Intersectionality, racism, and mental health of migrants arriving at borders in Latin America: a qualitative study based on in-depth interviews with key informants of the cases of Ecuador and Chile

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Summary

Background Migration is a social determinant of health, as human mobility is associated with the health outcomes of those who move. Social sciences research on migration and health needs to transition from an individual approach to models that reveal how place, processes of racialization, and structural elements impact immigrant health. We aim to describe, from the key informant's perspective in depth, the case of intersectionality, racism, and gender and related perceived effects on Venezuelan migrants' mental health at two relevant Latin American borders.

Methods The present study is a multisite observational cross-sectional qualitative project on two selected borders, the northern borders of Chile (Antofagasta, Iquique, Arica) and Ecuador (Tulcán, Nueva Loja). In-depth semi-structured interviews with key informants were collected in (n = 30) Chile from May to December 2022 and in Ecuador (n = 30) from October to December 2022. 22 participants were men, and 38 were women, and in-depth interviews were analysed using an inductive thematic approach.

Findings We found structural axes (i.e., socioeconomic, migration status, gender) of power that intersect in migrants' and refugees' conditions and experiences in their access to health and mental health care.

Interpretation We proposed the notions of intersectionality and racism to deliberately connect complex and dynamic concepts relevant to migrant and refugee health research, such as the racism faced by historically racialized populations based on their phenotypes, social class, and/or nationality and socioeconomic and gender inequalities.

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Introduction

Migration is a social determinant of health (i.e., human mobility is associated with the health outcomes of individuals and populations worldwide).[1,2] Globally, there are 272 million international migrants, representing almost 4% of the world's population. In 2021, there were 21.3 million refugees, 4.6 million asylum seekers, and 51.3 million internally displaced persons.[3] In this

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Research in context

Evidence before this study

We searched PubMed, Google Scholar, and SCOPUS for manuscripts that analysed qualitatively the inclusion of the intersectionality approach and that touched on ethnicity, class, and gender and how these elements may influence migrant's health, especially at borders in Latin America during the COVID-19 pandemic. We conducted this search from May 2022 to December 2023. We used the following terms ("migration" OR "social determinants of health") AND ("racism" OR "migrant health" OR "pandemic") AND ("mental health" OR "borders") AND ("intersectionality" OR "migrant health" OR "Latin America) AND ("decolonization" OR "structural racism" OR "internalized racism") among others. We did a first filter to avoid duplicated manuscripts. We only reviewed those manuscripts published in English and Spanish specifically conducted during the COVID-19 and the pandemic years (2020–2023) in Latin America. Our search identified 11 studies with those characteristics focused on the challenges that COVID-19 represented for migrants' and refugees' health in Latin America, with specific attention to mental health. We found the need for the inclusion of intersectionality in the study of health mobility at borders is fundamental to dismantling the apparent homogeneity of the migrant category and recognizing the vulnerability that some groups and individuals may experience. The research on migration and health needs to transition from an individual-based approach to models that reveal how place, processes of racialization, and structural elements such as violence, vulnerability, media, and immigration policies impact immigrant health.

Added value of this study

This study reveals that intersectional conditions faced by Venezuelan migrants during their migration journey and once they arrive in another country contribute to migrants' poor mental health (e.g., by placing them in a position where they are unable to access services to treat anxiety, depression, or other forms of psychiatric disorders). We are contributing to a broader analysis of how critical it is to combat racism in the health care of highly vulnerable populations such as refugees and migrants, as well as how imperative it is to consider the intersection between racism, social class, and gender to address and diminish inequalities and disparities among migrant in transit, but primarily in destination countries. The migration trajectories in Latin America are highly complex, and we do not expect to witness a reduction in the intricated migration journeys; on the contrary, the challenging political and social context may entail increased barriers to minorities, including migrants, displaced populations, and refugees in the region.

Implications of all the available evidence

The intersectional approach allows us to analyse multiple disparities and inequalities in which race is connected to other systems of social domination, such as class, gender, and sexuality, in a critical and historically situated manner. Intersectional and decolonial approaches deliberately connect complex and dynamic concepts relevant to migrant and refugee health research, such as the racism faced by historically racialized populations based on their phenotypes, social class and/or nationality, and socioeconomic and gender inequalities. It is critical to combat racism in the health care of highly vulnerable populations such as refugees and migrants in transit but also in the destination countries. In line with the above, key informants argued that health services face severe difficulties in meeting mental health needs and that there is a need to work on broader social protection measures, such as those that can be implemented in articulation with critical institutions like schools, community, and family systems.

scenario, the inclusion of intersectionality in the study of health mobility is fundamental to dismantling the apparent homogeneity of the migrant category and recognizing the vulnerability they may experience. Intersectionality is a theoretical approach that focuses on the intertwining of power relations among multiple structures, such as race, class, gender, and sexuality.[4,5] This approach makes it possible to comprehensively capture and address the influence of the intersection of these structural axes and the historical processes of the places and contexts in which they are produced.[5] The decolonial perspective, on the other hand, considers racism, constructed in the colonization of America by Europe in the 15th century, as the origin of capitalist class dynamics and heteropatriarchy.[6–9] Racism is understood as the foundational element of the socioeconomic and cultural system imposed by the colonial order, which acts as a mechanism of social domination of some human groups over others,[6] either because of their physical or phenotypic characteristics[10] or other markers such as their religion, nationality and/or migratory status.[11,12] This global system, which constitutes racism, manifests itself in social, economic, and cultural structures, as well as in the policies and norms that regulate access to social services such as health and education, and in the quality of services to which different social groups have access to.[6,10,13]

The decolonial approach makes it possible to visualize the historical continuity between the power relations involved in current mobility processes, and the colonial order under which the globalization of racism, capitalism, and patriarchy was inaugurated (e.g., the mobilization of precarious labour from the global south to the global north or zones of neoliberal development within the global south).[6] Moreover, an intersectional approach allows us to analyse multiple disparities and

inequalities in which race is connected to other systems of social domination, such as class, gender, and sexuality,[4,5] in a critical and historically situated manner.[6,7]

Migration and health research must move from an individual-based approach to qualitative and analytical models that reveal how history, place, processes of racialization, and structural elements such as immigration policies or the media affect immigrant health.[14–16] Intersectional perspectives allow for analysing structural social conditions in interaction with the individual's experiences. The historical, sociocultural, political, and economic circumstances in which people migrate impact different health outcomes.[6,7] Therefore, it is paramount to adopt anti-colonial/decolonial approaches to mental health, which recognize the influence of Eurocentric and racist cultural matrices, historically and socially constructed by the action of colonialism[6,8] and coloniality.[9] In turn, these frameworks help us understand how these permeate the understanding of subjects, normality, and abnormality, illness, and cure, and the very role of mental health professionals and disciplines (e.g., psychiatry and psychology) in contemporary contexts. The transformative power of critical approaches[4–7] can be harnessed to take a significant step towards achieving health equity.

The interaction between institutional conditions and practices and adverse experiences in transit and in the host countries negatively affects the mental health of migrants.[7,10,11] The confluence of these elements calls for a qualitative analysis of intersectionality and racism and possible every day or specific stressors faced by migrants and refugees in South America. This paper set out to explore qualitatively how intersectionality, particularly the axes of domination of race, gender, and social class,[12] and racism in a South–South migration context connects with the mental health of Venezuelan migrants and refugees in Chile and Ecuador, focusing on perceptions regarding health care to their mental health in conditions of mobility and border.

The Venezuelan diaspora

The Venezuelan diaspora has evolved in a scenario of complex Latin American and US and European power dynamics that have shaped structural dependencies.[12] After the "Bolivarian Revolution" in Venezuela, which challenged this order with openly anti-imperialist leaders, the government faced a severe social and economic crisis. Consequently, since 2010 a massive exodus of Venezuelans out of their country has taken place. To date, over 7 million Venezuelans live abroad: 2.5 million in Colombia, 1.5 million in Peru, and nearly half a million in Chile.[13]

The northern borders of Chile and Ecuador were two relevant borders in the Latin American region during the Venezuelan exodus. Chile closed its land borders with Peru and Bolivia in 2020 at the beginning of the COVID-19 pandemic. Hence, the migratory movement was cut off for almost a year and a half, and thousands of seasonal migrants remained in Chile and Ecuador for months before being able to return to their country of origin.[14] In this scenario, informal crossings became commonplace during the pandemic in South America and even afterwards. Sixty percent of irregular crossings reported since 2010 occurred between January 2018 and September 2020 in Chile, and the main nationality crossing Chile's northern borders was Venezuelan.[15] Similarly, Ecuador's northern land borders were closed in March 2020 and only reopened in 2022. Venezuelans are the main registered nationality entering through the northern border, and it is estimated that only 38.6% of Venezuelans living on the Ecuadorian side of the border are formally registered.[16]

Context: the Chilean and Ecuadorian northern borders

Chile's northern neighbours are Peru and Bolivia. The Chilean-Peruvian border extends 169 km and divides the cities of Tacna in Peru and Arica in Chile. A historic daily exchange of goods, services and people cross this border.[13] The border between Chile and Bolivia is more than 850 km long and divides the Bolivian departments of La Paz, Oruro and Potosí from the Chilean regions of Arica and Parinacota. This region is in the Atacama Desert, the most arid area in the world, with extreme conditions for living and traveling. Ecuador's northern neighbour is Colombia. International migrants in Chile represent 8.8% of the total population, with an essential presence of Venezuelans (33%), Peruvians (15%), Colombians (12%) and Haitians (11%).[17] There are approximately 200 thousand individuals with an irregular migration status in this country, which includes those who entered through an irregular crossing point or overstayed their visa.[18] Almost 70% of the migrants living in Chile have a job (i.e., formal or informal), but many of them (84%) are overqualified for the job they perform.[18] Although access to health in Chile is a universal human right, approximately 25% of the households do not have any medical health insurance. The regions of Atacama (35.3%), Coquimbo (35.5%), and Tarapacá (29.5%) have the least access to health that anyone with public health insurance should.[18] Mental health is considered an Explicit Health Guarantee (GES), which entails that anyone with public health insurance should have access to it. However, it is documented that for everyone, but especially for migrants with limited information and with other structural barriers, it is hard to access mental health services as only 2% of the entire health budget is destined for mental health disorders.[19,20]

According to the 2022 census, there were 16.9 million people in Ecuador. Of these, approximately 5% are foreign-born individuals.[21] An estimated 500,000 Venezuelans are currently in the country, with at least 268,000 having an irregular migration status.[22]

According to the Social Security Employment registry, as of December 2022, there were 3.68 million employed Ecuadorians, 21.330 Venezuelans, and 39.369 from other nationalities.[23] In other words, 21.8% of Ecuadorians are formally employed, while only 9.2% of Venezuelans are officially employed. Like unemployed Ecuadorians, unemployed migrants have access to the cost-free Ministry of Public Health facilities; however, this social system has a deficient number of psychologists (n = 248) and social workers (n = 46), so even the employed local population has limited access to mental health services.[24]

The Ecuadorian-Colombian border stretches 586 km, with two border controls, one in the Andes and the other in the jungle. The Rumichaca (Ecuador)-Nariño (Colombia) border is the main border crossing and place of trade with Colombia to and from Ecuador. Historically, the northern border has been marked by the coexistence of Colombians and Ecuadorians. For decades, Ecuadorian border towns have been a refuge for many Colombians who have resettled mainly because of the decades-long armed conflict in their country of origin or who have moved to access health and other social services. It is also, unfortunately, a typical passage for the smuggling of goods and drugs and human trafficking. Criminal groups dedicated to the sexual exploitation of girls, young women and adults routinely use these borders on their route to Ecuador and the rest of South America.[25] The purpose of this multisite qualitative study was to describe in depth the case of intersectionality and racism and related perceived effects on the mental health of migrants and refugees at two relevant Latin American borders.

This paper set out to explore qualitatively, from key informant's perspective (i.e., academics, members of civil society organizations, government, and local and international organizations), how intersectionality, particularly the axes of domination of race, gender, social class,[6] and racism in a South–South migration context connects with the mental health of Venezuelan migrants and refugees in Chile and Ecuador regarding migrant's health conditions of mobility and borders.

Methods

Description of the study

The present study is part of a multisite, observational and cross sectional study, on two selected borders, the northern borders of Chile (i.e., Antofagasta, Iquique, and Arica) (Fig. 1) and Ecuador (i.e., Tulcán, and Nueva Loja) (Fig. 2), whose purpose was to advance knowledge of the practical applications of human rights-based policies for highly vulnerable people (asylum seekers, refugees, displaced persons, undocumented migrants) during the COVID-19 pandemic in the Global South (Colombia, Ecuador, Peru, Bolivia, and Chile). The original project involved an extensive literature review of scientific and grey literature, an analysis of public policies aimed at the human rights of migrants, and a qualitative component based on ethnography and in-depth interviews.[26] This article focuses on the qualitative in-depth interviews conducted to key informants in Chilean and Ecuador. Qualitative methods allow us to understand social phenomena or events and researchers interpret the data collected and account for intersections and general patterns.[18]

Participant recruitment and data collection

The researchers and co-authors decided not to interview Venezuelan migrants to prevent revictimization and to hold ethical research standards given the critical context (i.e., COVID-19 pandemic and displacement) they were experiencing.[27] In-depth interviews with key informants from academia, governmental institutions, and local and international organizations were conducted in Chile from May to December 2022 and in Ecuador from October to December of the same year. Three participants refused to participate in Chile, and four in Ecuador. The main reasons were the need for more time or institutional permission to participate. Participants responded to a short sociodemographic survey, but we did not ask for information on their ethnicity. Four of the key informants interviewed in Chile were from Venezuela and Peru, and in Ecuador three of them were from Colombia. The semi-structured interview guide probed participants' opinions about Venezuelan migrants' access to health services and migrants' experiences upon arrival to Chile and Ecuador, including discrimination, mental health issues, and barriers to other social and health services.[28] For participant recruitment, we created a list of key informants in the health, governmental, academia, and social sectors from both countries who had worked for at least one year in such sectors and invited them by e-mail or telephone to an in-depth interview. We purposively chose experts in both countries who were part of the coauthors' networks, and we also used the snowball sampling technique by asking participants to provide peer contacts.[29] Chile's interviewer was a migrant researcher who has conducted extensive ethnography and qualitative work in multiple countries. This could have influenced the likelihood of participants responding more openly and trustworthy to outsiders.[30] In Ecuador, local researchers, who also had extensive experience and close ties to migrant organizations and institutions, conducted the interviews. These attributes could be associated with capacity of interviewing key informants and as well of the reflexivity and the deepness of the interviews' content.[31]

Study size

In total, 60 key informants agreed to participate (30 for each country). We conducted semi-structured online and face-to-face in depth-interviews. See Table 1 for details.

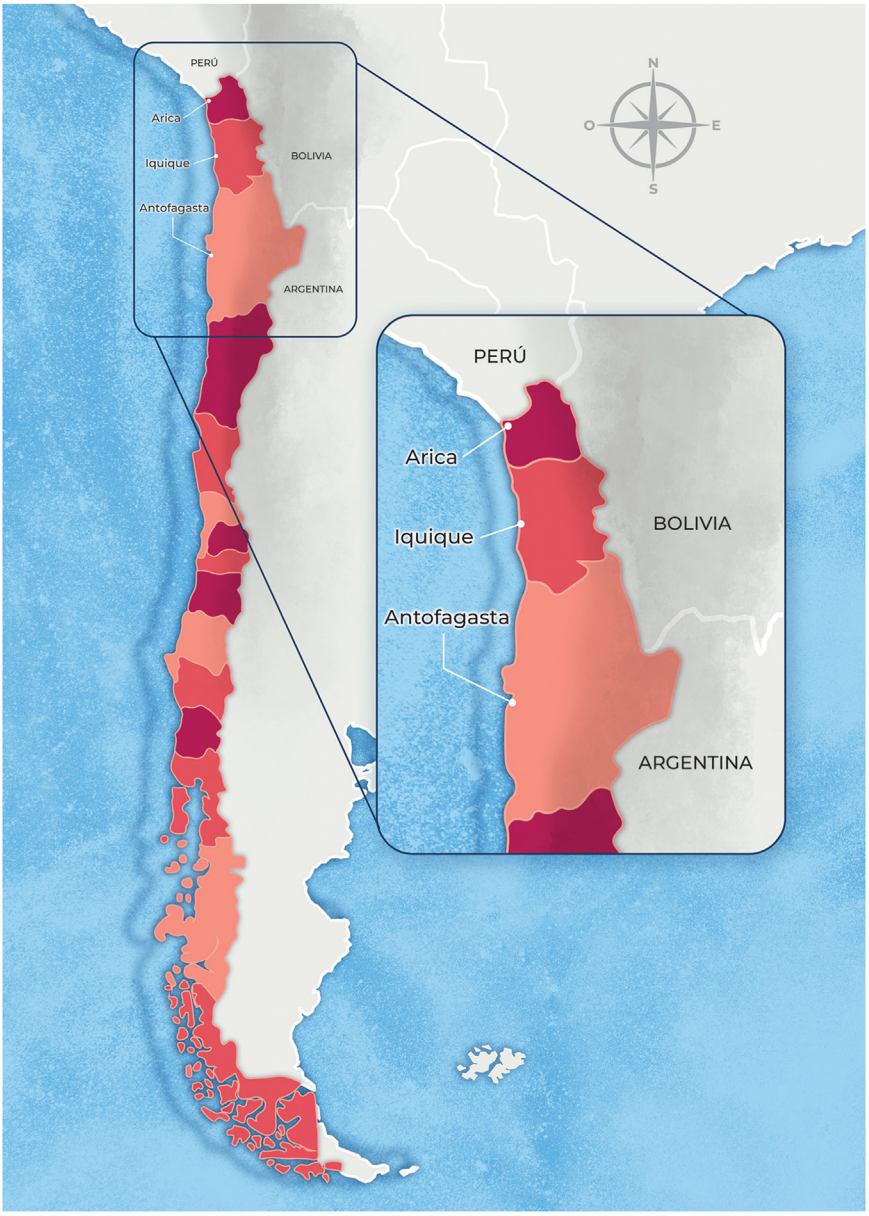

Fig. 1: Map I. Northern Border of Chile.

In total, 16 interviews were conducted in Chile via Zoom and 14 in person. In Ecuador, 15 interviews were conducted via Zoom and 15 in person. We interviewed 12 men and 18 women in Chile and in 10 men and 20 women in Ecuador. The interviews followed a semi-structured guide, which was designed and discussed by the co-authors thoroughly before conducting the in-depth interview, such guide included questions about their knowledge of the general situation on the Chile–Ecuador border during the COVID-19 pandemic, how it may have affected newly arrived migrants, their opinion of the human rights situation, and whether they had recommendations for improving access to health care for migrants in each country.

Ethics approval and consent to participate

This study's procedures were approved in Chile by the Universidad del Desarrollo, Chile, Ethics Committee (2021-90); and in Ecuador by the Institutional Review Board (2022-048E) of Universidad San Francisco de Quito and followed the Declaration of Helsinki guidelines. In Chile all 30 participants gave written informed

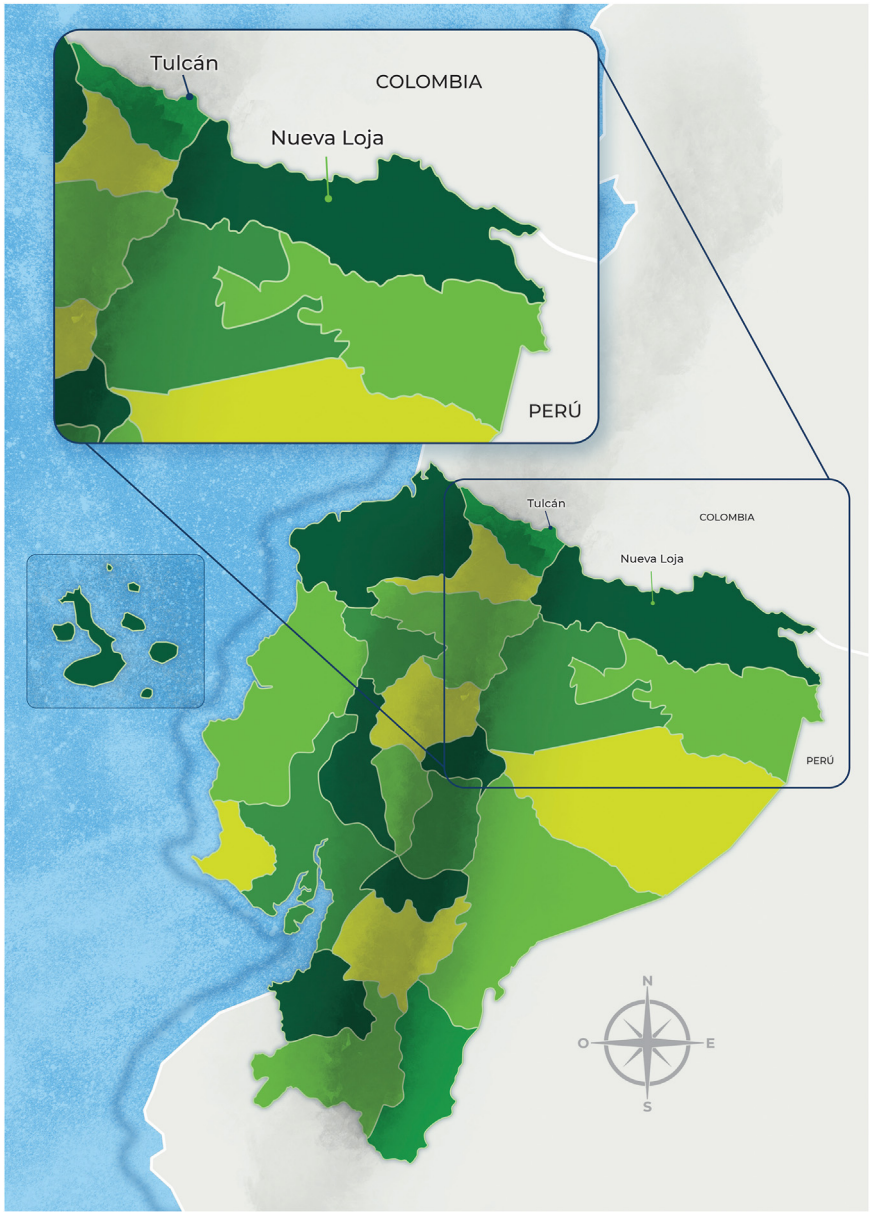

Fig. 2: Map II. Ecuador-Colombia Border.

	Chile (n)	Ecuador (n)	Total (N)
Local health sector	7	8	15
Academia	3	0	3
Civil society and NGOs	10	6	16
International NGOs	3	5	8
Government	7	11	18
Total	**30**	**30**	**60**

Table 1: **Key informants' sectors interviewed in Chile and Ecuador.**

consent to participate in this interview, and n = 28 accepted to have their voice audio recorded. The other two agreed to participate in the discussion and allowed us to take written notes but preferred not to be audio recorded. In Ecuador, the 30 participants gave written informed consent to participate, and all interviews were audio-recorded. We did not include any names or any information that could identify the participants. There was no compensation for this study's participants. However, we shared findings from this study by

sending a final summary report[26] to participants and presenting them in public seminars.

Data analysis

All audios of the in-depth interviews (N = 60) were transcribed verbatim by qualified personnel. To protect participant privacy, all personal identifiers were removed from the text. Data analysis followed an inductive thematic approach to identify major themes.[28] The transcription of all key informant's interviews were included in the analyses The authors created a codebook with main codes and subcodes, guided by the intersectionality and racism approach (which included the categories of gender, ethnicity, socioeconomic status, perceived power relations, and migrants' and refugees' experiences of mental health and health care in the two selected borders). The codebook was iteratively revised as data analysis progressed.[28] Manual coding was conducted using the Dedoose 9.0.54 online software.[32] Most of the coauthors (TRJ, BC, IT, DLC) coded the in-depth interviews and held regular meetings to discuss and agree on the coding strategy. As mentioned above, we also analysed field notes written during study site visits to understand the reality of intersectionality and racism and the mental health of newly arrived immigrants. All data analyses were conducted in Spanish and once completed, the study team translated relevant quotes into English.

Role of funding source

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Results

The results reveal that immigrants in an irregular situation face limited access to health care, which contributes to poor mental health. Migrants lack the financial means to care for their mental health and have difficulty generating these resources. The inability to access formal employment due to their migration status translates into informal jobs and lower socioeconomic status. Moreover, the intersectional conditions they face on the migration journey and in the country of arrival contribute to migrants' poor mental health (e.g., by placing them in a position where they are unable to access services to treat anxiety, depression, or other forms of psychiatric disorders). Gender plays a critical role in the conditions in which newly arrived migrants find themselves, in a context in which human trafficking and other criminal activities take place so that women face disproportionate risks of violence, illness, and trauma.

Intersectionality, racism and health at the borders

Below, we elaborate on the structural axes of power that intersect in the conditions and experiences of migrants and refugees on both borders in their access to health and mental health care and add some textual quotes on each to chart how our key informants perceive them.

Socioeconomic axis

A member of a well-known NGO in Chile mentioned that the local community prevents immigrants from obtaining a residency certificate and how this translates into a structural problem based on socioeconomic status:

> *"Neighbours do not want to provide migrants the residence certificate because of xenophobia. Thus, migrants could not register to the public health system. Those migrants come without money and without knowledge, or information of how to regularize their status, and that is enough to discriminate against them and try to make them leave since they cannot find any formal job. There was also a feeling that those migrants were going to keep the locals' jobs…it is highly complex, especially during a hard time like the pandemic" (NGO, Female Collaborator, Antofagasta, Chile).*

Making this segregation materially visible, in Iquique, Chile, a temporary migrant camp was set up in the middle of the desert, as migrants were homeless and living in public squares. This temporary solution further isolated the migrants, putting them in a particularly stressful situation and making it almost impossible for anyone living there to find work, as transportation options from the camp to the city were scarce and expensive.

Immigrants from Venezuela may be subject to discrimination due to perceptions of "jobs and resource" takers in Ecuador,[33] particularly in regions with a higher concentration of migrants from that country. For instance, a recent study found that young, low-educated Ecuadorian workers in these regions are experiencing reductions in employment quality and earnings and increases in job informality compared to workers living in areas with lower inflows of Venezuelan immigrants.[34]

As in Chile, migrants in Ecuador live poorly integrated with the host population and are concentrated in marginalised and impoverished areas of the main cities (e.g., Quito, Guayaquil). They go there mainly to earn income through informal jobs because they cannot be formally hired as they do not have regular documentation. According to an informant with 15 years of experience working with migrant populations in Ecuador,

contempt for these migrants due to their socioeconomic status is compounded by criminalization, the latter sponsored by state institutions.

> *Aporophobia implies discrimination based on economic status and "is suffered by the poorest or impoverished migrants" in Ecuador; in addition, the central government has "sponsored" an "institutional narrative" that crime has increased due to the arrival of foreigners in the country you can see it everywhere in the news, in the newspapers, it is hard not to perceive it like that (International NGO, Male Collaborator, Tulcán, Ecuador).*

Migrant status axis

The journeys faced by migrants due to restrictive migration policies entail dangers and traumas that are barely recognised in the host community (through the Atacama Desert in Chile, through jungles in Ecuador). The need for mental health services is evident to NGOs and health professionals on the other side of the border, but structural barriers and the myriad basic needs that must first be met relegate mental health to the bottom of the list of priorities.

In addition to the trauma migrants face during their perilous journeys, they suffer a range of rejections and mistreatment that increase the likelihood of depression or mental health problems. Mistreatment due to their "race", phenotypic characteristics,[27] nationality and/or migrant status,[35] as well as the limited capacities of local health services to meet the physical and mental demands of migrants, restrict their access to services such as counselling or mental health services. As the participants point out: *"This situation (poor access to health care) is more precarious at borders and when migrants first arrive in the cities of northern Chile. Furthermore, the capacity to attend and receive migrants was very limited at the time as we were dealing with the COVID-19 and everyone was scared" (NGO, Male Collaborator, Antofagasta, Chile).*

> *"We focus attention on the first basic needs for medical help, as migrants arrive with wounds, skin burns, and untreated chronic diseases that we forget the need for psychosocial care. During transit, they observe deaths, experience trauma, and hunger, and some of them are protecting their children and other people, which ends up generating an enormous amount of stress and anxiety. We tried to refer them to services and basic needs, but initially, we were overwhelmed and burned out" (International NGO, Female Collaborator, Arica, Chile).*

Medical staff in Ecuador mentioned that they observed migrants who had crucial mental health problems that may have existed prior to the migration journey (and may have been exacerbated or even triggered by it). However, health care does not take care of the mental health conditions of migrant populations: *"Being a forced migrant also takes its toll on mental health and, when they arrive, they are not treated as migrants but as a human being, man or woman in Ecuador" (International NGO, Female Collaborator, Tulcán, Ecuador).*

At the same time, in Ecuador, the services provided by the State (Ministry of Public Health) for the uninsured do not offer services aimed at migrants: *"We do not have a mental health or psychosocial support program designed to address the needs of mobile populations. It is not a matter of creating a specific program for this population group but of adapting and adapting what we have. It is a balance between a universal policy offering guarantees to all and universal coverage that recognizes particular or differentiated identities" (Male Consultant for an intergovernmental organization, Nueva Loja, Ecuador).*

In this regard, one of our participants points out that health personnel in Ecuador do not have the knowledge and skills to understand the specific needs of this recent Latin American migrants (hence the need to implement appropriate health programs for these populations): *"from a human rights perspective, health professionals need to understand better the potential barriers experienced by immigrants. The socioemotional burdens they face differentiate them from the local population, and therefore, the type of health care they receive should be adapted accordingly" (Ministry of Health Authority, Female Collaborator, Ecuador).*

Gender axis

Women face complex situations when crossing the border and arriving in the destination community. Participants mentioned that many of them came alone, pregnant, or about to give birth and had not received any preventive maternal health care throughout their journey. Several of them, especially those who crossed through irregular crossings, had nowhere to live or sleep and ended up homeless. This situation exposes them to a disproportionate risk of violence, illness, and trauma, compounded by any pre-existing medical conditions:

> *"A critical issue is how women experience precarity and mental health, especially in the aftermath of the COVID-19 pandemic and the economic crisis. They sometimes experience a double vulnerability, as women and mothers face dangers that men may not share that can trigger anxiety, guilt, and mental health problems. We have observed that helping women in street situations is fundamental, especially if they are pregnant or have children with them" (CESFAM, Female Doctor, Iquique, Chile).*

According to a key informant in Ecuador, gender as an axis of social oppression is not present in women's lives only when they arrive in the destination country. Rather, gender constitutes a factor of structural oppression, whose pernicious effects are present from the beginning of the migratory journey and on the way from the host country: *"structural gender structural*

discrimination against migrant women begins with the journey from their country of origin, through land transit and often irregular crossings, to the destination country, where they also experience the lack of family and other social networks" (Intergovernmental Organization Consultant, Female Collaborator, Tulcán, Ecuador).

Migrant women in an irregular situation also face the difficulty of denouncing an aggressor because they do not have the documentation to do so or fear deportation if they present themselves to a police agency. In addition, they may be victims of trafficking or sexual exploitation at some point in their migratory journey. This was the case of the temporary camp in Iquique: "*We have observed several domestic violence incidents, incredibly violent we had to call the police once. It is hard to know if they happened before arriving [to Chile] or if these are new cases with new partners; almost no one wants to denounce their perpetrators as they are afraid of possible consequences for their migration situation and their children… it is even less possible that they seek for professional or mental health in their precarious conditions" (NGO, Female Collaborator, Iquique, Chile).*

> *"We don't plan mental health, or psychosocial support thinking of the specific needs of mobile populations. It is not about creating a specific program for this population but about adapting and adjusting what we have […] recognizing different identities, whether I am talking about LGBTI populations or women" (Intergovernmental organization staff, Female Collaborator, Quito, Ecuador).*

Discussion

The intersectionality approach aims to show how various power structures, such as ethnicity, class, and gender, influence migrants' experiences. In this study, we proposed the notions of intersectionality and racism to deliberately connect complex and dynamic concepts relevant to migrant and refugee health research, such as the racism faced by historically racialized populations based on their phenotypes, social class, and/or nationality and socioeconomic and gender inequalities.[5,12,27,35,36] We analysed these issues in access to health and mental health care at the borders of Chile and Ecuador. Despite distant borders in South America, we identified similar complexities and challenges in migratory journeys[26,30] and similarities in the difficulties for migrants and refugees accessing mental health services. Thus, we describe intersectionality and racism operating interconnected in complex power relations across categories of social class, racial status and/or migratory status, and gender, and their profound effect on the mental health and health care experiences of migrants and refugees at the borders of the Latin American region.

As we illustrate in the results of this study, on both the Ecuadorian and Chilean borders, migrants face limited access to health care, especially if they are in an irregular migratory situation. The impossibility of formal employment translates into informal jobs and a deteriorated economic crisis (which, added to elements such as race and/or nationality), contribute to racism and xenophobia on the part of the host society. This situation has been widely documented in destination countries in North America and Europe (and more recently in some South American countries such as Chile). The COVID-19 pandemic further exacerbated these inequities, when it became more evident that migrants were not accessing vaccines and health care on equal terms with locals. A combination of both restrictive policies and misinformation about how and where to access vaccines and other primary care services are to blame.[31,37] It is important to remember that access to health care was limited across the board. Hence, tensions between migrants and locals were generally observed around the world.[38] Previous studies in Ecuador have shown that, within the public system serving the uninsured, the number and rate of health consultations among the local population have declined in recent years. In contrast, health consultations with foreigners have increased.[39] Thus, in the context of Latin American countries, given the significant resource constraints and persistent barriers to health care access and care, the arrival of migrants in relatively large numbers certainly poses a concern for the host countries.

The impact of racism and social class on the mental health of immigrants was a key finding of this study. In Ecuador and Chile, health personnel interviewed acknowledged that health providers in their countries rarely consider the impact on the mental health of immigrants who have left their country of origin and have often embarked on a difficult journey. Our findings reveal the existence of barriers to the provision of mental health care services, as well as little specialized training in the needs of refugee and migrant populations by local health care providers. Efforts are therefore needed to train healthcare personnel from anti-racist and intercultural approaches.[40] These approaches should recognise the historical nature of the racism faced by impoverished Afro-descendant, Indigenous, and/or mestizo populations in Latin America and the presence of a Eurocentric ideology that exalts whitening and despises local (Latin American) characteristics and manifestations, which has its roots in the European colonialism in force between the 15th and 19th centuries, and is deeply rooted in the contemporary social and cultural organization of Latin American nations.[41]

Our work shows that it is critical to combat racism in the health care of highly vulnerable populations such as refugees and migrants. Likewise, key informants argued that health services face serious difficulties in meeting mental health needs, and that there is a need to work on

broader social protection measures (e.g., those that can be implemented in articulation with critical institutions such as schools). For example, Canada has implemented a program for immigrants and refugees to access mental health services involving the school, community, and family systems.[33] This type of program could benefit immigrants and the local population since, as we have mentioned, mental health services are often limited in countries such as Ecuador and Chile. Like other countries in the Andean region, speaking Spanish may be considered a bridge between Venezuelan migrants and the local population. However, social markers of race and nationality (e.g., accent; skin colour) amplified by media and political/institutional actors are used to differentiate (otherize) Venezuelan migrants, which has led to instances of discrimination and xenophobia in Ecuador.[42–44] In our study, we observed how migrant women from Chile and Ecuador experience higher risks of violence, illness and trauma throughout their migration journey. Some of them, pregnant or about to give birth, had limited or no access to health care during pregnancy.[28] It is imperative to consider the intersection between racism, social class, and gender to address and diminish inequalities and disparities among migrant women in transit, but primarily in destination countries.[45] Furthermore, the intersection between gender-based violence and access to overall health services, with particular attention to mental health services. As supported by our testimonies, among migrants in Chile, there is an increase on reports of sexual abuse as well as in the suicidal ideations among women, in comparison to their male counterparts. However, this trauma does not translate into an increased demand in mental health services among this population.[18] The situation illustrates more profound vulnerabilities that migrant women face in the destination community where denouncing may not even be something that they consider plausible within the broader violent context in which they are embedded, let alone look for mental health assistance.[46]

Limitations and generalizability

We recognise the limitations of qualitative research, which does not seek causal inferences or generalize but is more interesting for comprehensively describing complex phenomena. This study was conducted in two different border settings in South America; therefore, the results may have limited scope of the reality of newly arrived migrants in these two countries. We acknowledge the possible bias of the testimonies included, as we did not interview Venezuelan migrants due to the context's complexity and to avoid revictimization; therefore, their experiences' perceptions and opinions may reflect only a part of the reality they went through. We also recognise that key informant' opinions on migrants' access to health services could have been enriched by asking about their ethnicity and racial identification (e.g., Indigenous, afro descent). However, we aimed to protect key informant's privacy in this study thus, we are not reporting any participant's personal disaggregated information. In addition, some of the in-depth interviews with key informants were conducted online, so the responses may be biased. However, this is the first study in South America that explores the mental health of migrants and refugees in Chile and Ecuador, with a focus on the perceived effects from an intersectional and decolonial approach. This approach shows the relevance of non-racist and intercultural health approaches in health interventions and policies aimed at migrants and refugees.[46] Our research can inspire other studies, improve it, and broaden its scope.

Conclusions

Historical racism in Latin America, in intersection with elements such as social class, nationality, and/or migrant status and gender, significantly affects the mental health of migrants and refugees in the northern borders of Chile and Ecuador. Qualitative research with intersectional and decolonial approaches is relevant for public health, as it allows an understanding of the interactions of different historical and power structures in the conditions faced by migrants in the Global South and, therefore, gives relevance to the need to implement relevant and migrant-centred, i.e., non-racist and intercultural, approaches in health interventions and policies aimed at migrants. Our findings have implications for the tension generated by much-needed anti-racist, intercultural, and inclusive health policies and practices in migration patterns affecting territories or people in the Global South.

Contributors

TRJ and BC conceptualized, did the formal analyses, and wrote the original draft. TRJ investigated and contributed to the methodology of the Chilean data. DLC and IT investigated and contributed to the methodology of the Ecuadorian data. MM validated the theoretical discussion and helped with the formal analysis. BC acquired the funding. TRJ, BC, DLC, IT, and MM reviewed, edited, and approved the final version of the manuscript. BC and TRJ had access to and verified the data.

Data sharing statement

The datasets generated and/or analysed during the current study are not publicly available because they include opinions and perspectives of key members of Chilean and Ecuadorian governmental institutions, local and international organizations. We promise privacy and confidentiality but are available upon reasonable request to the corresponding author.

Editor note

The Lancet Group takes a neutral position with respect to territorial claims in published maps and institutional affiliations.

Declaration of interests

The authors declare no competing interests.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.lana.2025.101040.

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