U Visas are a nonimmigrant classification created under the Battered Immigrant Women Protection Act, enacted as part of the United States’ Victims of Trafficking and Violence Act of 2000. Congress intended U visas to both aid law enforcement in detecting, investigating, and prosecuting certain criminal activity committed against undocumented immigrants, and to protect domestic violence victims consistent with the humanitarian interests of the USA. Congress created the U visa classification to protect certain categories of immigrants who were not covered under the Violence Against Women Act, including domestic violence victims abused by a lawful permanent resident or citizen in a dating relationship and immigrants’ spouses, children, and intimate partners victimized by an undocumented perpetrator.

U visa petitioners must prove four threshold eligibility requirements. A petitioner must show (1) that she “suffered substantial physical or mental abuse” as a victim of certain qualifying criminal activity, a term that is defined broadly under the statute and includes domestic-violence-related offenses; (2) that she “possesses credible and reliable information” proving her knowledge of the relevant criminal activity; (3) that she “has been helpful, is being helpful, or is likely to be helpful” to the enumerated law enforcement, judicial, or service-providers with authority to investigate or prosecute the criminal activity; and (4) that the criminal activity violated a law of the USA. Successful U visa petitioners obtain temporary lawful status. Petitioners may also obtain derivative lawful status for qualifying family members (e.g., parents, children, spouses). Three years after the U visa holder obtains nonimmigrant status she may then petition for lawful permanent resident status if she meets eligibility requirements, most notably by proving that she has maintained a continuous presence in the USA for 3 years and that she has not “unreasonably refused to provide assistance” to investigating authorities. These primary legal benefits, in turn, support additional secondary benefits that petitioners can obtain with their lawful status, such as access to health care services, better wages, and housing.

While indeed the U visa classification is accessible to a wide range of petitioners, both male and female, it is perhaps most frequently used in the context of domestic violence. Abusers often use the victim’s undocumented status as a further weapon of psychological or physical abuse, which jeopardizes many petitioners’ ability to seek derivative lawful status under other statutes as a spouse or child of a citizen, for example. U visas are therefore powerful tools for domestic violence victims to seek lawful status without the abuser’s assistance. Indeed Congress intended that U visas would position petitioners to report abuse without fear of negative immigration consequences – either from the government, law enforcement, or the abuser.

The “substantial physical or mental abuse” element reveals most directly the physical and psychological health implications involved for U visa petitioners. Petitioners can prove this element by presenting evidence of physical or mental abuse as statutorily defined to include injury or harm to the victim’s body, or harm to or impairment of the emotional or psychological soundness of the victim. These terms are broadly interpreted by the US Citizenship Immigration Services (USCIS), the federal agency with U visa implementing authority, yet petitioners must meet the modifying requirement of “substantial” abuse. USCIS interprets “substantial” abuse to describe both
the severity of the *injury* suffered by the victim and the severity of the *abuse* used by the perpetrator. USCIS weighs the substantial abuse requirement on a case-by-case basis, considering the following factors although no one factor is dispositive: the nature of the injury inflicted or suffered; the severity of the perpetrator’s conduct; the severity of the harm suffered; the duration of the infliction of harm; and the extent of permanent or serious harm to the appearance, health, or physical or mental soundness of the victim. USCIS reviews the degree of harm suffered by the individual victim based on the individual victim’s experience, allowing USCIS to consider the victim’s preexisting physical or mental conditions and the extent to which existing medical conditions were aggravated by the abuse. USCIS considers the substantial physical or mental abuse requirement under a totality of the circumstances approach, allowing petitioners to cumulate a series of abusive acts to meet the substantial requirement, even where no single act of abuse on its own meets the test.

U visa petitioners must submit certain required documentation to prove these requirements, such as a signed detailed petitioner affidavit describing the basis for her petition, including the details substantiating her claim of substantial physical or mental abuse. Other materials are strongly encouraged, including health care provider records documenting the diagnosis and treatments of physical or psychological injury resulting from the criminal activity; affidavits from advocates, social workers, counselors, or mental health professionals that document any physical and mental abuse or injury that the applicant has suffered; copies of any police reports on domestic violence or sexual assault; affidavits from witnesses with knowledge of the harm or injury; and photographs showing injuries or damage from the criminal activity.

**Related Topics**

- Intimate partner violence
- Violence Against Women Act

**Suggested Readings**


**Suggested Resources**


**Unaccompanied Minors**

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In immigration, “unaccompanied minors” refers to a diverse population of migrant children who are noncitizens, under the age of adult legal status in their receiving country, and are not with a legally responsible adult. Unaccompanied minors may not have been seen as minors in their sending countries – they may have had adult status there. There are four general categories of unaccompanied minors: (1) refugees, (2) solo migrants, (3) those separated from family following migration, (4) trafficking victims. Regardless of the category to which they belong, unaccompanied minors have often overcome many hardships prior to their arrival in a new country. They may have fled persecution, human rights abuses, war, and other violence. Because unaccompanied minors do not have adult legal status, there are specific concerns since they are a very vulnerable population.
Historically, unaccompanied minors have been refugees who arrived in their new countries through planned resettlement programs. Many unaccompanied minors were relocated to new countries during and following World War II. Since then the practice has continued, usually where there is war or political unrest. For example, in the 1980s, unaccompanied refugee minors came from Southeast Asian countries to the United States, with their relocation supported by the US government and private aid groups. When a government identifies refugee children overseas and selects them for resettlement, there is a screening process and services are provided to help with the transition. In the United States, the government agency in charge of unaccompanied refugee minors is the Office of Refugee Resettlement (ORR), which works closely with two organizations, the Lutheran Immigration Refugee Service (LIRS) and the United States Conference of Catholic Bishops (USCCB). Other countries usually have similar arrangements to address the situations of unaccompanied refugee minors who are identified prior to migration. These unaccompanied minors who are participants in organized refugee programs will have access to support for long-term care: foster homes and other housing opportunities, food, clothing, medical care, education, language training, counseling, and other forms of support and necessities. Although these forms of support may be officially available to unaccompanied refugee minors, they are not always easy for the minors to access, and their availability is not uniform. The number of such refugees throughout the world has increased dramatically in recent years, and continues to grow; at least half of the world’s refugees are estimated to be children below the age of 18.

Another group of unaccompanied minors are individual children who have traveled to a new country on their own to join family members who are already there, to escape the problems in their home country, or to take advantage of perceived economic opportunities. Children who are refugees but arrive without the support of an organized refugee program will find it difficult to navigate the legal systems surrounding asylum programs, and they will often lack the documentation to support their claims of refugee status. Children who are seeking to join family members who are already in the new country may be stopped at the international border, and detained and deported at that point. Even if they are able to cross the border successfully, they may not be able to navigate in the new country or find their family members. Some children believe that there are economic opportunities that will allow them to provide for their family, only to discover that the opportunities are non-existent or are unavailable to them as minors. They may fall prey to criminals after they arrive.

Children may become unaccompanied minors following immigration. This usually occurs due to some form of separation from their family. If a family has entered the country without documentation, then some family members may be more vulnerable to detention, separation, and deportation. Depending on national laws regarding citizenship, children may be considered citizens while their parents are considered illegal immigrants, which means that children may be able to legally stay in the country but without their parents. If children are separated from their parents when their parents are detained or deported, they may or may not have other external supports in the community. Children are vulnerable following their parents’ detention or deportation and may become homeless or victims of exploitation by adults or older children. Children have limited ability to access resources in the community. If children are themselves detained or processed for deportation, they are often separated from their family and may be held in juvenile facilities with children who have committed a variety of violent crimes, or even in adult criminal facilities. Children may be held for extended periods of time – months or years – in detention facilities.

Unaccompanied minors may be children who were trafficked and brought to a new country by adults who were intending to exploit them. Children are trafficked for profit all around the world, although it may take different forms in different places. International traffickers will bring a child into a country, and the child may subsequently escape or be abandoned by the trafficker, becoming an unaccompanied minor. Traffickers may lie to families about the opportunity that is being given to the child and children may be forced or coerced into accompanying the trafficker. Children who are trafficked may be sexually exploited or used in pornography; forced to labor in homes, farms or factories; or forced to beg. They are physically confined, starved, threatened, beaten, and abused. It is difficult to estimate the number
of children who are trafficked. UNHCR (United Nations High Commissioner for Refugees) has protection guidelines regarding trafficking. The guidelines provide nations with policy recommendations for addressing these situations.

How countries deal with unaccompanied minors varies widely—some countries have specific policies regarding the disposition of unaccompanied minors that are based on immigration status; other countries uniformly detain all unaccompanied minors in jail-like facilities; other countries place them in foster homes following the same practices that would be applied for native children. The legal claims of unaccompanied minors usually follow the same guidelines that are followed for anyone seeking to immigrate. Unaccompanied minors may or may not be able to adequately use any legal counsel provided for them—they usually will not have any documentation to substantiate their identity, any claims for asylum, or their history. Language barriers can also limit unaccompanied minors’ abilities to advocate for themselves or use the services available to them. United Nations policy stresses that it is important in making decisions regarding unaccompanied minors to keep the best interests of the child in mind. “No matter their status, children must be treated as children first and their best interests professionally identified and respected” (UNHCR 2008).

Related Topics
▶ Asylum
▶ Immigrant visa status
▶ Refugee youth
▶ Trafficking
▶ Trafficking Victims Protection Act
▶ Undocumented

Suggested Resources


Undocumented

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Undocumented migrants are foreign citizens who enter or stay in a country without the appropriate documentation. They may have managed to cross borders undetected or entered into the receiving country using fraudulent documentation (“illegal entry”). Others, after entering using legal documentation, remain in the country beyond the period for which entry was granted or otherwise violate the terms of entry and stay without authorization (e.g., working in violation of some or all of the conditions attached to their immigration status) (“overstay”). They differ from those with pending applications, though failed asylum seekers or immigrants who have no further right to appeal may become undocumented if they do not leave the country when instructed. The status is temporary and may change over time, whether leading to regularization or the opposite. Alternative terms often used include migrants in an irregular situation or irregular, unauthorized, unregistered, clandestine, noncompliant, semi-compliant, or illegal migrants, aliens, or nonnationals. Despite a certain ambiguity of the term (i.e., it refers both to migrants who have not been documented and those without documents), “undocumented migrant” is often preferred over “illegal migrant” as, in most countries, residing without appropriate documentation is considered an administrative infraction rather than a criminal offense.

It is difficult to obtain accurate estimates on the number of undocumented migrants globally and by country. Existing estimates suggest that 30–40 million or 15–20% of all migrants are undocumented worldwide. In 2009, the CLANDESTINO project estimated...
that there were up to four million undocumented migrants across the European Union (EU), almost half of the level of irregular residence previously assumed. Depending on the source, estimates in the USA range between 7 and 15 million or more, with 12 million undocumented workers being a figure often used. Around 3.5 million children, many of whom are US-born citizens, live in families where at least one member is undocumented. In Canada, another major immigrant-receiving country, estimates of undocumented people are particularly vague, with 200,000 to half-a-million being the figures most frequently quoted. Unlike the USA, where undocumented migration is associated with clandestine border crossing, in Canada the majority of undocumented migrants initially entered through authorized legal channels.

Most undocumented migrants access health care through hospital emergency units and community organizations and health clinics. Undocumented migrants at landings or at public health centers run by Médecins Sans Frontières in several countries often present with problems related to their journey (e.g., trauma and dehydration), their living and working conditions, social exclusion (e.g., depression), and changes in eating habits (e.g., gastritis and duodenal ulcers). Research has shown pervasive feelings of fear and isolation among undocumented migrants linked to domestic violence (due to stress about papers), alcohol and substance abuse, depression, anxiety, and other mental health conditions. Children and youth, as well as smuggled and trafficked women, face significant physical and psychological health risks.

Lack of legal status and health insurance are major barriers of access to health care. Undocumented migrants will delay seeking care unless extremely sick for fear of exposure or deportation. Thus, victims of domestic violence rarely report it and children entitled to care do not always receive it due to their family’s reluctance to approach the government if the head of the family or another family member is undocumented. Other barriers include inability to pay, long wait lists at centers that offer care, and lack of professionally trained interpreters and information on the system.

Research has shown that delayed care often aggravates minor health conditions, with particularly negative consequences for chronic conditions (e.g., hypertension and diabetes), infectious diseases, acute mental health problems (e.g., posttraumatic stress disorder and depression), and developmental problems in children (e.g., autism). Difficulties in accessing antenatal care in this population have led to serious complications of eclampsia and ectopic pregnancy, complicated labors and an increased rate of cesarean sections. Moreover, for undocumented women, pregnancy and birth render employment impossible, generate high health care costs, and disrupt precarious housing arrangements.

Exposure to hazardous living and working conditions and poor access to health care constitutes a public health challenge that transit and host countries increasingly have to deal with. Whereas some countries, such as Austria and Sweden, provide services to undocumented migrants on a payment basis only, others, such as Spain and Portugal, offer full access to healthcare. Generally, however, undocumented migrants are only entitled to emergency care or “immediately necessary” services.

Related Topics
▶ Illegal immigration
▶ Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
▶ Irregular immigration
▶ Trafficking

Suggested Readings

Suggested Resources
Introduction

The UK has a publicly funded health care system that provides most medical services to citizens free of charge at the point of service. Free medical care is also provided to most legal residents, including immigrants and refugees. Certain services such as emergencies and treatment for certain communicable diseases are free regardless of citizenship. Despite this, immigrants and asylum seekers may face several barriers to accessing care in the UK. Calls for immigration reform have increased in recent years among members of the UK’s major political parties, so changes may occur that improve or limit access to care for immigrants in the near future.

National Health Service

The National Health Service (NHS) is one of the oldest universal health care systems in the world. It was established after the World War II in 1948. The model was based on a system devised by social reformer William Beveridge, and implemented through the leadership of the minister of health, Nye Bevan. The system nationalized the hospitals, allowed general practitioners (GPs) to remain independent, and made the government the payer for all fees. Private care and private insurance are allowed to coexist in the UK, but private care accounts for less than 3% of total health care services. Since its inception, health care services have been free at the point of service without co-payments, coinsurance, or deductibles. The exception is a small co-pay for vision correction and on prescription drugs. However, certain groups such as children, pregnant women, the chronically ill, and the elderly are exempt from co-pays on prescription drugs, and these users represent 85% of all prescription drug orders filled.

UK residents pay for the NHS through general taxation. A national sales tax in the UK runs from 15% to 17.5% and the marginal tax rates are higher in the UK than in the USA, a developed country that does not have universal health care.

The NHS is actually a collection of four health systems, run independently by England, Scotland, Wales, and Northern Ireland. However, many citizens are unaware of the distinction as there is great coordination between the systems and citizens of one area can usually seek care in another area.

Certain health services are provided to all persons, including immigrants, regardless of citizenship. These include treatment for accidents and emergencies, compulsory psychiatric treatment, treatment for certain communicable diseases, and family planning services.

Other NHS treatments are available to immigrants who meet certain criteria. If they are establishing permanent residence in the UK or have been living in the UK legally for 12 months then they are entitled to health care. Students, refugees, asylum seekers, and detained immigrants may also be eligible for free medical care from the NHS.

The National Institute for Health and Clinical Excellence, or NICE, is the government agency that provides recommendations of what services and drugs the NHS should pay for and which they should not. Since this is a form of rationing, in some cases persons are denied care that they or their physicians would like. Immigrants may find that certain treatments available in their native land are not available in the UK or require an out-of-pocket payment.

Immigrants may also have to deal with longer wait periods than they would in their country of origin for treatment of certain types of conditions. Acute conditions are treated immediately. Cardiac problems are usually addressed the same day, and cancer within a few weeks. However, treatment for certain chronic conditions and “elective” procedures may require the patient to wait for months.
Immigration to UK

The current political state known as the UK of Great Britain and Northern Ireland, which includes England, Wales, Scotland, and Northern Ireland, was created in 1922. This entry will focus on immigration policies from that date to the present.

Immigration during this period has been substantial with most immigrants originating from Ireland or former British colonies, including India, Bangladesh, Pakistan, the Carribbean, South Africa, Kenya, and Hong Kong. Until the British Nationality Act of 1981, citizens of commonwealth nations were deemed to be British subjects, but this is no longer the case.

Immigration is also heavy from countries in the European Union due to agreements with the other EU countries that require that citizens of any EU country have a right to work in other EU countries. Currently about 11% of the UK population is foreign-born.

In response to fears of rising immigration from eastern European countries, the conservative-liberal coalition has moved to cap the number of non-EU immigrants allowed to enter the UK each year. Some have expressed concern that this will negatively affect care for all UK citizens as the system is dependent on physicians originating from former British colonies such as India and Pakistan. A 2005 report found that in 2003, 29.4% of NHS doctors were foreign-born and that 43.5% of nurses recruited to the NHS after 1999 were born outside the UK.

Emigrants to the EU and Abroad

Citizens of the UK, who migrate to other countries, may still be eligible for health care under the National Health Service. However, because the NHS is paid for through the taxpayers, rules are in place to prevent people from “free-riding.” Persons who have been citizens of the UK for at least 10 years are eligible for care under the NHS, provided they have not lived abroad for more than 5 consecutive years. UK state pensioners living abroad seasonally are eligible for care, provided they do not spend more than half of the year outside of the UK.

Medical Care of Asylum Seekers and Refugees

Refugees seeking asylum in the UK have been a focus of policy-makers in recent decades, with both Conservative and Labour Party officials claiming that too many refugees are entering the country each year. The case they make is that refugees are choosing to migrate to the UK because it has some of the most generous health benefits. International law requires refugee migrants to seek asylum in the first country they enter that will grant asylum. Critics claim that refugees are taking advantage of this rule, by “shopping” for countries that offer generous benefits, such as the UK.

Asylum seekers have a right to access free physician visits and hospital care from the National Health Service while their applications are being processed. Additional support may be available through the UK Border Agency such as prescription drug benefits, dental care, and vision and eye care. Persons with HIV, tuberculosis, or severe mental health diseases may be eligible for additional care.

A systematic review of studies focusing on asylum seeker mental health found high levels of mental health problems reported among detainees in all studies. Suicide ideation, anxiety, depression, and posttraumatic stress disorder were commonly reported. Longer detention time was positively associated with severity of distress. Longitudinal results have shown that the negative impact of detention persists even after release.

A High Court ruling found that failed asylum seekers were still granted a right to NHS services provided they lived in the UK for more than 1 year. However, in March 2009, this decision was overturned by the Court of Appeals, and failed asylum seekers no longer have a right to NHS services free of charge, other than emergency services and certain other care that is offered to everyone.

Conclusion

The UK has one of the most comprehensive health care systems in the world in that it provides universal coverage and also operates most of the health care facilities. This system is favorable to documented immigrants and refugees in that it provides access to health care that they may not be able to afford out of pocket. The UK has strict immigration policies, so foreign-born persons may find it difficult to move to the UK unless they are deemed to be highly skilled workers sponsored by an employer, or
students. Undocumented immigrants and failed asylum seekers still residing in the UK may have difficulty obtaining care under the NHS, but certain emergency services, mental health services, and treatment of communicable diseases can still be obtained free of charge. Immigration policies and immigration health policies in the UK are likely to change over the next several years as it continues to be a hot-button issue among policy-makers and voters. These changes may adversely affect immigrant access to the NHS.

Related Topics
▶ Asylum
▶ Colonialism
▶ European Court of Human Rights
▶ European Union
▶ International Health Regulations
▶ Refugee
▶ Socialized medicine
▶ United Nations High Commissioner for Refugees

Suggested Readings

Suggested Resources

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United Nations Convention on the Rights of the Child

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People have rights that are extended to them whether they are in their native country or have immigrated to a new land. These rights are civil, political, economical, social, and cultural. They belong to all human beings including children and young people. Since children are particularly vulnerable, it is widely accepted that they need special attention and protection.

In the early twentieth century the United Nations (UN) recognized that children were living in exceptionally difficult conditions in all countries around the world and that international cooperation was needed to remedy this situation. The Declaration of the Rights of the Child of 1924 was one of the first documents that stemmed from this joint initiative. Since then the United Nations has put forth several provisions which include the Declaration of the Rights of the Child, adopted on November 20, 1959, as well as the Convention on the Rights of the Child, adopted on September 2, 1990. The Convention is the most widely ratified human rights treaty in history.

It took an international elected body of independent experts over 10 years to negotiate the Convention on the Rights of the Child (“the Convention”). The result is a document that takes into account the importance of tradition and cultural values for the protection and harmonious development of the child.

The Convention emphasizes that the best interests of the child shall be primary. The Convention spells out provisions, protection, and participation that should be considered. These considerations are the right to life and to a name, identity, family, and nationality; freedoms of thought, speech, conscience, and religion, and freedoms of privacy and assembly; the right to regulate activities pertaining to parenting and the care of a child which includes physical safety, foster care and adoption, mental and physical disability, health care, and social and economic security; education, participation in their culture, and play; and the right to be free from exploitation and abuse, including physical and sexual abuse, economic and sexual exploitation, exposure to addictive drugs, and warfare. These rights are extended to children no matter what their country of origin is or their color, language, race, religion, or sex.

The Convention defines a “child” as a person below the age of 18, unless State law recognizes a different age of majority. States can define appropriate ages for majority such as when a child can become employed and complete his/her education. The Convention has clearly defined that those under 18 years of age be prohibited from life imprisonment or capital punishment.

Compliance with the Convention is monitored through the UN Committee on the Rights of the Child. Governments that have ratified this Convention are required to submit regular reports on the status of children’s rights in their country. The committee, which consists of internationally elected representatives, monitors and reviews the reports submitted by the governments.

The United States (US) government played an active role in the development of the Convention on the Rights of the Child and signed it on February 16, 1995. However, as of November 2009, the US has not ratified the Convention. There are several views on why this has not been done, but most feel it is partly due to the potential conflict with the US Constitution. In early 2009, there was an attempt by the State Department to review the Convention, but to date this has not been initiated. Because of this, the Convention has never been sent to the US Senate for ratification. The US has signed and ratified both optional protocols to the Convention.

Due to the Supremacy Clause in Article VI of the US Constitution, all treaties the US ratifies are considered the supreme law of the land. This would make any preexisting state and federal statutes null and void. This has created a conflict for ratifying the Convention. Parental rights groups feel the Convention would give the government a right to meddle in child rearing. Political and religious groups feel there is an issue of national control over domestic policies. The Obama administration has noted these objections constitute legitimate concerns. One answer could be addressed through the Reservations, Understandings, and Declarations (RUDs) process through which the US can sign a RUD that can hinder or negate responsibilities they would otherwise be bound to follow.

Most majority Muslim nations express reservations on some provisions of the Convention that are incompatible with Islamic Sharia law. This has been accomplished through the filing of RUDs which allows Islamic law to prevail.

Children will always be our future. They will be the future global leaders who set public policy and implement laws. Whether children are raised in the country of their birth or immigrants in another location, the rights of a child’s health and well-being have been laid out by the Convention on the Rights of the Child.

**Related Topics**

- Adoption
- Child
- Child abuse
- Child development
- Child health and mortality
- Child health care access
- Child labor
- Childhood injuries
- Child rearing
- Family reunification
- Identity

**Suggested Resources**


The definition of a refugee now follows the construction of the United Nations convention and is defined as a person who, “owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to avail himself of the protection of that country.” Today the UNHCR provides refugees with material support such as food, shelter, healthcare, education, and other related social services and works in conjunction with other United Nations agencies, peacekeepers, military forces, regional agencies, human rights organizations, and other international and local organizations and agencies. As an example of the assistance provided to refugees, refugees living with HIV in Botswana are being provided with treatment under a special UNHCR program.

Yet, measures to relieve the plight of those experiencing forced migration, internal displacement or asylum have drastically diminished in relation to the growing scale of the problem. Although the annual budget of the United Nations High Commissioner for Refugees rose to $1 billion in 1997 through voluntary government contributions, the agency is increasingly unable to meet the present demand for food and shelter to support refugees, or to invest in rehabilitation or repatriation of these refugees.

More recently, the UNHCR has undergone some harsh charges that it is simply a pawn of state and capitalist interests. The UNHCR has also been the focus of charges that it has acted as an imperialistic opportunist and has betrayed its fundamental values in pursuit of institutional predominance in the international humanitarian field. As a result, the UNHCR is a conflicted organization, torn between its legal and human rights obligations and its need to appease the Western states that pay its bills.

The UNHCR’s current emphasis appears in recent years to have broadened to include issues related to security of refugees: social security, economic security, and environmental security, and the all-inclusive “human security.” This new emphasis reflects the UNHCR’s continuing evolution from aid/development to legal protection to repatriation and, finally, to human security. The ability of the organization to undergo evolution had been envisioned for the UNHCR from the beginning. Because of its ability to
adapt to changing circumstances and address the needs of refugees, the office was awarded the Nobel Prize for Peace in 1954 and again in 1981.

Related Topics
▶ Asylum
▶ Disasters
▶ Displaced populations
▶ Refugee

Suggested Resources
Website for UNHCR. http://www.unhcr.org

United States

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Introduction
The United States is a country of immigrants. Nearly every person living in the United States is a descendent of immigrants that arrived in the past few centuries, or is an immigrant themselves. Despite this shared history of immigration among US residents, foreign-born persons in the United States face structural, cultural, and political barriers that impact their health and limit access to quality care. This entry will provide a profile of immigrants in the United States today, discuss the health of the immigrant population, and describe the US system of payers and providers and how it relates to immigrants’ ability to access care. Finally, it will look at health care reform and other recent policy changes and its impact on immigrant health.

Profile of US Immigrants Today
As of 2008, there were approximately 39 million immigrants living in the United States, accounting for 13% of the total population. Among these foreign-born persons, 31% are naturalized citizens and 38% are lawfully residing noncitizens. An estimated 11.9 million persons are undocumented immigrants, representing 4% of the population and 5.4% of the workforce. The primary reason that persons immigrate to the United States is to find employment.

Naturalized citizens are immigrants who qualified for and passed a citizenship test. These may include children of US citizens born abroad, documented permanent residents who have lived in the US for 5 years, or spouses of US citizens. These people are considered US citizens and have the same rights and privileges as US-born citizens. Lawfully residing noncitizens, or “legal immigrants,” include permanent residents that have a visa. These persons are not citizens, but do have access to many public programs. Refugees are also considered lawful noncitizen immigrants. Undocumented noncitizen immigrants are sometimes referred to as “illegal immigrants” or “illegal aliens” because they are often in the country illegally and subject to deportation. These citizens cannot access most public programs such as Medicaid and Medicare. Immigrants to the United States come from all over the globe. The majority of foreign-born persons living in the United States today have come from Latin America (54.6%), with Mexico alone accounting for 31.3% of the immigrant population. East/Southeast Asia (17.6%), Europe (12.5%), South Asia (5.5%), and the Middle East (3.5%) round out the top five regions of origin.

Fewer persons emigrate from the United States than immigrate to the country, and this has been true throughout the history of the nation. Even still, the State Department estimates over 5 million Americans currently live abroad. Additionally, many foreign-born persons in the United States will migrate back to their native countries at some point. Despite this, issues related to the emigration of US citizens from the United States are rarely studied including issues related to the health of these migrants. The focus of this entry will therefore be on the health of immigrants to the United States.

Immigrant Health and Hispanic/Immigrant Health Paradox
Health disparities exist in the United States, and low socioeconomic status is often associated with poorer health outcomes and reduced access to care. However, while immigrants, especially undocumented immigrants, tend to have a low socioeconomic status, they surprisingly score better on a variety of leading health indicators compared to domestic-born citizens. This
phenomenon has been called the “immigrant paradox,” or more commonly the “Hispanic paradox.” One review study found foreign-born persons in general to have better outcomes than the US-born population in many health indicators including mortality, perinatal health, body-mass-index, heart disease, diabetes, cancers, mental health, injuries, and infectious disease.

Several theories have been offered to explain this paradox, including the “salmon bias,” whereby immigrants return to their homeland before dying and hence are not included in US mortality statistics, and the healthy migrant hypotheses, which assert that the healthiest persons are the ones most likely to immigrate to a foreign country. Neither of these hypotheses has been able to fully explain the paradox. Cultural differences between immigrants and US-born citizens, as well as health behaviors before and immediately after migration, have been offered as an explanation. There is some evidence that the protective effects of immigration disappear over time as immigrants become more assimilated into American culture. This is especially true in the case of overweight and obesity.

Overview of Health Care in the United States

The health care system in the United States is not centralized at the payer or provider level. This is in contrast to most developed nations which have some sort of single-payer system (e.g., Canadian Medicare) or have a government-run health system (e.g., UK’s National Health Service). In the United States most Americans receive coverage through private and not-for-profit insurance plans. Because the federal tax code allows health insurance premiums to be purchased as a pretax deduction, the majority of Americans receive their insurance as a benefit through their employers. Others purchase it as individuals on the open market. An estimated 46 million persons in the United States did not have health insurance coverage in 2009, and 22% of these uninsured were immigrants. According to the Kaiser Family Foundation, 47% of immigrants (legal and documented) are uninsured.

Naturalized citizens and lawful noncitizens generally have access to private and public health insurance similar to US-born citizens. That is, they can receive private health insurance as a benefit from their employer. They also qualify for Medicaid, a public program for low income individuals and families, if they meet the eligibility requirements, and can receive Medicare, a public program for individuals over 65 years or who meet other special criteria, provided they have been here at least 5 years and they or a spouse have paid at least 10 years into the system or pay a monthly premium. Since the passage of welfare reform laws in 1996, most lawful noncitizens must be in the country for 5 years before they are eligible for Medicaid and the Children’s Health Insurance Program (CHIP). Some states allow legal noncitizens to enroll in Medicaid during their first 5 years in the country, but these programs do not receive federal matching funds.

Undocumented immigrants on the other hand do not qualify for public health insurance, and rarely receive employer-sponsored health insurance. Many of these immigrants work in low-wage industries that typically do not provide employer-sponsored insurance, or they are paid “under the table,” meaning unofficially and not on the records of the employer, and not offered benefits. Their main option for having health coverage is purchasing it on the individual market. As this is one of the most expensive ways to buy insurance, and most undocumented immigrants have low incomes, very few can afford to purchase private insurance.

Most health care in the United States is provided by private health care providers, including private hospitals and private-practice physicians. Exceptions are the Veterans Affairs hospital system, which provides care for veterans of foreign wars, public hospitals that receive support from the federal, state, and local level, and not-for-profit community clinics which provide care for the poor and uninsured, including immigrants. Noncitizen immigrants, both undocumented and documented, have access to public and private health care providers, provided they have the means to pay. All persons who show up to emergency departments must be treated regardless of their ability to pay. For this reason, emergency departments have become a primary source of care for the uninsured, including immigrants.

Health Care Reform and Immigration

The Patient Protection and Affordable Care Act (PPACA) and Reconciliation Act of 2010, both signed
into law in early 2010, made the largest reforms to health care in the United States since Medicare was passed in 1965. Among the changes in this law are provisions creating state-run insurance exchanges, where individuals and employees of small businesses may purchase private insurance plans. Persons purchasing insurance through this mechanism will receive income-dependent federal subsidies to help offset premium costs. The Medicaid program was expanded to cover all persons with income below 133% the federal poverty line (FPL), resulting in an increase in approximately 15 million enrollees when fully enacted. These reforms become fully enacted in 2014.

Naturalized citizens and lawful noncitizens will be able to purchase insurance on these exchanges and will be eligible to receive federal subsidies. Additionally, lawful noncitizens with incomes below 133% FPL will be eligible to enroll in Medicaid, provided they have continuously resided in the United States for at least 5 years. Naturalized citizens have the same access to Medicaid as US-born citizens.

Undocumented immigrants are not eligible for Medicaid or federal insurance subsidies. Furthermore, undocumented immigrants are banned from purchasing insurance policies on the exchange, even if they have the economic means to do so. This is concerning to undocumented immigrants that purchase individual private plans, as it is questionable whether this insurance market will exist after 2014. Many experts believe that insurance companies will offer all of their individual private plans through the exchanges. Undocumented immigrants wishing to purchase insurance, will in effect, become a niche market. This niche market may be too risky for insurance companies since they cannot deny coverage based on pre-existing conditions and undocumented immigrants are exempt from the individual coverage mandate. This would allow undocumented immigrants to purchase health insurance only at the time they needed it.

Border Health and the Recent Political Climate

Politicians and the public have taken an increased interest in recent years concerning the flow of undocumented immigrants into the United States along the US-Mexico border. The United States has increased border security through fences, surveillance equipment, and border patrol agents. Because border security is not one continuous system, but rather a patchwork, immigrants often try to cross in certain areas that may have less security, but may feature more inhospitable terrain. As a result, the act of migrating into the United States can pose a health risk as well. In 2009, 417 known deaths occurred among persons trying to cross the US-Mexico border. Many of them die in the deserts of Arizona or by drowning in the Rio Grande trying to enter through Texas.

The Development, Relief and Education for Alien Minors Act, or DREAM Act, is a bill first introduced in 2001 and reintroduced in 2010 in the 111th Congress that creates a pathway for persons who entered the country illegally as children to become citizens by completing 2 years of college, or 2 years of military service. Such a law would allow millions of undocumented immigrants in the United States to become citizens, and hence improving access to jobs, health insurance, and public insurance programs.

Most legislative efforts in recent years have moved toward restricting access to health care and public programs rather than expanding it for immigrants. Arizona passed a tough anti-immigration law in April 2010, causing many to fear that medical professionals will be required to report suspected undocumented immigrants who show up to their practice. The law may also have the effect of suppressing undocumented immigrants from utilizing health care services for fear of deportation. Opposition to the Arizona immigration law was widespread with many prominent voices calling for a boycott of the state. However, a Pew Research Poll showed public support for the law by a 59-32 margin. Given the popularity of such measures and budget shortfalls in most states, politicians may pass more laws designed to restrict lawful and undocumented immigrants’ access to public resources and health care services.

Conclusion

Health disparities in terms of access and quality of care exist in the United States, and these disparities are often tied to low socioeconomic status. Immigrants, especially undocumented immigrants, tend to be of lower socioeconomic status than natural-born citizens. Despite the “Hispanic paradox” whereby many undocumented immigrants perform better in several leading
health indicators, access to care remains a problem. Federal and state laws create barriers that prevent most undocumented immigrants from obtaining health insurance. Lack of universal health insurance and rising health care costs also prevent many lawful noncitizens from obtaining health coverage as well for financial reasons. Immigrant health is not only affected by laws pertaining to the health care system, but also the social, cultural, and political attitudes toward immigrants in the United States.

Related Topics
▶ Assimilation
▶ Ellis Island
▶ Health care access
▶ Health insurance
▶ Healthy immigrant
▶ Hispanic health paradox
▶ Illegal immigration
▶ Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
▶ Immigration Act of 1924 (U.S.)
▶ Immigration Act of 1990 (U.S.)
▶ Immigration and Nationality Act Amendments of 1965 (U.S.)
▶ Immigration and Nationality Act of 1952 (U.S.)
▶ Immigration Reform and Control Act of 1986 (U.S.)
▶ Labor migration
▶ Latinos
▶ Medicaid
▶ Medicare
▶ Melting pot
▶ Mexico
▶ Undocumented
▶ U.S.–Mexico border

Universal Declaration of Human Rights

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The Universal Declaration of Human Rights (UDHR) is regarded as one of the most pivotal documents of the last half century. The Declaration deems all people are entitled to basic human rights regardless of civil, political, economic, social, or cultural status. Although not a treaty, the UDHR has served as a human rights template incorporated into international treaties. For instance, the International Covenant on Civil and Political Rights and the International Covenants on Economic, Social, and Cultural Rights were ratified in 1966 and established many of the protections delineated by the UDHR. Together these covenants and the UDHR comprise the International Bill of Rights.

History paved the road for the evolution of the UDHR and provides insight into its relevance and impact. By the mid-1940s, society had lived through the devastation of two world wars and a fervent vision for a postwar era of justice and peace evolved. As a result, the recently formed United Nations established

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the Commission on Human Rights, which was comprised of 18 states and chaired by the former first lady Mrs. Eleanor Roosevelt. The drafting subcommittee was comprised of representatives from Australia, Chile, China, France, Lebanon, United Kingdom, USSR, and the United States. The Declaration framework was structured on core principles of nondiscrimination, social and economic responsibility, and political civil responsibility. After a 2-year drafting process, on December 10, 1948, the UDHR was adopted by the United Nations.

The UDHR consists of 30 articles relating to civil, political, economic, social, and cultural rights. The first three articles define the rights of the individual. Specifically, articles 1–5 cover freedom, liberty, and security, and in addition, ban slavery and torture. Articles 6–9 ensure equal protection and nondiscrimination, and ban random seizure and confinement. Articles 10–11 establish a right to fair public hearing, due process by an impartial tribunal, and presumed innocence until proven guilty.

Articles 12–17 recognize the right of an individual in society. For example, articles 12–15 protect the right to nationality or change in citizenship, the free movement within a state or between states, and to seek asylum from persecution. Articles 16–17 involve the right to marriage, family, and sole or community property ownership.

Articles 18–21 emphasize civil and political freedoms. In particular, articles 18–21 address the right to freedom of religion and expression, peaceful assembly, and the right to vote. Finally, articles 22–27 delineate social, economic, and cultural rights.

In summary, the UDHR revolutionized the landscape of international law, by inspiring the development of several core treaties with UDHR origins: (1) Convention on the Rights of a Child; (2) United Nations Convention Against Torture; (3) Convention Against All Forms of Discrimination Against Women; and (4) Convention Against All Forms of Racial Discrimination. Equally impressive was the reaffirmation of the UDHR at the Second Human Rights World Conference by 171 countries in 1993. Continued public awareness regarding the UDHR is paramount, as evident with its translation into over 360 languages. In addition, human right violations can be reported via a 24-h United Nations facsimile hotline.

**Related Topics**

- European Court of Human Rights
- Human rights

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**U.S.–Mexico Border**

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The border between the United States and Mexico extends approximately 2,000 miles from the southern tip of Texas to California. On the United States side, it extends along the states of Texas, New Mexico, Arizona, and California; and on the Mexico side, the states of Baja California, Sonora, Chihuahua, Coahuila, Nuevo León, and Tamaulipas. In the United States, Texas has the longest stretch of the border, while California has the shortest. In Mexico, Chihuahua has the longest stretch of the border, while Nuevo León has the shortest.

On March 2, 1836, the Texas Declaration of Independence was signed, creating the Republic of Texas. The Republic of Texas lasted only until 1845 when, on March 1, 1845, United States President John Tyler signed a bill that authorized the United States to annex the Republic of Texas. The continuous conflicts in the Texas region in the mid 1800s and the US annexation of Texas eventually led to the Mexican-American War (1846–1848), which ended with the Treaty of Guadalupe Hidalgo.

The Treaty of Guadalupe Hidalgo gave the United States undisputed control of Texas, established the US–Mexican border as the Rio Grande River, and
ceded to the United States the states of California, Nevada, Utah, and portions of the states of Colorado, Arizona, New Mexico, and Wyoming. From the Treaty, Mexico received $18,250,000 and the United States agreed to assume $3.25-million in debts the Mexican government owed to United States.

Five years later the Gadsden Purchase, named after James Gadsden, US Ambassador to Mexico at that time, completed the formation of the US–Mexico border. The Gadsden Purchase was signed by President Franklin Pierce on June 24, 1853, and ratified on April 25, 1854. It added southern Arizona and southwestern New Mexico to the United States and completed the US–Mexico border as we know it today.

Established in 1889, the International Boundary and Water Commission (IBWC) has responsibility for applying the boundary and water treaties between the United States and Mexico. The IBWC is an international body composed of the United States Section and the Mexican Section, each headed by an Engineer-Commissioner appointed by his/her respective president. Each Section is administered independently of the other. The United States Section of the International Boundary and Water Commission (USIBWC) is a federal government agency headquartered in El Paso, Texas. The USIBWC operates under the foreign policy guidance of the Department of State. The Mexican Section is under the administrative supervision of the Mexican Ministry of Foreign Affairs and is headquartered in Ciudad Juarez, Chihuahua, Mexico.

### Trade Relations
Mexico is the third largest US trading partner, after Canada and China; and the United States is Mexico’s largest trading partner. The United States bought more than 80% of all Mexican exports in 2008. The total trade between the two countries exceeded $367 billion in 2007. This stable trading relationship is due in part to the North American Free Trade Agreement (NAFTA), which is an agreement signed by the governments of the United States, Canada, and Mexico creating a trilateral trade bloc in North America. NAFTA went into effect on January 1, 1994. The Agreement gradually eliminates tariffs and dissolves many other trade barriers, for example quotas. NAFTA is structured to stimulate the border region’s industrial growth. Such growth has historically brought about numerous environmental problems. Therefore, NAFTA established two agencies to help deal with the vast environmental concerns along the US–Mexican border. The first such program is the Border Environment Cooperation Commission (BECC), a binational organization that helps develop environmental infrastructure projects related to wastewater treatment, the prevention of water pollution, and the management of municipal solid waste. The other program is the NADBank, which was set up to work in conjunction with the BECC, guaranteeing loans for projects certified by the environmental commission. Both the United States and the Mexican governments supply the funds to the NADBank.

### Immigration
Mexico accounts for approximately a third of all foreign-born residents living in the United States, and nearly two-thirds of all Hispanic immigrants to the United States. Of all people who leave Mexico to reside elsewhere, the United States is their principle destination. Recent data indicate there has been a substantial decrease in the number of new arrivals from Mexico to the United States. The flow of Mexican immigrants to the United States began to decrease in the mid-2000s, and has continued to do so through early 2009. This trend can also be found in data from the US Border Patrol, which tends to show that apprehensions of Mexicans attempting to cross illegally into the United States decreased by one-third between 2006 and 2008.

In 2008, an estimated 11.9 million unauthorized immigrants lived in the United States. The majority of these undocumented immigrants are from Mexico. The undocumented immigrant population grew rapidly from 1990 to 2006 but has now stabilized. There were approximately 8.3 million undocumented immigrants in the US labor force as of March 2008. Unauthorized immigrants make up approximately 4% of the nation’s population and account for almost five and half percent of the US workforce. In 2005, over 1.2 million illegal immigrants were apprehended by the US Border Patrol, which apprehends about one out of every four illegal border crossers.

Tunnel passages across the US–Mexico border are another challenge as the smuggling of drugs, weapons, and immigrants also takes place through such tunnels. One tunnel running from San Diego to Tijuana was
particularly advanced at one-half a mile long, 60–80 ft deep, and 8 ft tall with a concrete floor. That particular tunnel was wired for electricity and had drainage. The California entry was hidden in a very modern warehouse.

The Department of Homeland Security was established on November 25, 2002, by the Homeland Security Act of 2002. On March 1, 2003, the US Department of Homeland Security (DHS) took over the control of the Immigration and Naturalization Service (INS). Some of the agencies now under the Department of Homeland Security are: the United States Citizenship and Immigration Services, which processes citizenship, residency, and asylum requests; the US Customs and Border Protection, which staffs border checkpoints, collects tariffs, and patrols the border; and the US Immigration and Customs Enforcement, which conducts long-term investigations of border violations. The United States Border Patrol is a federal law enforcement agency within US Customs and Border Protection (CBP). The US Border Patrol has just over 20,000 agents and is primarily responsible for immigration and border law enforcement. There are 20 Border Patrol sectors; the Southern Border Sector covers the US–Mexico border, among others.

The US–Mexico border is guarded by over 17,000 border patrol agents. Yet, those agents only have effective control of less than 700 of the 2,000 miles of the border. In an effort to increase security of the US border and decrease illegal immigration into the United States, the Secure Fence Act of 2006 was enacted. The Secure Fence Act of 2006 is to establish operational control over the international land and maritime borders of the United States. The Secure Fence Act of 2006 authorized the systematic surveillance of the international land and maritime borders of the United States, including the use of unmanned aerial vehicles, ground-based sensors, satellites, radar coverage, and cameras; it also authorizes physical infrastructure enhancements to prevent unlawful entry by undocumented individuals into the United States and facilitates access to the international land and maritime borders by United States Customs and Border Protection, such as additional checkpoints, all-weather access roads, and vehicle barriers. The Act also allows for more than 700 miles of double-reinforced fence to be built along the US–Mexico border. Additional fencing was authorized for the states of California, Arizona, New Mexico, and Texas, which have experienced significant illegal drug trafficking and immigration.

A program called “Texas Virtual Border Watch” was created by the State of Texas to allow anyone with internet access to observe and report on the US–Mexico border via their computer. The program was funded by the Texas governor’s criminal justice office, at a cost of $2 million in its first year. The trial version of the Texas Virtual Border Watch received approximately 2,780 reports of suspicious activity by November 2008. The site has users around the world, including Australia. From November 2008 to February 2009, the program has been credited for four drug busts yielding 1,500 pounds of marijuana, and 30 incidents where illegal immigrants were repelled.

Related Topics
► Bureau of Immigration and Customs Enforcement
► Department of Homeland Security
► Hispanics
► Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (U.S.)
► Immigration and Naturalization Service
► Immigration Reform and Control Act of 1986 (U.S.)
► Mexico
► Undocumented
► United States

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