Immigration, Fear, and Public Health

Health Equity

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Between 2011 and 2014, the number of children fleeing narcotrafficking violence in Central America tripled. In 2014 alone, approximately 51,000 children from Honduras, El Salvador, and Guatemala were detained by or presented themselves to immigration authorities in an effort to escape from armed gangs and join family members living in the United States.

While U.S. human rights and child welfare groups immediately began to advocate for these children, other responses were rooted in fear. This fear was often framed in the context of public health with the argument that these groups of immigrant children were potential carriers of contagious diseases. The media focused on "outbreaks" of minor conditions like scabies, a rash caused by a mite, which is already common among American children and easily treated. Representative Phil Gingrey, a retired physician, wrote a letter to the Centers for Disease Control and Prevention (CDC) implying that children would be potential vectors of Ebola, disregarding that this viral illness is not found in Mexico or Central America.

We tend to fear things that we do not understand.

Framing the real issue

Hysteria notwithstanding, screening new immigrants for certain health problems is important. Early detection of the specific diseases and conditions that may affect these children is crucial for children themselves and

necessary to protect their new communities, especially schools and neighborhoods where children spend the majority of their time. However, as a health professional, it is upsetting to witness the misuse of health information to promote xenophobia and fear. What are some common examples of misinformation?

1. Conditions of public health concern in immigrant children are not typically health problems “foreign” to the U.S., but rather conditions – such as tuberculosis and Hepatitis B – that already exist in the U.S. population.
2. While we do need to invest more in our public health infrastructure, the public health system is not easily overwhelmed by the need to detect and treat these conditions. Public health departments routinely engage in surveillance, screening, and treatment of infectious diseases. However, in areas where undocumented children are denied access to preventive health care, children cannot be easily incorporated into existing immigrant health screening protocols.
3. Many conditions, such as minor intestinal worm infections or scabies, are not multi-drug resistant ogres waiting to harm the American populace, but rather are easily controlled through routine treatment. Very few children have an infection that can be easily spread to others. Even tuberculosis, a lung infection that is among the most common infectious diseases among immigrants to the U.S., is not contagious in the latent form that is most common among young children and is easily treated in the vast majority of cases.

Using public health to reduce fear

The best way to combat ignorance is through information. This is one of the reasons that we worked with colleagues from Washington, Colorado, Philadelphia, and Minnesota to create one of the first and largest epidemiological studies of newly arrived refugee children in the U.S. (For an infographic describing our study and results, click here). Although the population in our study – children from Africa and Asia who underwent a very brief public health screening prior to traveling to the U.S. – was different from those emigrating from Central America, other circumstances in their lives were very similar. Most came from regions that are very poor and where children have limited access to adequate nutrition or health services. These are areas where certain conditions, such as tuberculosis, are more common than in the U.S.

What we found:

1. Health profiles vary depending on children's countries of origin and the country where they lived prior to coming to the U.S. For example, a Burmese child who came to the U.S. from Malaysia was much healthier than a Burmese child who came to the U.S. from a refugee camp in Thailand.
2. Tuberculosis is common among refugee children relative to the general U.S. population, but it is almost entirely latent tuberculosis, which is not contagious.
3. Some conditions that used to be common in children from low- and middle-income countries are now uncommon. The best example of this was Hepatitis B, a liver infection that used to affect 8% of adults in regions of Asia, Africa and Oceania and that is typically acquired during childhood. Thanks to a vigorous, worldwide expansion of vaccination programs via Gavi and the World Health Organization, Hepatitis B now affects <1% of refugee children <5 years of age.

We need these data not only because they are helpful to health care providers, but also because accurate data can be used to combat fear. The CDC and state health departments should continue to collect screening data for refugee children and should pool and analyze these data in a timely manner, as refugee populations change significantly over time and data may otherwise lag behind resettlement. Ideally, we would have accurate, timely public health screening information about more groups of children entering the U.S. This will serve us well as we welcome other immigrants fleeing violence in their home countries, like children from Central America and Syria. As the CDC continues to strengthen our public health infrastructure through initiatives like the Refugee Health Centers of Excellence, we must ensure that all immigrant children, regardless of their formal refugee status, have access to equitable screening and treatment programs.

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Katherine Yun
Katherine Yun
MD, MHS
Faculty Member