

# A POPULATION IN PERIL:

## A Health Crisis Among Asylum Seekers on the Northern Border of Mexico

A SUMMARY OF FINDINGS AND AN URGENT CALL TO ACTION

A Report by HGHI in collaboration with BCSSW



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This report was conceived following an event hosted at Harvard University in November 2019 – **Public Health Crisis at the Border: The Mexican Perspective**. In subsequent conversations between speakers, it became clear that there was a need for a comprehensive, high level report highlighting the key health challenges faced by migrants and asylum seekers who are living in a state of uncertainty as they wait to enter the United States on the northern border of Mexico.

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**To cite this report:** Diamond, M. B., Testa, L., Novak, C., Kempton-Amaral, K., Porteny, T., and Olayo-Méndez, A., (2020). A Population in Peril: A Health Crisis among Asylum Seekers on the Northern Border of Mexico. Cambridge, MA: Harvard Global Health Institute. Available from [globalhealth.harvard.edu](https://globalhealth.harvard.edu).

Photography: Dr. Alejandro Olayo-Méndez

## EXECUTIVE SUMMARY

There is a public health crisis at the northern Mexico border. Increased violence in asylum seekers' home countries and new U.S. policies restricting the entry of migrants to the U.S. are leading to unprecedented numbers of people amassing along the border. As the number of people grows, the resources needed to provide essential health services remain limited.

By the time asylum seekers arrive at the border, many have already faced traumatic experiences in their home country and during their journeys. The living environment makes migrants vulnerable to new infections and violence and exacerbates existing health conditions. Inaccessible housing forces asylum seekers into overcrowded shelters, rented rooms, or tent encampments, which often lack sufficient access to basic sanitation, putting asylum seekers at risk for infectious diseases. Non-communicable diseases are often undiagnosed and therefore remain untreated, and mental health conditions are widespread. The high prevalence of criminal activity and violence in many cities along the border threatens the physical and mental health of asylum seekers and creates additional barriers to seeking care. As a result of government inaction, healthcare provision has predominantly fallen on non-governmental organizations and charities. While they fill a critical need, the absence of a standardized and widespread approach to healthcare delivery has led to inconsistent and inadequate care.

The full extent of the health crisis at the border has yet to be documented, but it is clear that it is growing. As such, sustainable solutions are needed now more than ever. Lessons from other health crises have shown the value of collaboration across government and non-governmental players, as well as the advantage of engaging with those directly impacted by the problem. A comprehensive response that addresses the acute and chronic health needs of asylum seekers is urgently needed to mitigate morbidity and mortality among this vulnerable population. ■



## RESUMEN EJECUTIVO

**H**ay una crisis de salud pública en la frontera norte de México. El aumento de la violencia en los países de origen de solicitantes de asilo y las recientes políticas migratorias que restringen la entrada de migrantes a los Estados Unidos han generado que un número sin precedentes de personas se acumule en la frontera. A medida que este número crece, los recursos necesarios para proporcionar servicios de salud básicos van siendo limitados.

Cuando los solicitantes de asilo llegan a la frontera entre México y Estados Unidos, muchos de ellos ya han tenido experiencias traumáticas tanto en su país de origen, como durante sus trayectorias migratorias. Las situaciones en las que viven, mientras esperan su proceso de asilo, hacen que los migrantes sean vulnerables a nuevas infecciones y situaciones de violencia; agravando así sus condiciones de salud. Vivienda inadecuada obliga a los solicitantes de asilo a permanecer en albergues sobrepoblados, habitaciones rentadas o campamentos informales, donde frecuentemente carecen de acceso suficiente a servicios sanitarios básicos poniéndolos en riesgo de adquirir enfermedades infecciosas. Con frecuencia, las enfermedades no transmisibles no son diagnosticadas y por tanto no son tratadas. Los problemas de salud mental también son muy frecuentes. La alta actividad criminal y la violencia en muchas ciudades a lo largo de la frontera amenazan la salud física y mental de los solicitantes de asilo, creando barreras adicionales que limitan que se busque atención. Como resultado de la poca acción del gobierno, la provisión de atención médica ha recaído principalmente en organizaciones no gubernamentales y de beneficencia. Si bien éstas satisfacen una necesidad crítica, la ausencia de un enfoque estandarizado para la prestación de atención médica ha llevado a una atención de salud inconsistente e inadecuada.

El alcance total de la crisis de salud en la frontera aún no se ha documentado, pero está claro que se está agravando y ahora más que nunca se necesitan soluciones sostenibles. Las lecciones de otras crisis de salud han demostrado el valor de la colaboración entre actores gubernamentales y no gubernamentales, así como la ventaja de incluir a las personas directamente afectadas por el problema. Por tanto, se necesita con urgencia una respuesta integral que aborde las necesidades de salud de los solicitantes de asilo para mitigar la morbilidad y mortalidad entre esta población vulnerable. ■



## I. INTRODUCTION

For decades, families, adults, and unaccompanied children have been traveling to the northern Mexico border to apply for protection from violence and harm—a right guaranteed under U.S. law.<sup>1</sup> Changes to the United States asylum policies in mid-2018 have slowed and limited asylum processing, resulting in a growing number of asylum seekers waiting along the northern Mexico border.<sup>2</sup> Since January 2019, more than 64,000 asylum seekers, predominantly from Mexico and Central America, have been sent back to Mexico to await their asylum hearings under the Migration Protection Protocols, also known as “Remain in Mexico.”<sup>3</sup> Meanwhile, the practice of “metering,” or limiting how many people can seek asylum at the border each day, has forced tens of thousands of additional migrants to wait along the northern Mexico border.<sup>1</sup>

Debates over immigration policies and practices are ongoing, but the growing physical and mental health implications have received less attention. In order to better inform humane policies, allocate resources, and decrease stressors on health systems along the border, there is an urgent need to better understand the immediate impacts of overcrowding, poor sanitation, and lack of access to health services for asylum seekers. An assessment of the long-term effects of chronic stress, violence, and idleness experienced by asylum seekers, especially children, is also necessary to inform context-specific interventions.

This report aims to provide a foundation for addressing these concerns, by collating the available information on the health situation of migrants along the northern Mexico border. Findings are based upon data collected by international NGOs, reporters, and service providers, and are augmented

with testimonials from individuals on the Mexican border who were interviewed for this report. This report focuses exclusively on the experiences of migrants along Mexico’s northern border with the U.S., though there remains a critical need for additional information on the specific health needs of those crossing Mexico’s southern border. It is important to note that migrants are spread across the nearly 2,000-mile northern border, and throughout Mexico, and each State faces unique challenges in providing services to migrants.<sup>4</sup> Additionally, within this report, the terms *asylum seeker* and *migrant* are used interchangeably. While there is a legal distinction between an asylum seeker and a migrant, both are used to give variety to the prose throughout the report. It is also recognized that there are people at the border who may be entitled to refugee protection but have not been able to claim asylum formally. ■

## II. BACKGROUND

An unprecedented number of asylum seekers are gathered along the northern Mexico border seeking entry into the United States. The drastic increase in the number of asylum seekers waiting along Mexico’s northern border is predominantly driven by two contributing factors: a rise in the number of people fleeing poverty and violence in their home country, and new U.S. policies meant to deter migrants from seeking asylum within the U.S.<sup>5</sup> While the total number of Central Americans crossing the border without proper authorization reached record highs in mid-2019, the number of migrants seeking asylum at official border crossings has remained consistent.<sup>6</sup> It is believed that this spike in unauthorized crossing is in large part driven by the long wait times to apply for asylum. Although a majority of migrants come from Northern Triangle of Central America (NTCA) countries,

others also arrive from South America, the Caribbean, Africa, and Asia.<sup>7</sup>

### Policy Changes and Implications

The Trump administration has enacted policies and encouraged practices that have had direct and immediate negative impacts on the health and safety of asylum seekers. One such practice is “metering,” which restricts the number of migrants permitted to request asylum at a U.S. port of entry each day.<sup>2,8</sup> Metering requires asylum seekers to wait in Mexico until it is their turn to claim asylum. This practice was used briefly in 2016 when thousands of Haitian migrants arrived at the border; however, the Trump administration has instituted it extensively and consistently.<sup>2</sup> In November 2019, an estimated 21,000 individuals were waiting to claim asylum at U.S. ports

of entry across 11 border cities due to metering.<sup>1</sup> Wait times vary based on location and may be as long as 6 months; this procedure contrasts sharply with the approach to processing prior to the enforcement of metering, in which migrants generally had no delay when requesting asylum at a port of entry.<sup>1,9</sup>

Less than a year after reinforcing the practice of metering, the Trump administration instituted the Migrant Protection Protocols (MPP), also known as the “Remain in Mexico” policy. Unlike metering, MPP applies to asylum seekers who have already been received and inspected by the U.S. government, and are going through the legal process of claiming asylum. Instead of remaining within the United States for their legal proceedings, as had been standard practice, the MPP policy sends these individuals to Mexico and instructs

them to return to an assigned port of entry at a specific date and time for their next court hearing.<sup>1,10</sup> Since January 2019, the U.S. government has sent over 64,000 individuals to Mexico to await their legal proceeding including at least 16,000 children and 500 infants under the age of one year.<sup>11-14</sup> Of these individuals, only 537 have been granted leave to stay in the U.S., and less than 6% have been able to obtain legal representation.<sup>3,15</sup> A report by the U.S. Immigration Policy Center found that for those sent to Mexico under MPP, the average wait time is 88.6 days before their initial immigration court date.<sup>16</sup> While the Trump administration has repeatedly claimed that the implementation of MPP was a success, it has undoubtedly amplified the health crisis on the Mexican side of the border.<sup>17-19</sup>

The Mexican government initially resisted the MPP policy, as the U.S. Department of Homeland Security (DHS) gave Mexico the responsibility for providing “all appropriate humanitarian protections” for the asylum seekers.<sup>20</sup> Under pressure from the U.S. government and amid threats of a substantial increase in trade tariffs, Mexico acquiesced. The Mexican government has, in turn, taken steps to reduce the movement of immigrants into and through the country. For example, the government of Mexico militarized its borders, positioning 15,000 troops on the northern border and 6,000 on the southern border, creating a bottleneck for many hoping to enter the U.S. through Mexico.<sup>21</sup> Further, the government limited the number of humanitarian visas, which had allowed migrants to enter and exit Mexico within a fixed number of days, and restricted the work visas only to states in southern Mexico.<sup>22,23</sup> These actions are contributing to a shift in Mexico’s relationship with migrants, as it shifts from a transit to a receiving country. Despite such actions, tens of thousands of asylum seekers have amassed along the country’s northern border to seek entry into the U.S.

## Migrant Journey

Before arriving at the northern Mexico border, many asylum seekers are exposed to violence and trauma, both in their home country and on their journey to the border. A study by Medecins Sans Frontieres (MSF) of migrants from NTCA countries found that half cited violence as at least one reason for fleeing their home country.<sup>24</sup> Along their journey to the northern border, asylum seekers are exposed to kidnapping, assault, robbery, and extortion by criminal gangs and, at times, by police and immigration officials.<sup>25</sup> Every year as many as 20,000 migrants are kidnapped, earning criminal gangs an estimated \$50 million annually.<sup>25</sup> Women are particularly vulnerable to sexual assault; a study conducted by MSF found that one-third of women surveyed reported being sexually abused during their journey to the U.S.<sup>24</sup> Such violence and trauma can have long-term implications for both physical and mental health.

## Arrival at the U.S.-Mexico Border

As migrants gather at the border, cities in the region are experiencing a spike in demand for basic services, including food, shelter, clean drinking water, toilets, and medical supplies.<sup>26</sup> A large number of migrants live in shelters run by faith-based organizations, commonly known as *casas de migrantes*.<sup>27</sup> Shelters remain underfunded and overburdened, unable to meet the growing demand.<sup>28</sup> As a result, some *casas de migrantes* have been forced to make desperate compromises, rationing meals, charging room and board, or delegating shelter management to migrants who act as unpaid workers.<sup>28</sup> In response to overburdened civil society shelters, a federally-operated shelter located in Juárez was opened in August 2019, with capacity for approximately 4,000 people.<sup>29,30</sup> Since the beginning of 2020, the shelter has recorded the arrival of over 5,000 migrants, a quarter of whom were sent back by U.S. authorities in the first three weeks of March alone.<sup>29,31</sup>

To date, this shelter in Juárez, as well as one opened in December 2019 in Tijuana, are the only two federally operated shelters along the northern border.

Insufficient housing has resulted in the creation of large-scale, makeshift tent encampments, exposing migrants to extreme weather, unsanitary conditions, and violence.<sup>32-34</sup> Some migrants choose to stay in tent encampments near the border, as opposed to a shelter, due to a fear of deportation or missing their place in line to apply for asylum if they are not present when their turn is called.<sup>32,35</sup>

While some asylum seekers are able to rent rooms, they are often overcrowded, costly, and located in unsafe neighborhoods.<sup>4</sup> As a result, many fall into homelessness, squatting in abandoned buildings, or sleeping in the streets. While statistics vary by location, a survey by the U.S. Immigration Policy Center in October 2019 found that more than one third of all migrants reported having experienced homelessness while waiting in Mexico, including a third of people with children under the age of 18 years.<sup>16</sup> ■



### III. HIGH-RISK POPULATIONS

The profile of the typical migrant traveling to the U.S. has changed significantly in recent years. In 2012, 90% of apprehended migrants were single adults. In 2019, this was down to 35% of migrants, with the majority being persons in family units or unaccompanied minors.<sup>7</sup> Of family units that were apprehended, mothers were the head of nearly half.<sup>7</sup> While most asylum seekers face grave danger both during their journey to enter the U.S. and at the border while awaiting entry, some groups are at even greater risk due to age, health conditions, gender, and sexual identity. While limited data currently exist on these populations, lessons from other humanitarian crises have shown their unique vulnerability.<sup>36,37</sup>

Children, for example, are a particularly high-risk group. In 2019, U.S. Customs and Border Protection (CBP) apprehended a record-setting 76,020 unaccompanied minors along the U.S.-Mexico border, a 52% increase from 2018.<sup>38,39</sup> The lengthy

stay at the border, coupled with unsafe conditions, has forced some migrant parents and guardians to send children to the U.S. alone, as children are protected from being sent back to Mexico under MPP.<sup>40,41</sup> Yet, there is evidence that once children arrive in the United States, they are still not safe from harm. From 2015 - 2018, over 4,500 unaccompanied minors reported sexual abuse while in government custody; of these, over 1,300 cases were referred to the FBI for further investigation.<sup>42</sup> Staff abuse remains an ongoing and overlooked problem; nearly 200 cases of shelter staff abusing a minor in their care have been reported, and this is likely an underestimate of the true burden.<sup>42</sup> Between 2018 and 2019, seven children died in U.S. immigration custody from infectious diseases, including the flu, after a decade of no such reports.<sup>43,44</sup>

Despite the MPP policy's exemption for vulnerable populations, lesbian, gay, bisexual, transgender, and intersex (LGBTQI) asylum seekers are still sent

to Mexico with little regard for their safety, even when they have suffered previous incidents of violence.<sup>45-47</sup> Local and private initiatives have sought to create safe spaces for LGBTQI asylum seekers including safe living conditions, access to healthcare, and legal aid, but provision is unreliable due to limited resources. Additionally, LGBTQI migrants have reported harassment from both local populations and other migrants, further perpetuating the marginalization of this group.<sup>48,49</sup>

Other high-risk groups include mothers and pregnant women, as prenatal care is generally not available in shelters, and pregnant women report feeling unsafe during their search for care.<sup>50</sup> Additionally, most shelters and facilities are not fully accessible for people with disabilities and there is a lack of social support for asylum seekers with physical and mental special needs.<sup>51</sup> ■

### IV. DISEASE BURDEN: CONTRIBUTORS AND CHALLENGES

Migrants at the northern Mexico border are subject to a gamut of communicable and non-communicable diseases. Illnesses can range from acute injury or infectious diseases acquired along the journey or on the border, to unmanaged chronic pre-existing conditions. At the government-run shelter in Juárez, over 85% of asylum seekers entering the facility were recorded as having health problems during their basic entry exam.<sup>51</sup> Healthcare capacity in many border states is limited and of variable quality, and facilities are ill-equipped to diagnose and treat the needs of the population.<sup>52</sup>

#### Communicable Disease

As a result of scant access to basic sanitation and overcrowded living conditions, infectious diseases such

as measles, cholera, tuberculosis, chickenpox, scabies, respiratory infections, rashes, and eye infections have all been reported.<sup>53-55</sup> Some shelters are accommodating migrants at three times their capacity,<sup>4</sup> and, as a result, do not have enough toilets or showers. In one extreme case, a shelter that is hosting over 300 migrants has only two restrooms.<sup>4</sup> The spread of disease has had a direct impact on housing availability; for example, a chickenpox outbreak at the federal shelter in Juárez led them to close their doors to new residents for nearly two months.<sup>56,57</sup>

Migrants living in tent encampments are particularly vulnerable to infectious diseases due to a lack of potable water and inadequate shelter. In a report by the aid organization Global Response Management (GRM), the most common ailments reported in the Matamoros

encampment included headaches, upper respiratory complaints, and gastrointestinal illnesses.<sup>58</sup> The Matamoros encampment's 2,500 residents share only a handful of outdoor showers and portable toilets, which have at times overflowed with human waste.<sup>32,59</sup> Before the provision of outdoor showers, many people were bathing in the Rio Grande,<sup>50</sup> which is known to be contaminated with *E. coli* and other harmful bacteria.<sup>32</sup> Insufficient access to clean water has also resulted in dehydration and heat stroke.<sup>60,61</sup>

Asylum seekers are at risk for the seasonal flu, and while efforts to provide flu vaccines in shelters are ongoing, many have been hampered by supervision regulations and the storage requirements of the vaccine.<sup>55</sup> In addition, U.S. CBP has refused to provide flu vaccines to detained

migrants before sending them to Mexico.<sup>62</sup> Infections and outbreaks have caused increased stigma and refugee isolation; the Trump administration has often repeated the unfounded claim that migrant populations pose a public health threat by bringing dangerous communicable diseases to the U.S.<sup>53</sup>

## Non-communicable Disease

Non-communicable diseases are pervasive among asylum seekers, but are often overlooked or not appropriately diagnosed and treated due to a lack of consistent screening.<sup>51</sup> Among the 2,500 people living in the Matamoros encampment, it is estimated that 25% of people have underlying chronic health conditions, such as diabetes or hypertension, and many people are malnourished or chronically dehydrated.<sup>63</sup> On top of this, life-saving medications for diseases such as heart disease and asthma are routinely confiscated by CBP officers, and it can take days, if not weeks, to obtain a new prescription.<sup>64</sup>

Inconsistent care and the absence of an established protocol for initial health screenings has had devastating consequences. Anecdotes include a failure to diagnose a child's congenital heart defect, which ultimately led to heart failure and a stay in the ICU,<sup>65</sup> as well as a woman with multiple chronic conditions who lost her eyesight after four failed attempts to request a medical

exemption to enter the U.S.<sup>15</sup> Similar stories of migrants' chronic conditions being undiagnosed and left untreated are commonplace; inconsistent initial screening protocols, language barriers, and a fear of identifying pre-existing conditions are all obstacles asylum seekers face at the border.<sup>51,65</sup> Human Rights Watch found that asylum seekers with disabilities and chronic health conditions were rarely provided with sufficient information about how they could access healthcare.<sup>51</sup>

In addition to underdiagnosis and misdiagnosis of existing conditions, living environments increase migrants' risks for new chronic conditions. For example, long-term exposure to smoke and dust from the burning of trash and human waste, as well as cooking on open cookstoves, puts migrants at increased risk of chronic respiratory illness, among other diseases.<sup>32,66</sup>

## Violence and Criminal Activity

Many asylum seekers have been subjected to violence in their home country, on their journey to the border, and at the border, including homicide; rape; kidnapping; extortion; theft; physical and sexual assault; and torture.<sup>4,60</sup> From 2014 to 2018, at least 4,000 migrants died or went missing during the journey to the northern Mexico border to claim asylum.<sup>67</sup> As of January 2020, there have been more than 1,114 publicly

documented cases of such crimes committed against individuals returned to Mexico under MPP.<sup>12</sup> Among these, there are 265 cases of children who were kidnapped or nearly kidnapped after being sent to Mexico. Additionally, the U.S. Immigration Policy Center found that approximately a quarter of migrants had been threatened with physical violence while waiting in Mexico for their court dates, with over half of those reporting that the threats resulted in actual experiences of violence.<sup>16</sup> Although much of this violence is perpetuated by cartels and criminal gangs, state actors have also been reported to commit such crimes.<sup>68,69</sup>

Living conditions on the border further increase the risk of physical violence. Despite the valuable services offered by *casas de migrantes*, there have been reports of mistreatment and dangerous living environments within shelters. These have included withheld donations, physical violence, and sexual assault.<sup>28</sup> In addition to crime within shelters, many asylum seekers express fear of the communities in which the shelters are located. Visits to hospitals and trips to purchase supplies leave migrants fearful for their safety.<sup>70,71</sup> In response, some *casas de migrantes* are kept "closed," preventing residents from going in and out of the shelter until they are ready to permanently move out.<sup>5,71</sup>

Migrants returned under MPP have little control over the port of entry at which they can apply for asylum, and must often wait in communities with very high levels of violence. For example, thousands of migrants must wait in Matamoros and Nuevo Laredo within the state of Tamaulipas, for which the U.S. State Department has issued a "do not travel" warning, the same warning given for North Korea and Syria.<sup>72</sup> As a result of border region instability, some migrants have been forced to abandon their court cases, and others have missed their court hearings because they were kidnapped or had their paperwork stolen.<sup>1</sup>

Here in Mexico, at the shelter, what can we do? I am fearful and frightened all the time. I do not know anyone, and I do not know what the future holds. I fear for my children, I fear that they will suffer. A couple of days ago, my little one had a very bad cold. Yes, they support us at the shelter, but it is difficult with so many people. I feel unsafe, even at the shelter.

Rebeca, age 32, Honduras

## Mental Health

Living with uncertainty at the border causes stress and fear for migrants. Coupled with violence, stress can exacerbate existing trauma and trigger mental health problems. Being sent back to Mexico under MPP has been described as a “catastrophic stressor on health” for migrants; time spent waiting is associated with an increase in complex mental health issues.<sup>68</sup> Individuals who are returned to Mexico after requesting asylum in the U.S. suffer considerably higher rates of psychiatric problems compared to non-migrant Mexicans, even when accounting for pre-migration health and other risk factors.<sup>73</sup>

Clinical assessments of asylum seekers in Tijuana found that more than three-quarters of interviewees suffered from post-traumatic stress disorder (PTSD), and over 65% of interviewed children displayed symptoms of PTSD.<sup>68</sup> While appropriate trauma-informed care for PTSD should focus first on establishing safety, this is nearly impossible given the security issues and uncertainty experienced by asylum seekers.<sup>74</sup>

Minors under the age of 18 years are particularly vulnerable to mental health problems associated with their migration experience. Studies have found a high prevalence of depressive symptoms

among minors seeking asylum, ranging from 14% to 40%,<sup>75</sup> compared to 3.2% in the U.S.<sup>76</sup> Forensic interviews conducted by Physicians for Human Rights found that over three-quarters of minors had survived physical violence, 60% of which was gang-related, and 18% had survived sexual violence. Of this same cohort, more than three quarters were suspected to have or were diagnosed with at least one mental health issue, including PTSD, depression, and anxiety disorder.<sup>77</sup>

Despite a high need for mental health and psychosocial services, care delivery is thwarted by pervasive understaffing and the transient nature of the population. This is consistent with other health and humanitarian crises, in which the need for such services is acknowledged, but service provision is perceived to be too difficult or expensive to implement.<sup>78</sup> Health providers working with MSF, the only humanitarian organization offering mental health counselling to the residents of the Matamoros encampment, are often only able to have one-time sessions with migrants.<sup>79</sup> In the absence of qualified mental health providers, other medical providers without training in mental health are forced to try to fill this need.<sup>80</sup> ■

I am seriously thinking of going back to my country. What am I doing here? I am afraid that I could be kidnapped, I am afraid that a drug cartel may kidnap me and kill me. What is going to happen to my body? The cartel is just going to dispose of it, to leave it anywhere. Here nobody is going to care. If I returned to my country and died there, at least there someone is going to care, they are going to have a wake for me ... Thus, we have no choice other than to return to our home country even if we return with the fear or the risk that we could get killed back home.

Rocio, age 24, Honduras

## V. ACCESS TO HEALTH SERVICES

The influx of migrants in cities along the border further strains an already overwhelmed health system. In three border States, the physician to population ratio is approximately 0.6 to 1,000; compared to 2.35 per 1,000 across all of Mexico.<sup>81,82</sup> Relative to other countries, Mexico performs poorly on many quality of care indicators, including mortality due to myocardial infarction, amputations in diabetic patients, and avoidable hospital admission.<sup>83</sup>

MPP states that it is the responsibility of the Mexican government to care for

the needs of asylum seekers waiting in Mexico for their court date.<sup>84</sup> In practice, however, this responsibility of providing protection, support, and humanitarian assistance has fallen on the shoulders of faith-based organizations and NGOs. Mexican law gives asylum seekers the right to access the country’s public hospital system through Instituto de Salud para el Bienestar (INSABI), a government agency that provides medical services to those not covered under social security, yet the proportion of asylum seekers who are utilizing INSABI remains unknown.<sup>85</sup> Obstacles to acquiring

necessary documents is suspected to be a limiting factor. Interviews with staff at *casas de migrantes* suggest that a lack of coordination and information from the Mexican government has contributed to challenges with documentation. Beyond documentation, safety concerns, restricted movement, potential costs, and other obstacles can prevent asylum seekers from visiting hospitals.

Even when care is accessed through the public health system, it is often poor quality; there are reports of patients being discharged prematurely, leading to fatal or near-fatal injury, or

It is believed that there are 11 shelters providing support. All with different capacities to respond to the situation. This means that access to basic health care varies depending on the resources available. Furthermore, we are aware that there are people that have found other ways to remain at the border, hiding somewhere, but have no contact with organizations that can provide support. All people are vulnerable, but people that have no contact with shelters or organizations providing support are even more at risk.

**Calvillo, Shelter Director**

being misdiagnosed.<sup>15</sup> Additionally, some hospitals lack essential medications, and when they are available, migrants are often expected to pay, which can be costly.<sup>86</sup>

In the absence of a robust governmental response to address the health needs of asylum seekers, non-governmental organizations, local charities, and volunteer medical professionals have stepped in to fill the gap. For those living in tent encampments, health services are provided by a broad range of providers. INGOs provide targeted interventions to communities along the border; Médecins Sans Frontières (MSF) and Global Response Management (GRM) are providing some of the most robust services. Charities, such as Catholic Charities of the Rio Grande Emergency Assistance Program, are also playing an active role in providing health services through medical needs vouchers, medical consultations, and prescription assistance.<sup>87</sup> For those living in *casas de migrantes*, on-site care is provided through weekly visits by physicians who come from both NGOs and government-coordinated efforts.<sup>4,28,88</sup> Given that the responsibility to provide humanitarian assistance has been deflected to organizations outside the Mexican government, there remains ongoing concern about the lack of standards in the provision of care.

With civil society providing the majority of services,<sup>4</sup> cross-border collaborations have proven critical to providing essential health assistance. Various partnerships between U.S., Mexican, and internationally based organizations allow for the flow of medical resources and volunteers across borders to high-need communities. For example, the International Rescue Committee (IRC), based in the U.S., works with local partners in Mexico to support programming providing medical care, counseling, and legal services to women and girls who have experienced

violence.<sup>89</sup> Additionally, the Kino Border Initiative (KBI)—a binational organization based in Nogales, Arizona and Nogales, Sonora—offers first aid care, among other services, while collaborating with organizations, parishes, and individuals on both sides of the border.<sup>90</sup> Healthcare providers from both sides of the border have volunteered their time to care for migrants, creating the concept of ‘borderless medicine.’<sup>80</sup>

Despite the efforts of these entities to provide care, substantial unmet needs remain. Even when health services are technically available, xenophobia and racism, particularly targeting African migrants, have resulted in individuals being denied medical services.<sup>62,91</sup> Low health literacy, language barriers, stigma, restricted movement, and safety concerns are also deterrents to using health services.<sup>4,52,92</sup> Physicians have worked alongside lawyers to request that patients in need of urgent care receive treatment in the U.S. However, these requests are only made in the most severe cases out of fear that the privilege may be revoked; as a result, life-saving care is often delayed.<sup>93</sup> ■

For migrants not receiving assistance in the Federal Shelter access to information became more complicated. [My organization] distributed flyers and handouts with information about access to health services, but the reach is always limited. In all, the government has not been able to properly inform asylum seekers and migrants about how and where to access medical and other services.

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## VI. RECOMMENDATIONS

The health crisis at the northern Mexico border shows no signs of abating. The healthcare system is already stretched thin, and the reliance on non-governmental actors to fill the need is not sustainable. Indeed, the COVID-19 pandemic has already demonstrated how external shocks can quickly change the dynamic at the border and undermine the limited care that is being provided to asylum seekers. Lessons from other health crises have shown the value of collaboration across government and non-governmental players, as well as the advantage of engaging with those directly impacted by the problem. A comprehensive response that addresses the acute and chronic health needs of asylum seekers is urgently needed to mitigate against preventable morbidity and mortality among this vulnerable population. The following recommendations are made:

### GOVERNMENT OF THE UNITED STATES:

1. **End the Migrant Protection Protocols and metering practices** in favor of policies and practices that do not put the health and safety of migrants and asylum seekers at risk.
2. **Provide clear, consistent, and enforceable guidance regarding the populations considered “high-risk”** and therefore exempt from MPP. For example, exemptions should extend to unaccompanied minors, pregnant women, LGBTQI individuals, and individuals with physical and mental disabilities.
3. **Reinstate family case management systems**, which have proven successful in the past, as a more humane alternative to detention or MPP.
4. **Call on Congress to defund the Migrant Protection Protocols and allocate additional resources** for hiring of immigration judges and providing legal counsel.

### GOVERNMENT OF MEXICO:

5. **Proactively coordinate non-governmental and governmental actors, including NGOs and charities**, to inform a standardized and comprehensive response to the health needs of asylum seekers, from the time they arrive to the time they leave the border.
6. **Increase federally supported accommodation capacity** to reduce vulnerability to violence and disease among asylum seekers living outside shelters and to increase access to physical and mental health services.
7. **Develop a long-term, strategic plan for providing healthcare** to asylum seekers living on the northern Mexico border.
8. **Mobilize services to provide mental health support and training**, as untreated trauma could have both immediate and long-term consequences on the well-being of asylum seekers.
9. **Improve access to toilet and bathing areas**, including ensuring such areas are well-lit and secure in order to reduce vulnerability to violence for asylum seekers living outside shelters, especially women and children.
10. **Increase engagement between civil society organizations providing services and local Mexican policy leadership** to improve transparency of the key barriers to providing care.
11. **Engage asylum seekers in response plans and activities** to ensure interventions are appropriately tailored to address the most urgent health needs.

### NON-GOVERNMENTAL ORGANIZATIONS, CIVIL SOCIETY ORGANIZATIONS AND ACADEMIC CENTERS:

12. **Create context-specific educational materials for asylum seekers, while strengthening the capacity of religious leaders to deliver information** on the health-care rights of migrants and the services that are available to them.
13. **Advocate against policies and practices being implemented in the U.S. and/or Mexico** that reduce standards in the provision of medical services and minimize safeguards for asylum seekers.
14. **Generate evidence to better understand the needs of “high-risk” populations at the border**, including unaccompanied minors, mothers and pregnant women, people with disabilities, and the LGBTQI community.
15. **Encourage capacity-building and scale-up of existing infrastructure** as opposed to funding and supporting short-term and isolated initiatives. ■

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