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COMMENT

Health and access to care for refugees, asylees, and unaccompanied children

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INTRODUCTION

There are many reasons a family may leave their home country, including better opportunities for their children, available work, climate, and fear. While opportunities exist for people to immigrate to the US, an immigrant is often required to have a desirable occupation or skill, is a citizen of a specific country, have employer support in the US, and sufficient time to wait for the current lottery-based process. However, children who are fleeing a fearful, unstable, or unsafe situation have two options: become a refugee or seek asylum. This can occur in the company of a family member or as an unaccompanied minor. The regulations governing refugees and aslyees are different and confusing. In any case, these children require the expertise of general and subspecialty pediatricians, most of whom work in systems that were not designed for their needs. There is an urgent need to better understand how a child's legal status affects access to care. Here we propose ways in which we can ease barriers to care within our institutions, our communities, and our nation.

REFUGEES

The Immigration and Nationality Act of 1980 defines refugees and the circumstances under which they can be admitted to the US.[1] Those who qualify are admitted as refugees under the US Refugee Admission Program. This program is administered by the Departments of State, Homeland Security, and Health and Human Services and requires the applicant to first register with the United Nations High Commissioner for Refugees (UNHCR) in the country to which they have fled. The UNHCR determines whether an individual qualifies as a refugee and, if so, helps the refugee find the best possible long-term solution. Under the US law, a refugee is someone who is located outside of the US, is of special humanitarian concern to the US, demonstrates that they were persecuted or fear persecution due to race, religion, nationality, political opinion, or membership in a particular social group, and has not been firmly resettled in another country. Over half of the world's refugees are children. The number of refugees admitted to the US declined from 122,066 in 1990 to 11,411 in 2021.[2] Thirty-one percent of those admitted to the US are aged ≤14 years.[3]

ASYLEES

Those who have not registered as refugees with the UNHCR and assigned to the US but meet the definition of refugee can enter the US and apply for asylum at their port of entry or within 1 year of entry. The US defines two types of asylum seekers, those who apply affirmatively through a US Citizenship and Immigration Services (USCIS) asylum officer or defensively in removal proceedings before an immigration judge of the Department of Justice's Executive Office for Immigration. For example, during the autumn of 2021, 599,772 of those who applied to USCIS (46%) were granted asylum. If the USCIS denies asylum, seekers go to court and are considered a defensive applicant.[4] During the same time, 249,413 (26%) were granted asylum by Immigration Judges (IJ).[5] Spouses and unmarried children under the age of 21 years who are listed on the principal's asylum application but not included in the grant of asylum may obtain derivative asylum status. A principal asylee may petition for follow-to-join benefits for qualifying derivatives up to 2 years after being granted asylum, as long as the relationship between the principal and their spouse and/or child existed on the date the principal was granted asylum. In 2019, 96,052 family members applied affirmatively and 210,752 defensively for asylum.[4] The outcome for those seekers who have their cases reviewed in Immigration Court depends on the judge; overall the denial rate is approximately ≥70%.[5] Currently, the average wait time for the first hearing is 1621 days,[5] time during which children are not eligible for federal services. However, these children can receive health care from county health department clinics, free health centers, emergency departments, or may pay out of pocket for services. More than one court hearing may be necessary, and this increases the length of time when children are ineligible for federal services, such as Medicaid. In addition, it may take additional months until a final decision is reached by an IJ. The IJ can grant asylum at which time the applicant is granted access to government services, or the judge can deny asylum.

UNACCOMPANIED CHILDREN

The US defines an unaccompanied child (UC) as one who has no lawful immigration status in the US, is <18 years of age, and has no parent or legal guardian in the US or no parent or legal guardian in the US is available to provide care and physical custody.[6] Following apprehension by a federal agency, the UC is placed in the care and custody of the Office of Refugee Resettlement (ORR). ORR then places the UC in the least restrictive setting that is in the best interest of the child. While in ORR custody, the federal government is responsible for their care and

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education. Thus, children are eligible for services that include classroom education, health care, socialization/recreation, vocational training, mental health services, family reunification, access to legal services, and case management until their final destination is legally decided. They are screened for infectious diseases, health conditions, and immunization status. In 2020, 15,381 UC were referred to ORR, a decrease from 69,488 in 2019.

CHILD HEALTH

The health of children admitted to the US reflects the journey they took. Prior to admission to the US, refugee children are housed in camps throughout the world, where access to clean water, food, and preventative health services varies widely. Camps with limited access to health care put children at risk for infections, malnutrition, and poor access to vaccines. A refugee's health is assessed prior to arrival in the US to identify infectious diseases that would disqualify them for entry. Upon entry into the US, refugees immediately qualify for government assistance, such as Medicaid, Supplemental Nutrition Assistance Program, etc. This means that their health and nutrition issues could be addressed immediately.[7] Unfortunately, it can take ≥90 days to activate services.

Newly arriving refugee children are often in poor health, medically vulnerable, and have experienced psychological and social stress that impact their health. They may have developmental delays and require prosthetics that are not available prior to arrival. Yun et al. applied the Centers for Disease Control (CDC) screening guidelines for health assessment[8] to newly arrived children in four states and found that health profiles vary with country of origin and the location of refugee camps where families were housed. The most common health problems included anemia, hepatitis B, inactive tuberculosis, and positive strongyloides serology. In camps where car batteries were used for heat or cooking, children had elevated lead levels. Other diseases, general undernutrition, and specific nutrient deficiencies were also identified and were compounded by the situation in the camp.

Children who enter as asylum seekers have not been in a refugee camp and have not received the minimal support granted to refugee children. Since they are not eligible for federal assistance until their asylum application is accepted, they do not have the benefit of Medicaid-supported health assessment and preventative measures. As the process for their asylum decision may take years, these children access health care through county health departments or as provided on a humanitarian or volunteer basis. These resources can be limited depending on where the child is located. Infectious diseases, poor nutrition, dental disease, psychological health, and developmental delays may not be appreciated or treated. Vaccinations can be provided at no cost through the federally funded Vaccines for Children (VFC)[9] program at county health department clinics or by an enrolled provider. Vaccinations are extremely important because children cannot register for school without them. Once asylum is granted, the asylee and the family can access federal benefits, including Medicaid, Temporary Assistance for Needy Families, etc. Similar to asylees, UCs have not been housed in camps prior to their arrival in the US. However, they are immediately eligible for federally funded services upon entering custody of the ORR.

Children who enter the country as refugees, asylees, or UC have been exposed to physical disruption and have witnessed war and other traumatizing events, with secondary adverse health outcomes. Javanbakht et al. found[10] that Syrian children exposed to conflict suffer from psychological distress, identified up to 2 years after leaving a conflict zone and several months after arriving in the US. This can have lifelong negative medical and psychiatric effects. Other investigators found that 97.4% of children migrating from Central America and Mexico experienced at least one premigration traumatic event.[11] Post-traumatic stress disorder symptom severity was predicted by premigration trauma and duration of parent–child separation. Access to mental health services for most children and youth in the US is difficult; finding resources for this high-risk group is even more problematic.

BARRIERS TO DELIVERING CARE

The most significant barrier to health care is poverty, especially for asylum seekers. Even after a family is insured, accessing health care can be challenging. Most adults do not know how the system is organized and depend on the quality of translational services to even book an appointment. Parents themselves are often traumatized, ill, frightened, or worried about the disposition of family members remaining in an unsafe environment. Barriers perceived by mothers include financial, lack of information, racism/discrimination, language, stigma, feeling isolated, and unheard by service providers.[12] In addition, cultural understanding of western-style medicine may lead to rejection of services when the family does not perceive the child has a problem.[13] Health care workers perceive barriers that include the quality of translation services, understanding the cultural perspective of the families they serve, and access to specialty services. Unfortunately, the ability to access pediatricians has been identified as a barrier to care. While pediatricians have economic constraints and many work in institutions that do not understand care for these children, there are opportunities for pediatricians to positively affect care.

Poverty impacts other domains relevant to child health. Lack of resources may lead to food insecurity, compounded by limited access to grocery stones and food pantries. Availability of culturally appropriate foods, difficulty identifying packaged foods, discomfort with preservatives, and lack of knowledge on how to prepare food items add to the challenges of living in America.[11] Private agencies that can assist refugees and asylees have resources and the ability to overcome some barriers.

OPPORTUNITIES FOR ADVOCACY

Pediatricians are dedicated to care for all children and can try to understand the culture of the countries from which their patients come, the journey they took, and how that impacts their health and development. Most academic medical centers are located in cities that have significant refugee and asylee populations. Ambulatory settings can assure easy access to useful guidance. This includes CDC information on the geography and culture of refugee groups and recommendations for health screenings and vaccinations,[14] the American Academy of Pediatrics (AAP)[15] guidance for evaluating and caring for immigrant children, and contacts for local resettlement agencies and county and state health departments.[16,17] Pediatricians can enroll as a provider in the VFC program so that free vaccines can be provided to all qualified children. Support staff and students should understand the challenges faced by refugee and asylee families. Training and ongoing discussions should routinely occur. Finally, pediatricians can be strong advocates for these vulnerable children and help facilitate access to any available services.

Resettlement agencies support immigrant families by providing housing, food, legal aid, public assistance, health care, insurance, safety, youth education, employment, and advocacy. Other essential services include English classes, support for survivors of trafficking and domestic violence, translation, and community engagement among others. These agencies can usually access community resources where patients and families live and collaborate with city or county health departments where screenings can be conducted and vaccines administered through the VFC program.

The AAP policy statement on providing care for children of immigrant families lists 13 advocacy and policy recommendations.[15] Both State and Federal policy impact the ability of pediatricians to care for children. Many states have a variety of services for children of refugees. The AAP (federal, state chapters, Council on Immigrant Child and Family Health) and other major pediatric organizations (through the Pediatric Policy Council) are actively involved in educational and advocacy efforts to improve care for refugees, asylees, and UC minors.[15] Pediatricians have a unique and respected voice as advocates for children regardless of politics.

The world is changing rapidly and children are affected by these changes. As former APA and AAP president Bernard Dreyer has quoted from the Tikkun Olam: "It is not your obligation to complete the task of perfecting the world, but neither are you free to stop from doing all you can."

REFERENCES

1. Immigration and Nationality Act. https://www.uscis.gov/laws-and-policy/legislation/immigration-and-nationality-act (2019).
2. Refugee admissions in the US FY 1990-2021. https://www.statista.com/statistics/200061/number-of-refugees-arriving-in-the-us/ (2021).
3. Refugees and asylees in the United States. https://www.migrationpolicy.org/article/refugees-and-asylees-united-states-2021 (2021).
4. Baugh, R. Refugees and asylees: 2019. https://www.dhs.gov/sites/default/files/publications/immigration-statistics/yearbook/2019/refugee_and_asylee_2019.pdf (2020).
5. Trac Immigration Newhouse School of Public Communications and the Whitman School of Management SU. https://trac.syr.edu/immigration/reports/672/ (2021).
6. Unaccompanied Children Office of Refugee Resettlement. https://www.acf.hhs.gov/orr/programs/ucs/about (2021).
7. Refugees US Citizen and Immigration Services. https://www.uscis.gov/humanitarian/refugees-and-asylum/refugees (2022).
8. Guidance for the U.S. domestic medical examination for newly arriving refugees. https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic-guidelines.html (2021).
9. Vaccines for Children Program. https://www.cdc.gov/vaccines/programs/vfc/index.html (2016).
10. Javanbakht, A. et al. Biological and environmental factors affecting risk and resilience among Syrian refugee children. *J. Psychiatr. Brain Sci*. **6**, e210003 (2021).
11. Sidamon-Eristoff, A. E., Cohodes, E. M., Gee, D. G. & Pena, C. J. Trauma exposure and mental health outcomes among Central American and Mexican children held in immigration detention at the United States-Mexico border. *Dev. Psychobiol.* **64**, e22227 (2022).
12. Tulli, M. et al. Immigrant mothers' perspectives of barriers and facilitators in accessing mental health care for their children. *J. Transcult. Nurs.* **31**, 598–605 (2020).
13. Fadiman, A. *The Spirit Catches you and You Fall Down* (Farrar, Strauss and Giroux, 1997).
14. Immigrant, refugee, and migrant health. https://www.cdc.gov/immigrantrefugeehealth/index.html (2021).
15. Linton, J. M., Green, A. & Council on Community Pediatrics. Providing care for children in immigrant families. *Pediatrics*. **144**, e20192077 (2019).
16. Resources and contacts in your state. https://www.acf.hhs.gov/orr/map/find-resources-and-contacts-your-state (2022).
17. Administration for Children and Families State Human Services Agencies. https://www.acf.hhs.gov/state-human-services-agencies (2022).

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S.S.B. conceived, deigned, and acquired the information used in this commentary. She drafted the article and approved the final version. D.K. critically revised the commentary for intellectual content and approved the version to be published.

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The authors declare no competing interests.

ADDITIONAL INFORMATION

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