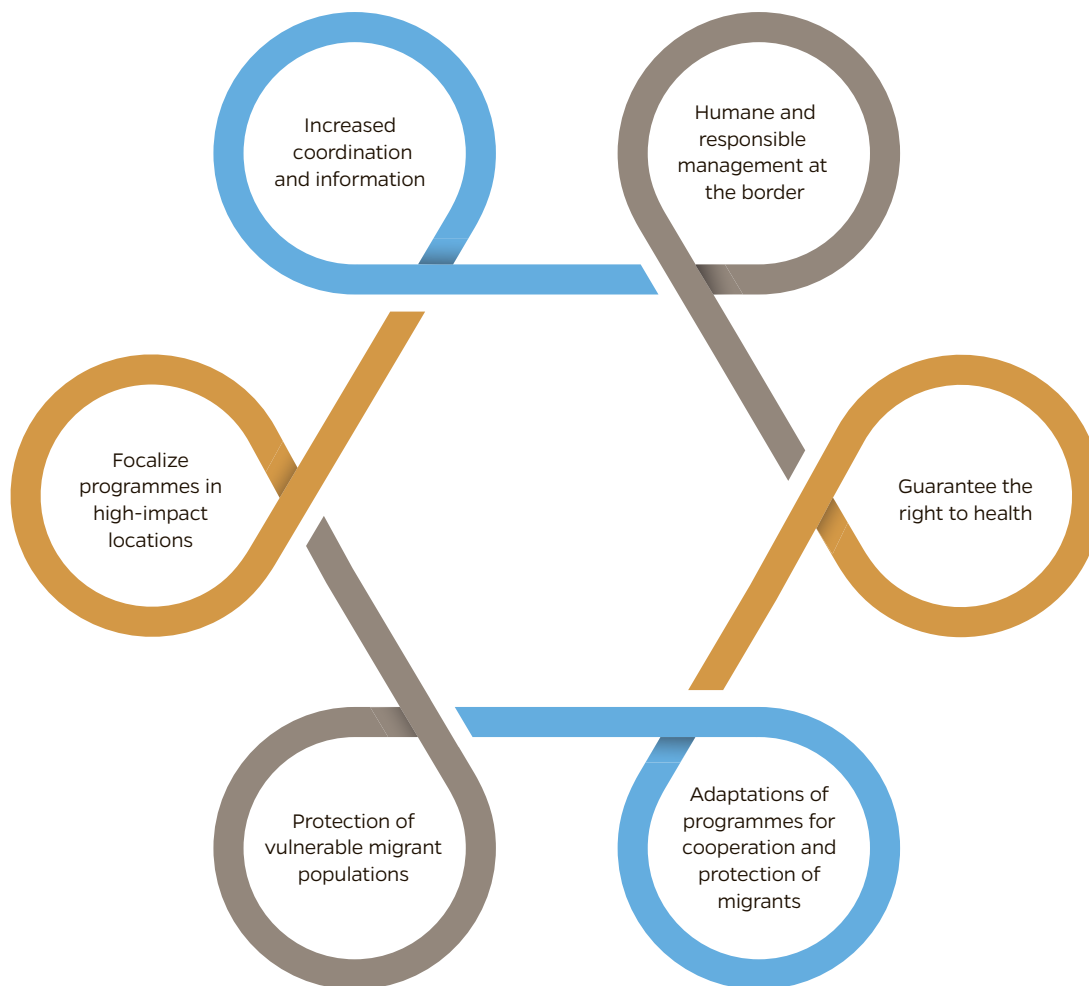


Fig 5— Actions implemented on behalf of the Colombian government in response to the pandemic in migrant populations.
Author elaboration based on Colombian Coronavirus Response.

Fig 5 and **Table 6** summarize the strategies implemented within Colombia.

PUBLIC POLICY RESPONSE TO HEALTH NEEDS OF MIGRANTS DURING THE PANDEMIC

The Colombian government formulated the Temporary Statute of Protection for Venezuelan Migrants that was implemented in May 2021. It is a “complementary mechanism to the international refugee protection system, which allows filling the existing gaps within this program, based on the

migratory reality and the response capacity that the country has in institutional, social and economic matters.”⁵⁵ In addition to the above, migrants are included within the National Vaccination Plan under the same conditions as the national population, by the priorities established therein; however, given the vaccination coverage rates in the national territory, the MOH decided to expand access to vaccination for migrants in irregular migratory status.⁵⁷ To the extent that the coverage of the Colombian population with at least one dose of the vaccine has gradually increased, the availability of biologics can be applied across the national territory, as indicated by one of the interviewees.

BACKGROUND	2015	2016	2017	2018	2019	2020	2021	LAW
Decree 1239/2003	Decree 1075	Decree 1495	Decree 228	Health sector response plan to migration phenomenon	Resolutions	Decree 064	National Vaccination Plan against COVID-19	Law 2136/2021: Política Integral Migratoria
CONPES 3603/2009	Resolution 714	Decree 780	Resolution 3015	CONPES 3950	1465	Resolutions 385		
Law 1465/2011	Decree 1768	Law 1815	Decree 866		2540	Resolutions 380		
Decree 4062/2011	Decree 1770		Memo 012		2634	Guidelines for case detection and management		
Law 1565/2012	Decree 1772		Memo 029		1567	Guidelines for the prevention, detection, and management of COVID cases for the migrant population in Colombia		
2018	Decree 1814				3548	Guidance for screening travelers from areas with COVID circulation		
2020–2021	Decree 18978				2278	Management protocol for the arrival of passenger ships of international maritime and river traffic		
					3877	Guide for the repatriation of nationals; Decree 402; Decree 412; Decree 1109 (PRASS)		

Table 6— Normative timeline of healthcare in migrant populations.

Source: This table was created based on the regulations implemented for the health care of the migrant population from 2003 to 2021.

“The technical standard is in place, the arrival of biologics is here, which little by little...has been solved, as [the] availability of biologics [improves] and the majority of Colombians are vaccinated... It can make...irregular [migrant population] gain access to COVID-19 vaccination.”

— Official Multilateral Organization, September 2021

Although there has been access for the migrant population to the vaccination coverage plans offered by the Colombian State, given the scarcity of vaccines in the country, migrant populations compete against unequal access to the vaccines available within border areas, as pointed out by one of the interviewees:

“Now with the issue of vaccination...[migrant populations], have also remained in the queue... [well] after...[having launched]...the National Vaccination Plan...the migrant population was not included and only until very few months have been included...again the bottleneck is in the capacity of the territories to be able to provide these services, then, in the territories, the Colombian population continues to be prioritized over the migrant population, because resources are not enough, nor the capabilities.”

— Official, Multilateral Organization, September 2021

The barriers to the implementation of the PRASS, as stated in the report by the Directorate of Epidemiology and Demography of the Ministry of Health and Social Protection, indicate that there have been difficulties in coordinating with Venezuela concerning the binational regularization of migratory flows. This has made it difficult to identify COVID-19 cases. In addition, the same report highlights other barriers to accessing health services by the migrant population, which can make treatment and continuity of care challenging, even in already confirmed COVID-19 cases.

The PRASS strategy was designed for citizens and non-citizens alike within Colombia, which included

individuals residing within their territory. The latter has made it even more challenging to access services for non-regularized individuals, despite this having changed over time as pointed out by one of the individuals interviewed:

“The Sustainable Selective Testing, Tracking and Isolation strategy has gradually included migrants, which allows early detection, and if the person becomes complicated, they go to a hospital and... they activate the route [of care for COVID-19]... For example, Pamplona, which also has a transit city...has applied 5,690 antigen tests with emphasis on the migrant population and that has allowed them...sometimes to stand out.”

— Multilateral Organization Official, September 2021

The health care policies designed for migrant populations within Colombia include multilateral coordinated responses which require implementation at a national level with the support of different government bodies and local levels that strengthen each of the formulated strategies. Such policies are not focused exclusively on migrant populations. Rather, they have been included within the public health response aimed at the general population.

ADEQUACY OF HEALTH SERVICES

The documents analyzed in this report fail to explicitly describe the process for capacity-building in response to the adaptation of sociocultural needs of migrant populations within Colombia. Furthermore, the realities that the country experienced reflect important migration flows. This analysis shows the importance of proposing policies that consider the emerging needs within moving populations, even within the Colombian territory (including transit, circular, temporary and permanent stay).

According to the Inter-American Development Bank, migrant populations in countries within their jurisdiction — Colombia, Costa Rica, Panama, Ecuador, and Perú — experience increased vulnerabilities that

may constitute a challenge to improve the social determinants of health which influence positive life and health outcomes for migrant populations.

It is essential to develop and focus on coordinated strategies that integrate migrant individuals within the receiving societies, thus seeking to mitigate the impact of the pandemic on the population, which in return will reduce the present gaps and therefore decrease vulnerabilities to ill health and well-being. To this end, the Inter-American Development Bank suggests carrying out permanent data monitoring strategies as well as to identify factors that may increase their risk (eg, xenophobia). In addition, they suggest implementing strategies which focus on translational policy to be carried out by governments based on evidence-informed research designed to highlight lessons learned from existing strategies.

Moreover, according to interview findings, there is still a need for migrant-sensitive capacity-building aimed towards health professionals to respond to the health needs of migrant populations in a culturally and informed manner. In addition to the strengthening of human resource capacity with cultural aspects, as well as to raise awareness of the vulnerabilities faced by migrants, it is necessary to increase the human resources availability to provide a timely response to the health conditions that have been exacerbated by the pandemic. Some areas of opportunity reflect mental health services, as well as measures to prevent GVB, xenophobia and discrimination.^{58,59}

Despite no information indicating the adequacy of health services for migrant populations within the study's review, there was data within the grey literature and interviews with study participants related to the contribution of individuals working within government institutions, multilateral organizations, as well as health service providers. An important aspect of service adaptation was aimed at strengthening the healthcare network, including the expansion of services offered before and after the pandemic:

“We focus on working on institutional strengthening issues...we support hospitals so that services will be expanded...[including]...the Intensive Care Unit part...complementary to the national purchase of respirators and we seek...donate...beds, monitors, infusion pumps, which are other medical equipment necessary for the expansion of the ICU offer in various territories, especially those that are recipients of [migrant population].”

— Official, Multilateral Organization, September 2021

The Health Sector Situation Report (October to December 2020) carried out by the Interagency Group of Mixed Migratory Flows (GIFMM) and R4V (Response for Venezuelans, 2020), mentions activities carried out by international cooperation as well as evaluates the adequacy of services in response to the needs of migrant. The report highlights the following actions carried out by the State, which have been mainly focused on three aspects of care:

1. Maternal, perinatal health and sexual and reproductive health.
2. Care for people with communicable and non-communicable diseases and mental health.
3. Health information, education, and communication. These actions are expected to improve health care for the migrant and refugee population within the framework of the 2020 Migrant and Refugee Response Plan (RMRP).

In response to the adequacy of services, authors Fernández-Niño et al⁴⁸ propose four recommendations to respond to the needs of Venezuelan migrants in Colombia in line with WHO's guidelines:

1. Reduce person-to-person transmission by swift identification and isolation of confirmed cases.
2. Carry out detection and control strategies in the border area.
3. Within border areas, guarantee isolation and the necessary quarantine measures, as well as provide personal protection equipment for migrants, the general population, and personnel.

4. Avoid border closures as the primary measure for control of the pandemic; borders must remain open while also guaranteeing safe border crossing for migrant populations.

The adaptation of health services must always be accompanied by intercultural training strategies, to develop broad approaches to provide comprehensive, intergenerational, timely and collaborative, inter-departmental responses towards health and migration.

AVAILABILITY OF INFORMATION ON MIGRANTS

Within the public health analysis, there was no explicit information regarding information availability for migrant populations. Nevertheless, several key informants mentioned several strategies that included sociodemographic information of migrant populations within their decision making and deployment of activities at a national, regional, and local level. The intention was to monitor the COVID-19 situation within the migrant population and to achieve their inclusion as part of the National response strategy.

The following interventions were carried out: a control panel to monitor the availability of intensive care, availability of beds, and level of contagion; and collection of a census within territories, including information related to family groups. Based on this information, decisions were made to reopen economic sectors, which will gradually support economic reactivation.

“When the pandemic arrived, migrants were the final factor that was considered. With the United Nations High Commissioner for Refugees we did advocacy to calculate what was the estimated migrant population that needed vaccination; for example, we did present some very judicious estimation exercises to the Ministry of Health.”

— Multilateral Organization Official, September 2021

Although there was support for collecting information on the migrant population, there were also administrative and financial barriers to gathering information needed for decision-making, especially at a local level:

“It should be understood that in Norte de Santander everything is categories, those poor municipalities do not have money to pay the Personería Secretariat, and much less are they going to have money to get 30 nursing assistants, go to make census lists, because they always resort to the Interagency Group on Mixed Migratory Flow.”

— Multilateral Organization Official, September 2021

With regard to the Colombian Government, sensitive information such as – number of COVID-19 cases, individuals recovered, and COVID-19 related deaths were centralized. The data collected was differentiated by sex, age, territorial distribution, and nationality. Venezuelan migrants were included within the information presented for foreign populations. The registry is managed and reported by the National Institute of Health, through the National Health Observatory, giving free access to this information for decision-making at all levels of Government. The information is updated weekly and is available at <https://www.ins.gov.co/Noticias/Paginas/coronavirus-extranjeras.aspx>.

The database from which this information is used includes a mandatory identification form — which is filled out following a confirmed COVID-19 case within the Country in the national territory — in accordance with the provisions of the strategy for the implementation of guidelines for detection and case management by health service providers in the face of the introduction of Coronavirus issued by the MOH on March 19, 2020.

An essential aspect for data monitoring and tracing of migrant populations has to do with the mobility patterns and migratory flows of both individuals under a regular and irregular status — including returnees, pendulum migration and binational

populations. All information is concentrated within the context of mixed migratory flows, as is the case of migration from Venezuela. The latter poses several challenges to data collection and contact-tracing, an important PRASS strategy as indicated within the progress reports issued by the Department of Epidemiology within the MOH and Social Protection.

According to the report of Social Policies in Response to the Coronavirus carried out by the Inter-American Development Bank (2020), a condition that substantially affects migrant population's access to health services and, in turn, the possibility of receiving benefits from social programs, affects an individuals' legal status. These challenges exacerbate the vulnerable conditions already present within this population, increasing dire external factors, which in the context of the pandemic could generate worse health outcomes for citizens and non-citizens alike.

In the context of care for the population within border areas, it is necessary to have information on migrant populations and international travelers, which will facilitate response actions towards vulnerable groups. In this regard, difficulties have also been identified within the analysis which directly affected the monitoring and tracking pillars within the PRASS strategy.⁶⁰

FINDINGS FROM KEY STAKEHOLDERS INVOLVED IN THE RESPONSE

Between the period of March 1, 2020 — the date on which the health emergency was declared throughout the national territory—to May 31, 2021, a total of 385 policy documents were issued (decrees, resolutions, circulars, among others) formulated by 39 government institutions responsible for the response at a federal level, so that both public and private sector organizations and entities applied political decisions in response to the pandemic. Of these, 16 documents were selected as they had actions relevant towards migrants — including

individuals with irregular and regular status, travelers, foreign visitors — from areas with circulation of COVID-19 at the beginning of the pandemic. Within those documents, only eight were issued by the MOH, five were issued by the Ministry of Foreign Affairs and the Government of Colombia, and three were issued by the Ministry of Interior. Although these documents were not specifically directed towards the migrant population, they refer to sanitary measures to manage the entry, transit and stay of this population in the context of the pandemic.

Within the implemented measures, one of the actions that generated the greatest impact on the migrant population was the closure of borders that affected both the circular migration of the population in the border area, as well as the return of the Venezuelan population who expected to return home, when the health response measures aimed at controlling and mitigating COVID-19 began in the national territory. In Colombia, political negotiations were established with Venezuela and international organizations to facilitate the return of Venezuelans through humanitarian corridors, thus seeking to prevent further spread of the virus in the face of the precarious conditions of vulnerability that many migrants were suffering.

Part of the implementation and start-up of the strategies and interventions carried out by the Colombian government and aimed at the migrant population has been possible thanks to the support of international cooperation and civil society organizations, who have become key actors in this response. Some of the interviews carried out show this relationship.

International cooperation has supported this strategy by setting up dialogue, on issues of insurance, affiliation, mental health, nutrition, access to health services and care for mothers, among others, to articulate the response between the national, departmental, and local governments to the challenges both in the framework of mixed migratory flows and those caused by the COVID-19 pandemic.

“The issue of the situational room for us is super important to follow-up, that it be done...with the migrant population...who do not have access to the health system [it belongs to]...our interest too, and how is this done? then, through routes, strengthen inter-institutional agreements with cooperation partners, with the same institutional framework...[because] we consider [that it is] a space for articulation and coordination... [through]...the Sectorial Board of Health and that is space...absolutely everything that is going to be carried out in the territory is agreed...always seeking the benefit of the population that does not have the possibilities of direct access to the health system.”

— Multilateral Organization Official, September 2021

In addition, it was necessary to strengthen government interaction with international organizations, civil society and academia as indicated in one of the interviews:

“At the national level, we are already talking about public migration policy, but in local contexts such as the department of Norte de Santander, we have tried to leverage some intersectoral tables for integration from civil society, academia and the media, others more community-based...but even so, working on these issues every day, we do not have...the representativeness or the impact that we should have, because still, let’s say, the role of civil society is stigmatized a bit.”

— Representative, Multilateral Organizations,
October 2021

Although the Federal government formulated health care policies that included various sectors, emphasizing intersectoral strategies, it was also necessary to consider decentralization strategies that gave autonomy to the regions, where international cooperation and civil society organizations could be an important support, both in the implementation and in the oversight and control of the resources.

CHAPTER 3

THE CASE OF PERU

SUMMARY

Perú has experienced dramatic shifts in national migration trends. Previously a nation of emigration, Perú has recently become home to an increasing number of migrant populations due to the Venezuelan crisis. However, this growing migrant population has placed strain on the nation's already fragile health system, which has been unprepared to support these vulnerable groups in the context of the COVID-19 pandemic. This research evaluates the Peruvian health system response to the needs of migrants in the COVID-19 pandemic and provides recommendations for key stakeholders and decision-makers moving forward.

The findings of this research suggest primary barriers to accessing health care for migrant populations throughout the pandemic include economic barriers, access to information, language, discrimination, and specific requirements around legal documents for identification. Furthermore, the border closures resulted in increased irregular routes of immigration and exacerbated the many health needs of migrant populations. The research demonstrates that Peruvian policy efforts to improve conditions focused too heavily on short term solutions and lacked a long-term vision to address the needs of migrant populations, resulting in unsustainable programs and policies. Recommendations to improve the health system response to migrant needs in the context of the pandemic include addressing barriers to health system services to advance health system equity—particularly as it pertains to eliminating discrimination against migrant populations and expanding health insurance coverage for migrant populations—and enhancing coordination of key stakeholders between local, regional, national, and

international levels to improve the availability and quality of care.

HEALTH AND MIGRATION CONTEXT IN PERU

Perú has been one of the countries receiving the greatest number of Venezuelan's leaving due to the economic crisis. As of June 2021, the Superintendencia Nacional de Migraciones reported that 1,200,000 Venezuelans were residing in Perú.⁶¹ Perú has historically been a country of emigrants rather than immigrants and this has resulted in a more diverse Peruvian society. It is now also a country experiencing a transition towards being a country of transit and destination for migrants.⁶²

THE PERUVIAN STATE'S RESPONSE AND ACCESS TO HEALTH SERVICES TO MIGRANTS

From 2017–2018, Perú's migration policy allowed rapid documentation of migrants entering Perú and created conditions that attracted a greater quantity of Venezuelan migrants. In mid-2018, there was a change in attitude of the population towards migrants, and measures were implemented that tended towards blaming Venezuelans for citizens' insecurity, which coincided with the declaration of a State of Emergency on the northern border of Perú. Perú's response to Venezuelan migration could be described as territorial and legal openness, without translating into access to services (ie, their admission to Peruvian territory did not translate into integration into the formal economy and public services, as discussed later in this section). This contradiction



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can be observed in the limitations in access to the health system for migrants. For example, although there has been rapid legal documentation of migrants through the temporary residency permit (PTP) the reality in practice is difficulties in accessing the health system, particularly via public health insurance (SIS). While the law of Migration Policy of 2017–2025 (DS 15-2017-RE) proposed in principle a lack of criminalization and discrimination of migrants, it concurrently established administrative sanctions (such as fines, voluntary departure, and expulsion) for irregular entry to the territory or overstaying a residency permit. Furthermore, it granted the National Police of Perú the right to detain offenders to determine their migration status, creating a potential space for abuse. This punitive approach intensified in 2019 with the Secure Migration Plan, which was never recorded in an official document and was only made known through dissemination in the media outlets. The Equilibrium CenDE (2021) study detected

that migrant expulsion in 2018 reached a total of 1,266 Venezuelans,¹⁸ and the state propaganda justified this by claiming that migrants have criminal histories and are sources of disorder.’

THE HEALTH SYSTEM IN PERU: FRAGMENTED AND BASED HEAVILY ON OUT-OF-POCKET SPENDING

The Peruvian health system is fragmented, in that different providers target different populations, but without coordination between them. For example, the Ministry of Health (MINSA) covers economically vulnerable populations, ESSALUD for those with formal jobs, and private clinics and insurance plans for higher socio-economic status. ESSALUD offers more complex services, but MINSA has the most important network of health centers and outposts in remote regions. The health system

financing is divided into two categories: contributory (ESSALUD and the private sector) and subsidized (Comprehensive Health Insurance of MINSA, SIS). Inaugurated in 2002, the SIS initially aimed to finance a basic plan but gradually has expanded its coverage to be fully comprehensive (current PEAS), but without the necessary budget. In November 2019, President Vizcarra announced that from now on, there would be a SIS 'Para Todos'/'For everyone' at no cost, for any citizen who is regularized and does not have other health insurance. On the other hand, ESSALUD operates through payroll discounts, using funds from employers and employees, which amounts to a 9% of payroll deduction. Perú's public spending on health is 3.2% of the GDP; in 2017, this was below the average public spending on health in the region, which was 6%. There have been major shortcomings in terms of achieving universal health coverage, including in the areas of human resources and infrastructure. The Peruvian health system has long been characterized by a significant gap between the met and the unmet needs. In summary, it was not a strong health system that received the migrants, but one already facing challenges to meet the health needs of its national population.

FINDINGS FROM POLICY ANALYSIS, LITERATURE REVIEWS AND STAKEHOLDER INTERVIEWS

The Peruvian state commits to guarantee and protect health and access to services without distinctions, including nationality or national origin, in Articles 7 and 11 of the Peruvian Constitution. Furthermore, with Perú's transition from a country with a profile of emigrants to one also of immigrants, it issued specific regulations to adjust to this new reality. In January 2017, the 'Migrations Law' was published, which specifies that the Peruvian state recognizes the right to health for people of foreign origin, among other fundamental rights. In March of the same year, a regulation of this law was issued, which assigned the Minister of Health the responsibility to generate standards to guarantee that migration status was not an obstacle in guaranteeing equal health access for

all. In summary, the Peruvian regulations express a principled universalist point of view, even if this is not guaranteed in practice.

One of the most relevant rules regarding migrant health was the Legislative Decree N° 1466, issued in April 2020, which expanded the SIS coverage to temporarily include those foreigners suspected of having COVID-19, regardless of their migration status. This extended their right to health but was restricted only to COVID-19 cases and no other medical needs. As of December 2020, 2,643 Venezuelan migrants with suspected COVID-19 cases were admitted [to SIS] due to the implementation of this law. In addition, from March to December 2020, the total number of insured Venezuelans increased from 46,638 to 66,159. Castro has highlighted this measure and its practical implementation, which was enacted through informal channels such as WhatsApp.⁶³ Despite the increase in insured Venezuelans, the vast majority were still not integrated into the SIS (public insurance) nor into ESSALUD (employer-based insurance), highlighting further barriers to coverage (Fig 6). The insured included 66,152 migrants, representing just 5.5% of all migrants. One of the barriers identified, was that while the policy of registering migrants with suspected COVID for SIS was broad, the request for an identification document to qualify for this insurance limited migrants achieving their right to access healthcare, as established by the legislative decree N° 1466-2020.

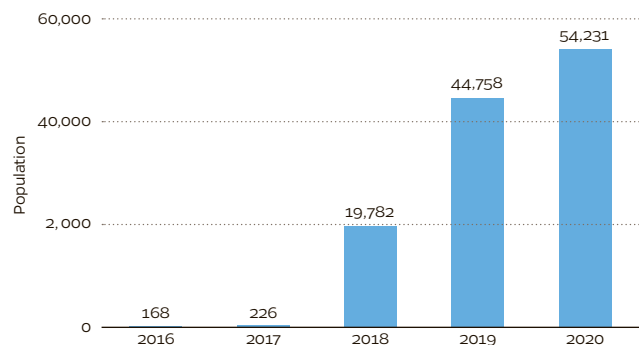


Fig 6 — Venezuelan population insured with SIS, February 2020.

Source: SIS database, October 14, 2020.

Similarly, two health measures generated further barriers for migrants. One was the policy that sought to regulate the management of cadavers with COVID-19 (RM N° 189-2020-MINSA), which established that to exhume or cremate a body, it was necessary to present a national identification document or a foreigner identification card. The problem with this requirement was that it excluded migrants of any other migration status, including those without permanent residency.

PUBLIC POLICY RESPONSE TO HEALTH NEEDS OF MIGRANTS DURING THE PANDEMIC

In September 2020, Ministerial Resolution N° 928-2020-MINSA was issued, which approved the Preparedness and Response Plan for a Possible Second Pandemic Wave of COVID-19 in Perú. It aimed to prepare the Peruvian State for a possible second wave of COVID-19 infections. In this resolution, “Venezuelan migrants” were explicitly mentioned as part of the target population (making a distinction from Peruvian nationals), making explicit for the first-time migrants’ inclusion in a general intervention plan in Perú.

There have been various measures of inclusion of migrants within social support during the pandemic, with one example being the distribution of necessities to vulnerable families, among which were included families experiencing poverty (Emergency Decree N° 033-2020). Although no explicit reference to migrants was made, they can be considered part of this population considering that the vast majority work informally. However, at the time of publication of the *Guide for the Effective Delivery of Family Basket* in May 2020, a requirement was then introduced that recipients of the basket should present formal identity document, effectively excluding migrants subsequently.

Another group of policy measures was aimed at creating working groups that would produce reports and recommendations regarding the migrant

population in Perú, so that evidence-based decisions could be made. Thus, an Advisory Working Group on Socio-Cultural Matters of the Impact of COVID-19 (RM 213-2020-MINSA) was formed, with experts who could provide adequate information to the MOH about the impact that the pandemic would have on Peruvian society. This Working Group, consisting of 15 social scientists, which prepared eight reports, one of which was focused on the situation of Venezuelan migrants and the barriers faced in the context of the pandemic, among which were the general conditions around access to health and medical care for Venezuelan migrants during the pandemic. Later in October 2020, a body within the MOH was created to focus on health policies specific to the migrant population. This ministerial team, titled the Functional Health Unit for Migrant and Border Populations, has as its primary goal the development and supervision of policies, plans, projects, and regulations aimed at promoting the health and human development of migrants in Perú (RS N° 266-2020-MINSA). Although at first the State’s attempts to keep itself informed about migrants had a more narrow and temporary scope, the creation of the Functional Unit demonstrated more thorough considerations with a long-term vision, and the possibility of a longer-term sustainable focus on migration health policies.

It is important to mention the impact that Perú’s State of Emergency had on migrants and border management during the pandemic. The objective of national policies aimed at preventing the transmission of COVID-19, was reflected in the recurrent imposition of the State of Emergency, a situation in which the country remained throughout the study period. At first, in March 2020, the country closed all its borders, preventing the entry of passengers by land, river, and air. Although the borders opened in October 2020, greater control was exerted over the northern border in December of the same year. In 2021, this trend was accompanied by the militarization of said border to curb the growth of illegal immigration.

As an agent of an international organization explained:

“Legal status is an important issue, as in recent months there has been an entry of the irregular population. Let’s remember that the borders are closed with some countries. So, there has been an issue of irregular income that does not get any attention. As a result, the irregular migrant does not like to go to the health center very much because they believe they could be captured and reported.”

The reluctance to receive new migrants reached its climax in February 2021, during presidential campaigns with xenophobic proposals and requests for an explanation from the Legislative Power to the Executive regarding its actions in the face of what some sector of the population perceived as an increase in crime by Venezuelan migrants.

POLICIES FOR THE INCLUSION OF MIGRANT HEALTH PROFESSIONALS

One of the health policies where the Peruvian State was most focused on the inclusion of migrants, in terms of several regulations, was the supply of medical personnel for the health system. Perú urgently needed health professionals to sustain adequate health service provision during the pandemic, and in April 2020, the COVID Special Service — SERVICER (Emergency Decree N° 037-2020) — was created. Through this provision, national and foreign medical personnel are hired through a special route that allows them to count that time as part of the compulsory Rural and Urban Marginal Service (SERUM). The rule that regulates the SERUM was modified, permitting medical professionals, both nationals and foreigners, to perform this service (RM N° 215-2020-MINSA). A few months later, in August 2020, another measure aimed at increasing numbers of medical personnel was published to reduce the overburden of the Peruvian health system during the high demand from the pandemic. Article 4 of Emergency Decree N° 090-2020 establishes a provisional exception for foreigners, which temporarily authorized those who graduated and licensed abroad in health sciences careers to regularize their

credentials their work in public health establishments immediately. It provides a period of up to 6 months for them to continue working following the end of the COVID-19 health emergency.

MIGRANTS’ PERCEPTION OF ACCESS TO HEALTH SERVICES

Migrant’s perception of their access to and quality of health care provides an idea of the actual implementation of the policies and norms, and how much policies are translated into practice. In the MMC survey (2021), the main barriers to accessing health services perceived by immigrants in Perú were a lack of economic resources (88%), lack of documentation (56%), and perceived discrimination (46%).⁶⁴

A portion of the migrants did not go to public services because of their perception that they were congested:

“Oh, the hospitals have collapsed...There is not even [enough] for Peruvians, much less for Venezuelans.”

— Migrant from Lima, woman
(27 years old)

Another portion of the interviewees explicitly commented on the scarce insurance and limited social support:

INTERVIEWER: “Have you received any help?”

MIGRANT: “No, they don’t help anyone here.”

— Migrant from Lima, woman
(27 years old)

Interviews with migrants revealed that those who were treated privately did not have ESSALUD insurance because they did not have a formal job.

Another reason for not using public services lies in the lack of knowledge about the health services and health system:

“Since you arrived in Perú, have you had any problem receiving health care? **ANSWER:** “No, and I also don’t know how the system would be for Venezuelans who go to a health center. No, I don’t know how, or what the protocol would be.”

— Migrant from Lima, female, 27 years old

Other reasons for not approaching the public system were mistrust and fear of catching COVID-19 in the facilities:

“[I went] an appointment, to a private consultation, because I didn’t trust the public sector; I went to a hospital and no, no...I went to see if they would assist me, if they could assist me, but I left just as I came...I wasn’t sure if I would catch something worse or if I would leave.”

— Migrant from Lima, male, 54 years old

A worrying aspect is the high perception of discrimination and xenophobia in the Peruvian health system; this highlights the imperative need for awareness among health personnel to prevent these episodes (MMC, 2021).

AREAS OF PUBLIC POLICY ANALYSIS

Documentation of policies for migrants in the pandemic: regularization and digitization

Perú was a pioneer in establishing a provisional identity document for migrants, which allowed them to enter the country and obtain employment. This was the PTP, created in January 2017. Its validity period was extended every six months until 2018 when President Vizcarra demanded a passport and humanitarian visa from migrants, which are difficult to obtain. When the pandemic arrived in March 2020, the Peruvian government established a mandatory lockdown measure, with which the National Superintendency of Migration (MIGRATIONS) was obligated to continue granting immigration documents, but under these new conditions. Due to the

mobility restrictions, it was impossible to access the MIGRATIONS offices in person.

For this reason, on March 19, 2020, the first regulation aimed at migrants and the administrative procedures to regularize their immigration status was issued. This rule rescheduled appointments, extended the validity periods of the different migratory qualities, and suspended for 45 days the sanctions imposed on those who overstayed their visa (RS N° 000104-2020-MIGRATIONS). In a measure with a similar spirit of temporary response, on May 5, 2020, the deadlines were extended in May for an additional 15 days (RS N° 000120-2020-MIGRATIONS). In addition, that same day, they began to identify alternatives to the valid documents needed to initiate procedures, given the impossibility of obtaining documentation due to the paralysis of administrative activities in the context of the social immobilization (RS N° 000121-2020-MIGRATIONS).

At the end of the same month, the first measure was taken to signal the beginning of a new stage, in which bureaucratic procedures would be digitized, demonstrating a strategy oriented to the medium and long term. Thus, the RS N° 000131-2020-MIGRATIONS announced the creation of the “Virtual Agency for MIGRATIONS”, within which the “Virtual MIGRATION Party Board” would operate. The pandemic demanded it. In October 2020, the Ministry of the Interior issued a Supreme Decree that sought to regularize migrants who were in an irregular migratory situation, either because their permit expired or because they entered the country without going through immigration control (Supreme Decree N° 010-2020-IN). It is possible to observe a change in the political tone; although it can be considered permissive in offering to admit irregular migrants, the ruling also has a punitive aspect. It lists the different sanctions that those who enroll in this process may face. Registration was open for 180 days, and virtual registration was enabled from January 2021 through April 7, 2021.

The evolution in the logic of the state’s action was first dedicated to preventing the suspension of processes

due to the mandatory lockdown, a stage with a short-term vision aligned with the uncertainty present at the pandemic's beginning. Subsequently, it opted for the digitalization route, progressively migrating to integrating legal processes to the virtual platform, demonstrating a long-term vision.

Adequacy and adaptation of health services

The data collected by the Peruvian MOH did not include nationality until the end of 2020. The Peruvian government does not use the term “migrant” in health regulations. Only in some cases was there reference to the foreign population, without distinguishing between residents or non-residents, which would imply a different treatment between formal migrants, prior to the Venezuelan wave, and immigration after 2017, with provisional documentation or with no documentation. Only one policy, the prevention plan for the arrival of the second wave of COVID-19, specifically mentions Venezuelan migrants, while almost all the written regulations focus on the foreign population in general.

A significant number of policies do not mention the pattern of mobility, that is, whether they are migrants in transit or residents. Of those that do, destination is the most frequently mentioned pattern. Only one policy focuses on transit. The majority of the policies do not describe communication strategies to inform immigrants about how to access services. The only state body that deals with the publicity of these regulations is MIGRATIONS, which shares its policies on its website. This is not an ideal strategy, as it requires Internet access and migrants must search for this information. One possible explanation for the lack of outreach communication strategies is that not many services are offered specifically for migrants and those that do depend, in large part, on their immigration status.

However, the critical situation created by the pandemic did not leave much space on the public agenda for this particular target audience. The literature confirms the fact that the Peruvian government did not design strategies to assist and inform migrants and affirms that most of the effort in this

regard was carried out by multilateral organizations through social media. Perú represents a universalist country in discourse, which hadn't imagined needing specific health legislation or ad hoc adaptation to the million migrants. In addition to not seriously considering outreach migrant population seriously, none of the policies mention trainings for cultural competencies, measures to mitigate racism, discrimination, or xenophobia, nor do they consider important cultural and linguistic factors for migrants.

Barriers to accessing healthcare

The reduced access to the health system experienced by Venezuelan migrants living in Perú can be categorized according to four types of barriers: economic, legal, cultural, and informational asymmetry. The COVID-19 pandemic mainly affected groups in vulnerable situations, such as the case with migrants.^{65,66} There was territorial access but much less access to public service providers as we described. Informality, irregular migratory status, economic barriers to accessing to health services and the labor market are the main areas in which migrants in Perú would need state policies to help them confront the difficult scenario that the pandemic presented for them.⁶⁷

Economic barriers to accessing healthcare

First, the economic aspect represents a barrier that is closely related to, and mutually reinforcing of, the lack of access to health. Zambrano-Barragán et al describe this connection with the following: “The lack of social protection for migrants in Perú also means that they have to finance their expenses without help from the State and, consequently, they have less disposable income”.⁶⁸ Having to use private health centers and finance their own medicines requires spending power that most Venezuelan migrants do not possess, given they have only had access to jobs in the informal economy. Low income, instability, and lack of labor rights — such as ESSALUD health insurance, which is the public health insurance for formal workers — make the economic barrier to access the health system considerably high. The economic situation of migrants worsened during the pandemic, mainly due to their informal employment status. A survey conducted by Equilibrium CenDE finds that

43% of migrants saw their income reduced by more than 50%, while in October 34% had lost their job due to quarantine and had not been able to get another after it. As a vulnerable population dependent on daily work for subsistence, they could have benefited from the family bonus that the government distributed. However, they were not considered for this measure.⁶⁹

Legal barriers to accessing healthcare

We find that many of the procedures necessary to obtain health insurance are very complicated and, in some cases, are not in touch with the reality in which migrants live. Such is the case of ESSALUD, which, as we mentioned before, requires having a formal job and excludes the majority of Venezuelan migrants. The same happens with the process to join the Comprehensive Health Insurance (SIS), which to be admitted, you must first be registered in the Home Focalization System (Sistema de Focalización de Hogares) (SISFOH). This process requires a visit to the applicants' homes and that all the inhabitants of the house present their documents. Because a significant number of migrants live in rented and shared houses with people who are not their relatives or who do not have their documents in order, this requirement hinders their access to health.⁷⁰ However, there are also complications during the process of appointments for care, such as delays in scheduling them,⁷⁰ in addition to the delays and extra costs incurred for migrants residing outside of Lima, as the vast majority of procedures are carried out there.

Cultural barriers to access to accessing healthcare

The discrimination experienced by Venezuelan migrants in society in general and in health facilities is particularly due to cultural barriers to access the health system. Various sources indicate the prevalence of this phenomenon. Equilibrium CenDE found that 72% of Venezuelan migrants have suffered discrimination. Zambrano-Barragán et al state that 53% of those interviewed suffered discrimination in the health system, mainly by medical personnel (2020). This phenomenon is increased outside of the capital city.⁷⁰ Furthermore, discrimination within the

health system does not only reflect a risk for migrants to receive below-standards care, but also a deterrent for seeking care due to the discrimination within and across the health system, increasing their risk of unresolved health needs.⁷¹ It is important to highlight point out that throughout history, the large-scale emergence of contagious diseases has exacerbated “fear of the other”, a phenomenon that may explain a resurgence of xenophobia during a pandemic. This merits concern, as xenophobia was already present before the pandemic, both in the general population and in the actions of the State, which went from an initial position of solidarity to one of criminalization of Venezuelan migrants.

Barriers due to information asymmetry on the functioning of the health system

The information asymmetry around the procedures and the health system, that is, the lack of knowledge about the health services in Perú, constitutes another obstacle that migrants faced in accessing the health system. Migrants are largely unaware of how to access health services, file complaints — in general, and concerning the health system — and their rights.⁷¹ Similarly, the medical staff also demonstrated that they are unaware of the most current updates in regulations related to the migrant population. This lack of knowledge became clear in complaints received about the denial of the SIS for migrant girls, boys and pregnant women; and requests by medical personnel for documents for the care of suspected COVID-19, even though recent regulations had established that these requirements were not necessary.⁷²

AVAILABILITY OF INFORMATION ON MIGRANTS

Five different sources of information were identified on the health situation of Venezuelan migrants in Perú during the COVID-19 pandemic, but within a general state of scarcity of aggregate national information. The National Superintendency of Migrations keeps the registry of regular entrants through the border posts. In addition, it manages the process of regularization of the documentation of migrants,

which began in 2017 and allows for some updating of the information of migrants in a regular situation. An alliance of specialized organizations, such as the one that produces the monthly 4xV platform, produces the most relevant information to date, albeit partially, as it relies heavily on specific surveys or regular registration at borders. Another source, although partial, is the community defence (Defensoria del Pueblo) which collects specific information on the Venezuelan population in Perú for its Ombudsman Reports, such as the one published by Deputy Office N° 002-2020-DP/ADHPD with the title *Venezuelans in Perú — Analysis of the Situation Before and During the Health Crisis Generated by COVID-19*. This report, issued in July 2020, analyzed the impact of the pandemic on Venezuelan migrants in terms of labor processing of refugees, returns/deportations to Venezuela, discrimination, and evictions. In the MINSA, nationality was not collected until October 2020 and in an imperfect way. It included a box that allows for the determination of the nationality of those served in its care records, although its database is limited. Finally, multilateral organizations also assisted the Peruvian State in collecting and analyzing information on the health of migrants, such as PAHO and IOM.

STAKEHOLDERS INVOLVED IN THE RESPONSE

One could say that Venezuelan migration has motivated the activation of the Intersectoral Worktable for Migration Management, formed in 2011 with the SD 067-2011-PCM, for the issue of migration, based on the initiatives of the Ministry of Foreign Affairs and IOM.

For the recent Venezuelan migratory wave, the stakeholders have been of three types:

1. Decision-makers: Presidency, Premier, Chancellery.
2. Actors promoting the issue; cooperating agencies (IOM, UNHCR, PAHO, etc), humanitarian assistance agencies (Red Cross, NGOs, etc).
3. State actors that provide services (MINSA, MTPE, MINEDU, MININTER, etc). Insofar as legal documentation of the migrants, the most active were the National Superintendency of Migration and the Foreign Ministry. The service providers were public and private. On humanitarian assistance, the key agencies were IOM, UNHCR, and international cooperating agencies.

There was no prioritization on the part of normal service providers by the social service Ministries of the state, likely because they have been attending to COVID-19 since March 2020. However, the migratory phenomenon has been emerging and notorious in Perú since 2017. However, the precarious situation of migrants motivated international cooperation and humanitarian support from international organizations. In April 2018, the Secretary-General of the United Nations gave guidelines to coordinate the regional response to migrants and refugees from Venezuela. Thus, the Interagency Platform for Refugees and Migrants from Venezuela (R4V) was formed to coordinate response actions in 17 Latin American countries together with key allies.

As a second milestone, the Regional response plan for migrants and refugees (RMRP) was formulated to achieve the objective set by the R4V. Those in charge of managing and implementing this plan are organized at the national level and are allies of R4V through the Working Groups for Refugees and Migrants (GTRM).

During the pandemic, the assistance of multilateral organizations, either through the provision of food, basic services, access to information and legal procedures, has been useful and has served to reduce the existing gaps in the assistance of the Peruvian State. However, this support is clearly insufficient as it has only covered a small proportion of migrants. This is evidence that the situation of migration must be approached with State policies and not only as a question of humanitarian assistance.

COMPARISON OF FINDINGS BY COUNTRY

DIMENSION	COLOMBIA
Context: migration	Main types of migration — emigration of Colombians (to USA, Spain, Venezuela); since 2010, return of Colombians; since 2015, increase in arrival of Venezuelans and Colombians returning from Venezuela; circular migration in the border area between Colombia and Venezuela; tradition of emigration, significant inflow to the country is relatively recent
Context: health system	Fragmented — public and private care, through affiliation to contributory (workers with capacity to pay) or subsidized (people in condition of poverty/vulnerability) schemes; access depends on employment status (regular vs irregular) and ability to pay
Access for migrants: regulations	Regulatory barrier — only regular migrants can join the system
Access for migrants: barriers	Those who are not affiliated with the system have limited access and continuity of care; access depends on ability to pay and migratory status
Responding to the pandemic: public policies on migrant health	<p>The mechanisms for the migrant population to effectively access services are not made explicit; the response is then the responsibility of the territorial entities and the EAPB. Temporary Protection Statute for Venezuelan Migrants (facilitates access to the health system, among other benefits)</p> <p>Vaccination regardless of migratory status; response to migrants based on migratory regularization</p>
Pandemic response: adequacy of health services	Cross-cultural appropriateness is not considered; different types of migrants are not considered
Pandemic response: information gathering	
Agents involved	Health sector; territorial entities and EAPB; the support of international cooperation has been fundamental

In this section we show a comparative table of the findings for each country. This comparison is discussed further in the conclusions.

MEXICO

Main types of migration — Mexicans to and from the US, Central Americans and others in transit, increase in immigration/refuge, but volume is still small, except in areas of concentration (eg, borders); tradition of emigration, important inflow to the country is relatively recent

Fragmented — social security, open population, private. Access depends on employment status (formal vs informal) and ability to pay; change in the open population system (from Seguro Popular to INSABI), which coincided with the COVID-19 pandemic

The General Health Law stipulates that the right to the public health system is independent of migratory status

Administrative barriers (eg, in practice documents are required); lack of knowledge of migrants of their rights and access mechanisms; the system provides free care, but due to shortages, users must pay out-of-pocket expenses for medicines and interventions; access depends on ability to pay, and in practice also on migratory status

Focused on migrants in transit (not Mexican migration); focused on COVID-19 detection and care, epidemiological surveillance, hygiene measures and identification of populations at risk of complications, mental health
Vaccination regardless of migratory status; response to migrants based on attention to the epidemiological contingency

Cross-cultural appropriateness is not considered; different types of migrants are not considered; they do not describe strategies to inform migrants how to access services; no mention of measures to mitigate racism/xenophobia

Response policies emphasize epidemiological surveillance and mention the identification of people at risk of complications

MOH, Ministry of the Interior, at their different levels; health jurisdictions are responsible for the health response; CSOs are responsible for the shelters they operate; in the response to migrants in transit CSOs and INGOs have been key

PERU

Main types of migration — Peruvian emigration has occurred for generations, but its change to an immigrant-receiving country is recent, starting with the Venezuelan exodus

The Peruvian health system is fragmented, in that different providers target different populations; the MOH covers economically vulnerable populations, ESSALUD for those with formal jobs, and private clinics and insurance plans for higher socio-economic status; the SIS has expanded its coverage to be fully comprehensive (current PEAS), but without the necessary budget; ESSALUD operates through payroll discounts, which amounts to a 9% of payroll deduction; Perú's public spending on health is low — 3.2% of the GDP

The General Health Law stipulates that the right to the public health system is independent of migratory status, but access and effective coverage for immigrants is limited

Affiliation to public health insurance does not guarantee full access or care; the barriers to accessing health services in Perú most frequently perceived by migrants were lack of economic resources (88%), lack of documentation (56%) and perceived discrimination (46%)

Legislative Decree N° 1466, issued in April 2020, expands SIS coverage to include foreigners suspected of having COVID-19, regardless of their immigration status; the regulation on management of corpses excluded migrants; most policies aimed at prevention of transmission; response to migrants based on epidemiologic contingency care

Cross-cultural appropriateness is not considered; types of migrants are not considered; they do not describe strategies to inform how to access services; no mention of measures to mitigate racism/xenophobia

The data collected by the Peruvian Ministry of Health does not record the variable nationality until the end of 2020; there is a lot of underreporting and the databases are not of high quality

Executive branch on migration, lesser role of health authorities. International cooperation, international organizations

CONCLUSIONS

This analysis demonstrates commonalities and differences in the health and migration context and response for Mexico, Colombia and Perú regarding the inclusion of migrants and refugees in their health systems during the COVID-19 pandemic. All three countries have recently experienced major changes in their migration landscape, with an increase in the arrival of foreigners as part of mixed migration flows of economic migrants and those displaced by violence, economic crises, or natural disasters in their countries of origin. These are composed mainly of Central Americans for Mexico, and Venezuelans for Colombia and Perú. These migration flows also include people of other nationalities and represent new challenges for health systems due to the higher proportion of women, children, adolescents and older adults compared to the demographic characteristics of previous migration flows.

Health care provision for migrants has been integrated into the three countries' health systems in varying degrees, and with different characteristics in terms of their organization, financing, governance, among other elements. Normatively, access to the public health system in Mexico and Perú is independent of migratory status, while in Colombia irregular migrants are entitled to only some health care services compared to nationals. In practice, however, administrative, and economic barriers persist in all three countries, making migrants' access to health care limited compared to that of the local population. In the response to the health of migrants during the pandemic, Ministries or Secretariats of Health and others related to migration were involved in all three countries to craft and implement policies to include migrants in health systems. In Mexico, civil society organizations played a more fundamental role than in the

other two countries; however, in all three countries, the support and response of international organizations and international cooperation agencies were essential.

During the COVID-19 pandemic, the health systems of Mexico and Perú had in common a response towards the migrant population that focused on the health emergency created by the pandemic, the development of contingency plans, and reduction in transmission of COVID-19. There was less attention to the longer term sustainable health system response. In contrast, Colombia's pandemic response did not come only from the health system, but also included migration policy action. For example, the longer term strategy of implementation of the Temporary Protection Statute to regularize the stay of Venezuelan migrants in the country was adopted; this regularization of the migrant population allows for migrants to have access to health insurance schemes, addressing some of the health needs of migrants and refugees in the longer term. In all three countries there were relatively few health policies issued in response to the pandemic specifically aimed at migrant populations. Rather, many of the COVID-19-related policies issued were more general in nature, and could indirectly benefit migrants. For example, none of the three countries excluded migrants from COVID-19 vaccination policies. However, the direct impact of the vaccines on migrant health is difficult to assess as migrant-specific data was not collected.

In the review of public policy documents and through interviews with key informants, some limitations and strengths in the responses of the health systems were identified. None of the three countries seem to have considered the need to



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adapt services to the particular conditions and contexts of the migrants. There does not appear to be any mention of cultural adaptation measures, the need for translators, nor are there any strategies to inform migrants about their rights and how to access services. However, in the case of Colombia, some strategies were implemented to attempt to humanize and mitigate discrimination against the migrant populations during the pandemic. In all three countries, policies often focused on particular types of migrants, to the detriment and exclusion of others. For example, in Mexico and Colombia, no strategies were issued for migrants living amongst national communities. In Perú, policies addressed

the needs of Venezuelans, without considering those of other nationalities. Another common limitation in health policy response was the scarcity of data and information on health issues and health services for migrants and refugees in the public health systems in the three countries, although there was some effort to generate and disseminate statistics on the situation of COVID-19 amongst these groups. The COVID-19 pandemic offers an opportunity to progress on the necessity to include of all migrants and refugees in different contexts into countries' health systems, and to better address the barriers of these populations in accessing such systems.

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ANNEX I

List of interviews conducted (Mexico).

Nº	TYPE OF INFORMANT	INTERVIEW DATE
1	Healthcare professional	07/21
2	Civil society worker	07/21
3	Civil society worker	09/21
4	Civil society worker	09/21
5	Federal government official	09/21
6	Healthcare professional	10/21
7	Healthcare professional	10/21
8	Civil society worker	10/21
9	Civil society worker	10/21
10	Healthcare professional	10/21
11	Civil society worker	10/21
12	Civil society worker	10/21
13	Migrant individual	10/21
14	Municipality government official	11/21
15	Migrant individual	11/21
16	Civil society worker	11/21

ANNEX II

List of interviews conducted (Colombia).

Nº	TYPE OF INFORMANT	INTERVIEW DATE
1	Healthcare professional	09/21
2	Healthcare professional	10/21
3	Healthcare professional	11/21
4	Healthcare professional	10/21
5	Healthcare professional	10/21
6	Government official	09/21
7	Government official	09/21
8	Government official	09/21
9	Government official	10/21
10	Government official	10/21
11	Multilateral organization official	09/21
12	Multilateral organization official	09/21
13	Multilateral organization official	09/21
14	Multilateral organization official	09/21
15	Multilateral organization official	09/21
16	Multilateral organization official	09/21
17	Multilateral organization official	09/21
18	Multilateral organization official	10/21
19	Multilateral organization official	09/21
20	Migrant Individual	09/21
21	Migrant Individual	10/21
22	Migrant Individual	10/21

ANNEX III

List of interviews conducted (Perú).

Nº	TYPE OF INFORMANT	INTERVIEW DATE
1	Healthcare professional	6/21
2	Healthcare professional	6/21
3	Healthcare professional	7/21
4	Government official	6/21
5	Government official	6/21
6	Government official	6/21
7	Government official	6/21
8	Government official	7/21
9	Government official	7/21
10	Government official	7/21
11	Multilateral organization representative	6/21
12	Multilateral organization representative	6/21
13	Multilateral organization representative	7/21
14	Multilateral organization representative	7/21
15	Multilateral organization representative	7/21
16	Migrant	10/21
17	Migrant	10/21
18	Migrant	10/21
19	Migrant	10/21
20	Migrant	10/21
21	Migrant	10/21
22	Migrant	10/21
23	Migrant	10/21
24	Migrant	10/21

ANNEX IV

Public policy documents analyzed for the case of Mexico.

Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
1	Systematic Operation Procedure in the face of the new Coronavirus COVID 19 outbreak Procedimiento Sistemático de Operación ante el brote nuevo Coronavirus COVID 19	Secretary of the Interior	01/27/2020	Guidelines for international travelers from Wuhan and other high-risk cities in China
2	Agreement by which the General Health Council recognizes the epidemic of SARS-CoV2 virus disease (COVID-19) in Mexico, as a serious disease of priority attention, as well as establishing the activities of preparation and response to said epidemic Acuerdo por el que el Consejo de Salubridad General reconoce la epidemia de enfermedad por el virus SARS-CoV2 (COVID-19) en México, como una enfermedad grave de atención prioritaria, así como se establecen las actividades de preparación y respuesta ante	Ministry of Health	03/23/2020	General guidelines do not mention migrant populations
3	Agreement establishing the preventive measures that must be implemented to mitigate and control the health risks that the SARS-CoV2 virus disease (COVID-19) implies Acuerdo por el que se establecen las medidas preventivas que se deberán implementar para la mitigación y control de los riesgos para la salud que implica la enfermedad por el virus SARS-CoV2 (COVID- 19)	Health Ministry	03/24/2020	General guidelines do not mention migrant populations

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Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
4	<p>Decree sanctioning the Agreement establishing the preventive measures that must be implemented to mitigate and control the health risks that the SARS-CoV2 virus disease (COVID-19) implies</p> <p>Decreto por el que se sanciona el Acuerdo por el que se establecen las medidas preventivas que se deberán implementar para la mitigación y control de los riesgos para la salud que implica la enfermedad por el virus SARS-CoV2 (COVID-19)</p>	Health Ministry	03/24/2020	General guidelines do not mention migrant populations
5	<p>COMAR informs about the operations and measures taken for COVID-19</p> <p>Avisa COMAR sobre la operación y medidas por el COVID-19</p>	Commission for Refugee Aid	03/25/2020	Does not mention themes related to health
6	<p>AGREEMENT announcing the days on which the applicable deadlines and terms will be suspended in the administrative procedures and procedures carried out before the Ministry of Foreign Affairs, due to the coronavirus contingency (COVID-19)</p> <p>ACUERDO por el que se dan a conocer los días en que se suspenderán los plazos y términos aplicables en los trámites y procedimientos administrativos sustanciados ante la Secretaría de Relaciones Exteriores, con motivo de la contingencia coronavirus (COVID-19)</p>	Secretary of Foreign Affairs	03/26/2020	Does not mention themes related to health
7	<p>DECREE declaring extraordinary measures in the affected regions of the entire national territory in terms of general health to combat the serious disease of priority attention generated by the SARS-CoV2 virus (COVID-19)</p>	Ministry of Health	03/27/2020	General guidelines do not mention migrant populations
8	<p>General guideline for the mitigation and prevention of COVID-19 in closed public spaces</p>	Government of Mexico	03/27/2020	Recommendations for measures within closed spaces, including migrant shelters

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Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
9	AGREEMENT by which the epidemic of disease generated by the SARS-CoV2 virus (COVID-19) is declared a health emergency due to force majeure	Ministry of Health	03/30/2020	General guidelines do not mention migrant populations
10	AGREEMENT establishing extraordinary actions to address the health emergency caused by the SARS-CoV2 virus	Ministry of Health	03/31/2020	General guidelines do not mention migrant populations
11	Guidelines for the implementation of COVID-19 temporary care centers (CAT-COVID19) and Mobile Hospitals (EMT)	Ministry of Health	04/09/2020	General guidelines do not mention migrant populations
12	Comprehensive regional framework for protection and solution	Comprehensive regional framework for protection and solutions (MIRPS)	04/12/2020	It is not considered a normative document issued by the Government of Mexico
13	AGREEMENT that prohibits the incineration of unidentified and unclaimed bodies that died as a result of the SARS-CoV2 virus (COVID-19) and suggests measures for the registration of deaths in the framework of the health emergency	Ministry of Health	04/17/2020	Recommendations for measures within closed spaces, including migrant shelters
14	Protocol of action for the prevention and care of suspected and confirmed cases of COVID-19 within the National Institute of Migration immigration stations and provisional stays	Government of Mexico	04/19/2020	
15	AGREEMENT amending the similar agreement establishing extraordinary actions to address the health emergency generated by the SARS-CoV2 virus, published on March 31, 2020	Ministry of Health	04/21/2020	
16	Sentinelle Epidemiologic Surveillance	Ministry of Health	05/06/2020	
17	Operational plan for the attention of migrant populations in the face of COVID-19	Ministry of Health	05/11/2200	

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N°	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
18	Sanitary recommendations for temporary shelters and voluntary isolation centers (CAV) in the context of COVID-19	Ministry of Health	05/20/2020	Indicates that voluntary isolating centres must be created for migrants and other populations without a permanent addresses and recommendations for their functioning
19	Agreement SIPINNA/EXT/01/2020 approving essential actions for the care and protection of children and adolescents during the health emergency due to force majeure due to the epidemic of disease generated by the SARS-CoV2 virus (COVID-19)	Government of Mexico	05/26/2020	Does not mention themes related to health
20	Strategy for health promotion, prevention, care and mitigation of COVID-19 within the framework of primary health care	Ministry of Health	07/24/2020	General guidelines do not mention migrant populations
21	National vaccination policy against the SARS-Cov-2 virus, for the prevention of COVID-19 in Mexico	Ministry of Health	01/11/2021	General guidelines do not mention migrant populations
22	Agreement by which special brigades are established, as an extraordinary action in matters of general health, to carry out vaccination as a measure for the mitigation and control of the COVID-19 disease, throughout the national territory	Ministry of Health	01/21/2021	General guidelines do not mention migrant populations
23	Agreement by which it is established as an extraordinary action in matters of general health, that the governments of the federal entities in their capacity as health authorities, as well as the individuals and legal entities of the social and private sectors, members of the National Health System, collaborate with the Federal Ministry of Health in the implementation of the National Vaccination Policy against the SARS-CoV-2 virus for the prevention of COVID-19 in Mexico	Ministry of Health	01/25/21	General guidelines do not mention migrant populations

ANNEX V

Public policy documents analyzed for the case of Colombia.

Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
1	Resolution 385 of March 12, 2020	Ministry of Health and Social Protection	March 12, 2020	“Order the EPS, territorial entities and IPS to facilitate the official affiliation to the General System of Social Security in Health of the Colombian population and of regular migrants, using the virtual channels that this Ministry has provided” (page 4); within the health care measures adopted, the EPS, Territorial Entities and IPS, must facilitate formal affiliation to the SGSSS of Colombia, for the Colombian population and for regular migrants affiliated to the SGSSS
2	Resolution 000380 of March 10, 2020	Ministry of Health and Social Protection	March 10, 2020	Discusses migratory flows in general, however, it does not mention the Venezuelan migrant population
3	Guidelines for the detection and management of cases by health service providers, facing the introduction of SARS-CoV-2 (COVID-19) to Colombia	Ministry of Health and Social Protection	March 11, 2020	Guidelines are aimed at tourist or returnee population; however, it established guidelines for specific populations such as being 60 years of age or older, current diagnosis with diabetes, having cardiovascular or chronic respiratory disease, diagnosis of any immunodeficient disorder It does not make specific reference to the Venezuelan migrant population
4	Guidelines for the prevention, detection and management of COVID-19 cases for the migrant population in Colombia	Ministry of Health and Social Protection	April 2020	“It is oriented to the SGSSS actors, the detection, management and suspicions of cases of virus in migrant populations in order to contain the risk of transmission and to channel health services in a timely manner”

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Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
5	Guidance for screening travelers from areas with circulation of coronavirus	Ministry of Health and Social Protection	February 28, 2020	Discusses travelers from countries with circulating COVID-19 including travelers and returned population; through this, the implementation of the Migration Screening Survey is directed at the country's entry points, which oversees migration in Colombia and port health in the case of ports
6	Management protocol for the arrival of passenger ships of international maritime and river traffic from any country of origin	Ministry of Health and Social Protection	March 12, 2020	"Guidelines for the management for the arrival of passenger ships of international maritime and river traffic from any country of origin"; despite the document making reference to returned population, it does not explicitly discuss the protocol and case management of the Venezuelan population
7	Actions to take against the coronavirus, January 31, 2020	Ministry of Health and Social Protection	January 31, 2020	The document focuses on "actions in health promotion, prevention and care of Acute Respiratory Infection (IRA) before international alert for New Coronavirus 2019-nCoV" (page 1); however, it does not refer to the Venezuelan migrant population
8	Guidelines—GIPSo6. Guidelines for the management of home isolation, against the introduction of SARS-CoV-2 (COVID-19) to Colombia	Ministry of Health and Social Protection	March 16, 2020	Recommendations to consider during home isolation: waste management, cleaning and disinfection, use of personal protection elements Clinical management in accordance with the case detection guidelines according to criteria established by health service providers; it includes the traveling population; however it does not focus on the Venezuelan migrant population

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Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
9	Inter-institutional guide for the repatriation of nationals at risk of contagion from the new coronavirus COVID-19	Ministry of Foreign Affairs and Ministry of Health and Social Protection	February 20, 2020	It focuses on “Establishing the procedures to be applied in the repatriation operation of Colombian nationals who come from an area with circulation of the new coronavirus (COVID 19), in Wuhan, Hubei province” (page 1); although it refers to travelers, it does not refer to the Venezuelan migrant population.
10	National vaccination plan against COVID-19	Ministry of Health and Social Protection, National Planning Department, Ministry of Finance and Public Credit, Institute of Technological Evaluation in Health	February 2021	It focuses on providing guidelines for the implementation of the vaccination plan against COVID-19 in the regular and irregular migrant population; however, this document only discusses vaccination for the migrant population with legal status, until the mechanisms for vaccinating the irregular migrant population are established
11	Oficio AMC-CIR000400-2020	Mayor’s Office of Cartagena de Indias	March 12, 2020	“Management protocol for the arrival of passenger ships of international maritime and river traffic from any country of origin only once for the Monarch cruise” (page 1); however, it does not mention the Venezuelan migrant population
12	Decree 402 of March 1, 2020	Ministry of Interior, Ministry of Foreign Affairs, Ministry of Health and Social Protection, Ministry of National Education, Ministry of Transport	March 13, 2020	Although it does not mention health issues for the migrant population, this document is important as it focuses on the closure of borders, which affects the mobility of migrant populations

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N°	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
13	Decree 412 of March 16, 2020	Ministry of Health and Social Protection	February 28, 2020	Discusses travelers from countries with circulating COVID-19 including travelers and returned population; through this, the implementation of the Migration Screening Survey is directed at the country's entry points, which oversees migration in Colombia and port health in the case of ports
14	Resolution 1265 of 2020	Ministry of Health and Social Protection	March 12, 2020	"Guidelines for the management for the arrival of passenger ships of international maritime and river traffic from any country of origin"; despite the document making reference to returned population, it does explicitly discuss the protocol and case management of the Venezuelan population
15	Decree 216 of 2021	Ministry of Health and Social Protection	January 31, 2020	The document focuses on "actions in health promotion, prevention and care of Acute Respiratory Infection (IRA) before international alert for New Coronavirus 2019-nCoV" (page 1); however, it does not refer to the Venezuelan migrant population
16	Decree 1109	Ministry of Health and Social Protection	March 16, 2020	Recommendations to consider during home isolation: waste management, cleaning and disinfection, use of personal protection elements Clinical management in accordance with the case detection guidelines according to criteria established by health service providers; it includes the traveling population; however it does not focus on the Venezuelan migrant population

ANNEX VI

Support from international agencies in the response to migrant population within the framework of COVID-19 (Colombia).

MULTILATERAL AGENCIES INVOLVED	SERVICE PROVIDED TO MIGRANT POPULATION IN THE CONTEXT OF COVID-19
UNICEF	Basic sanitation
UNICEF-Save the Children	Education
World Food Fund	Food Safety
WHO PAHO UNAIDS	Health care support
UNHCR Norwegian Refugee Council IMO	Humanitarian transport
OIT OIM	Support for the integration of the migrant population
UNICEF	Nutrition
UNHCR Hebrew Immigrant Aid Society (HIAS) UNICEF UNFPA UN Women IOM World Vision International	Protection to: Child/children and adolescent populations Women (protection against gender-based violence) Migrant populations
ACNUR OIM Norwegian Refugee Council	Shelter

Source: The authors' elaboration based on the regional coordination structure for support to the migrant population given by R4V (2021)

ANNEX VII

Public policy documents analyzed for the case of Perú.

Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
1	Supreme Decree N° 044-2020-PCM declaring a State of National Emergency due to the serious circumstances that affect the life of the Nation as a result of the COVID-19 outbreak	Presidency of the Council of Ministers Protection	March 15, 2020	Border closure and state of emergency for 15 days
2	Supreme Decree N° 045-2020-PCM that specifies the scope of Article 8 of Supreme Decree N° 044-2020-PCM, which declares a state of national emergency due to the serious circumstances that affect the life of the nation as a result of the COVID-19 outbreak	Presidency of the Council of Ministers	March 17, 2020	Exceptional permit for residents (nationals or foreigners) to return to Perú
3	Resolution N° 000104-2020-Migraciones that authorizes the rescheduling of appointments related to the procedures of administrative procedures and services provided by the organic units of the National Superintendency of Migrations, suspends administrative deadlines and dictates other provisions	National Superintendency of Migrations	March 19, 2020	Migration's agency rescheduled appointments and extends validity of permits
4	Supreme Decree N° 051-2020-PCM that extends the State of National Emergency declared by Supreme Decree N° 044-2020-PCM	Presidency of the Council of Ministers	March 27, 2020	Border closure and state of emergency for 15 days
5	Emergency Decree 033-2020 that established measures to reduce the impact on the Peruvian economy of the prevention provisions established in the declaration of a state of national emergency in the face of the risks of the spread of COVID-19	Government of Perú	March 27, 2020	Distribution of basic goods baskets

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Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
6	Supreme Decree N° 064-2020-PCM that extended the State of National Emergency due to the serious circumstances that affect the life of the nation as a result of COVID-19 and dictates other measures	Presidency of the Council of Ministers	April 10, 2020	Border closure and state of emergency for 15 days
7	Emergency Decree N° 037-2020 that dictates complementary measures for the health sector in the framework of the health emergency due to the effects of the coronavirus (COVID-19)	Government of Perú	April 12, 2020	MINSA creates SERVICER
8	Ministerial Resolution N° 189-2020-MINSA that modify the Sanitary Directive for the handling of corpses by COVID-19	Ministry of Health	April 12, 2020	Protocol issued for the management of corpses
9	Legislative Decree N° 1466 that approves provisions to strengthen and facilitate the implementation of the exchange of health benefits in the national health system, which allow the adequate and full provision of prevention and health care services for infected people and with risk of contagion by COVID-19	Government of Perú	April 21, 2020	Facilitates the benefits exchange and SIS for migrants
10	Resolución Ministerial N° 215-2020-MINSA Amendment to the articles of Law N° 23330, Law of the Rural and Marginal Urban Health Service	Ministry of Health	April 21, 2020	Modifies SERUMS to accept participation in SERVICER as experience
11	Ministerial Resolution N° 213-2020-MINSA. Advisory Working Group on sociocultural matters due to the impact of COVID-19	Ministry of Health	April 21, 2020	Creates working group of social sciences
12	Supreme Decree N° 075-2020-PCM that extends the State of National Emergency due to the serious circumstances that affect the life of the nation as a result of COVID-19	Presidency of the Council of Ministers	April 25, 2020	Border closure and state of emergency for 14 days

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N°	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
13	Superintendence Resolution N° 000120-2020-Migraciones, extension of the suspension of the calculation of the period established in Article 4 of Superintendence Resolution N° 000104-2020-Migraciones, in accordance with the provisions of Article 1 of DS N° 076-2020-PCM	National Superintendency of Migrations	May 5, 2020	Appointments and validity of permits extended 15 more days
14	Superintendence Resolution N° 000121-2020-Migraciones authorizes the use of certificates in favor of foreign citizens who, having carried out various procedures, did not obtain the immigration card or the PTP, due to the mandatory social isolation measure decreed within the framework of the Health Emergency by COVID-19 and dictate various provisions	National Superintendency of Migrations	May 5, 2020	Permits use of certificates to replace original documents
15	Supreme Decree N° 083-2020-PCM that extends the State of National Emergency due to the serious circumstances that affect the life of the Nation as a result of COVID-19 and establishes other provisions	Presidency of the Council of Ministers	May 10, 2020	Border closure and state of emergency for 14 days
16	Supreme Decree N° 094-2020-PCM that establishes the measures that citizens must observe towards a new social coexistence and extends the State of National Emergency due to the serious circumstances that affect the life of the Nation as a result of COVID-19	Presidency of the Council of Ministers	May 23, 2020	National Reopening Plan, maintains closed borders
17	Superintendence Resolution N° 000131-2020-Migraciones, creates the platform 'Virtual MIGRATIONS Agency' and the 'Virtual MIGRATIONS Table of Reports', the same that will work through the 'Virtual MIGRATIONS Agency' and approve other provisions	National Superintendency of Migrations	May 28, 2020	Virtualization of migrant permits

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N°	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
18	Decreto Supremo N° 116-2020-PCM que establece las medidas que debe observar la ciudadanía en la Nueva Convivencia Social y prorroga el Estado de Emergencia Nacional por las graves circunstancias que afectan la vida de la Nación a consecuencia del COVID-19	Presidency of the Council of Ministers Superintendency of Migrations	June 26, 2020	Border closure and state of emergency for 30 days
19	Superintendence Resolution N° 000121-2020-Migraciones authorizes the use of certificates in favor of foreign citizens who, having carried out various procedures, did not obtain the immigration card or the PTP, due to the mandatory social isolation measure decreed within the framework of the Health Emergency by COVID-19 and dictate various provisions	Presidency of the Council of Ministers	July 31, 2020	Border closure and state of emergency for 30 days
20	Decreto de Urgencia N° 090-2020; decreto de Urgencia que establece medidas excepcionales y temporales que coadyuven al cierre de brechas de recursos humanos en salud para afrontar la pandemia por la COVID-19	Government of Perú	August 3, 2020	Modifies requirements for the hiring migrant health workers, including migrants that have not been able to validate their degrees
21	Supreme Decree N° 116-2020-PCM that establishes the measures that citizens must observe in the New social coexistence and extends the State of National Emergency due to the serious circumstances that affect the life of the Nation as a result of COVID-19	Presidency of the Council of Ministers	August 28, 2020	Border closure and state of emergency for 30 days

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N°	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
22	Superintendence Resolution N° 000188-2020-Migraciones approves the protocol called Attention of Registration in the Central Registry of Immigration and Duplicate Immigration Card through the Virtual MIGRATIONS Table of Reports	National Superintendency of Migrations	August 31, 2020	Migration protocol for registration procedures and for migrant residents
23	Superintendence Resolution N° 000189-2020-Migraciones authorizes the use of various certificates in favor of citizens who, having obtained their 'Título de Nacionalidad' would not have been able to obtain the physical copy, due to the State of Sanitary Emergency by COVID-19 and dictate various provisions	National Superintendency of Migrations	August 31, 2020	Increases the number of valid documents that can be used for migration procedures
24	Superintendence Resolution N° 000190-2020-Migraciones approves the virtual processing of the services provided exclusively called 'Cancellation of Residence' and 'Certificate of Registration in the Central Immigration Registry', provided for in the TUPA Migraciones, through the MIGRATIONS Digital Agency platform	National Superintendency of Migrations	September 2, 2020	Increases virtual functions of migrations
25	Superintendence Resolution N° 000204-2020-Migraciones approves the information and design of an immigration card (Immigration Card for Adults and Immigration Cards for Minors)	National Superintendency of Migrations	October 12, 2020	New design of immigration card (adults and minors)

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N°	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
26	Superintendence Resolution N° 000207-2020-Migraciones approving the virtual processing of the services provided exclusively called 'Modification of Data in the Central Immigration Registry' and 'Transfer of Stamps (of Residents)'	National Superintendency of Migrations	October 13, 2020	Increases virtual functions of migrations
27	Supreme Decree N° 170-2020-PCM modifying Supreme Decree N° 116-2020-PCM, that establishes the measures that citizens must follow in the new social coexistence and extends the State of National Emergency due to serious circumstances that affect the life of the Nation as a result of COVID-19, modified by Supreme Decrees N° 129-2020-PCM, N° 135-2020-PCM, N° 139-2020-PCM, N° 146-2020-PCM, N° 151-2020-PCM, N° 156-2020-PCM, N° 162-2020-PCM and N° 165-2020-PCM	Presidency of the Council of Ministers	October 22, 2020	International transport is again permitted, and borders are reopened
28	Supreme Decree N° 010-2020-IN approving special, exceptional and temporary measures to regularize the immigration status of foreigners	Ministry of Interiors	October 22, 2020	Regular and irregular migrants must update their information within 180 days
29	Secretary Resolution N° 266-2020/MINSA	Ministry of Health	October 23, 2020	Creates Functional Health Unit of Migrant and Border Populations

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Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
30	Superintendence Resolution N° 000220-2020-Migraciones approves virtual processing of the service provided exclusively called 'Permission to Work' through the MIGRATIONS Digital Agency Platform	National Superintendency of Migrations	October 28, 2020	Increases virtual activities, permits online applications to PTP
31	Supreme Decree N° 174-2020-PCM that extends the State of National Emergency due to the serious circumstances that affect the life of the nation as a result of COVID-19	Presidency of the Council of Ministers	October 29, 2020	Extends state of emergency, 30 days
32	Ministerial Resolution N° 928-2020-MINSA, a preparedness and response plan for a possible second wave of the COVID-19 pandemic	Ministry of Health	November 9, 2020	Issues preparation plan for a second wave
33	Supreme Decree N° 184-2020-PCM declaring a State of National Emergency due to the serious circumstances that affect people's lives as a result of COVID-19 and establishes the measures that citizens must follow in the new social coexistence	Presidency of the Council of Ministers	November 30, 2020	Extends state of emergency, 31 days
34	Supreme Decree N° 201-2020-PCM that extends the State of National Emergency due to the serious circumstances that affect the life of the Nation as a result of COVID-19 and modifies Supreme Decree N° 184-2020-PCM	Presidency of the Council of Ministers	December 21, 2020	Strengthens control of northern border and extends state of emergency for 31 days

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Nº	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
35	Supreme Decree N° 207-2020-PCM that establishes sanitary measures to prevent the spread in the national territory of new variants of the SARS-CoV-2 virus	Presidency of the Council of Ministers	December 31, 2020	Establishes a 14 day quarantine for all who enter Perú as of January 4, 2021
36	Superintendence Resolution N° 000009-2021-Migraciones provides for the implementation on the Migraciones website of the module called 'Pre-registration for the Extraordinary Regularization of Foreign Persons-DS10' and approve other provisions	National Superintendency of Migrations	January 1, 2021	Allows online pre-registration for extraordinary regularization of foreign individuals
37	Supreme Decree N° 023-2021-PCM that approves the alert level by province and department and modifies Supreme Decree N° 184-2020-PCM and amendments	Presidency of the Council of Ministers	February 13, 2021	Temporary closure of land borders to Passenger transit
38	Supreme Decree N° 036-2021-PCM that extends the State of National Emergency declared by Supreme Decree N° 184-2020-PCM, extended by Supreme Decrees N° 201-2020-PCM and N° 008-2021-PCM and amends Supreme Decree N° 184-2020-PCM	Presidency of the Council of Ministers	February 27, 2021	Strengthens immigration control of northern border State of emergency extended 30 days until April 1
39	Supreme Decree N° 046-2021-PCM amending Supreme Decree N° 184-2020-PCM and Supreme Decree N° 207-2020-PCM	Presidency of the Council of Ministers	March 13, 2021	Strengthens migration control of northern border

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N°	DOCUMENT TITLE	ISSUED BY	DATE PUBLISHED	CONTENT RELATED TO MIGRANT HEALTH
40	Superintendence Resolution N° 000069-2021-Migraciones that extends of the term of migratory pre-registration for the extraordinary regularization of foreigners	National Superintendency of Migrations	March 25, 2021	Extends for another 30 days the previous measure
41	Supreme Decree N° 058-2021-PCM that extends the State of National Emergency declared by Supreme Decree N° 184-2020-PCM, extended by Supreme Decrees N° 201-2020-PCM, N° 008-2021-PCM and N° 036-2021-PCM, and modifies Supreme Decree N° 184-2020-PCM	Presidency of the Council of Ministers	March 27, 2021	Strengthens migration control of northern border. Extends state of emergency 30 days until April 1



