



MIGRANT CLINICIANS NETWORK



# Failures of US Health Care System for Pregnant Asylum Seekers

**A Migrant Clinicians Network  
White Paper**  
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# Contributors and Acknowledgements

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**Migrant Clinicians Network is a national nonprofit with the mission to build practical solutions at the intersection of migration, vulnerability, and health.** We envision a world based on health justice and equity, where migration is never an impediment to well-being. Learn more about MCN at [www.migrantclinician.org](http://www.migrantclinician.org).

This white paper seeks to gather current knowledge on the health needs and health care access of pregnant asylum seekers recently released from detention at the US-Mexico border, in order to better understand their health needs and provide effective continuous prenatal and perinatal case management from their release, through their arrival at receiving communities.

This paper does not seek to address immigration policy; recommendations on governmental action with regard to who may enter the country and how are outside the purview of this paper. Rather, this paper addresses the health care system's alarming deficiencies for a vulnerable population for which the United States has assumed responsibility. All findings, interpretations, and conclusions based on interviews do not necessarily represent the views of Migrant Clinicians Network, its funders, or its partners.

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## **Abstract**

Many people requesting asylum in the United States are already pregnant when they arrive at the US southern border and are in need of essential medical care. Thousands are permitted into the US pending their immigration hearings, but under current conditions, they face extreme obstacles to secure services like prenatal care despite their legal presence within the country that has been granted by government authorities. Flawed design and poor execution of various systems and policies contribute to insufficient care for a vulnerable population under the responsibility of the United States. Without access to adequate health care options, pregnant asylum seekers and their pregnancies face grave dangers, and the health care system faces higher costs of care for the emergency care, delayed care, and health complications that may result. Comprehensive change to the system must occur to ensure humane treatment.

## **Introduction**

Each year, thousands of desperate migrants arrive at the US-Mexico border seeking asylum in the United States.<sup>1</sup> In 2021, just 36,000 people successfully requested asylum,<sup>2</sup> while the vast majority of migrant encounters at the border – around 1.2 million – resulted in immediate repatriation.<sup>3</sup> Since 2019, most asylum seekers who present at the US-Mexico border are immediately removed from the US, to await asylum proceedings in Mexico (under the Migrant Protection Protocols)<sup>4</sup> or ejected due to the COVID-19 pandemic (through Title 42).<sup>5</sup> Some with urgent health needs, however, are permitted to stay in the country while they await an asylum hearing. Among those who are often permitted to stay are pregnant asylum seekers, mostly in the third trimester of their pregnancies, with their families.

After their release from detention, pregnant asylum seekers encounter numerous systemic failures and other obstacles that make their search for prenatal care extremely difficult, a fact that endangers their lives and their pregnancies. While they may be eligible for certain public assistance programs during this period, they are not provided resources or government assistance to help them access those programs to attain the care they need both at the border and in their receiving communities.<sup>6</sup> Additionally, they are arriving to a health care system that is, in many areas of the country, overextended and fragile. Some not-for-profit organizations such as Migrant Clinicians Network (MCN) provide support to some of these newcomers. However, these efforts only reach a small percentage of the people who need them. Such services address immediate needs of pregnant asylum seekers but do not address systemic deficiencies that leave many of them without access to care.

## **Condition of Migrants Upon Arrival at The Border**

Pregnant migrants who cross the US-Mexico border typically enter the country exhausted and marred. During their intense journey to the US southern border, pregnant migrants are at risk of kidnapping, rape, extortion, and physical violence.<sup>7</sup> The natural environment poses significant threats such as heat stress as well.<sup>8</sup> Many do not have access to sufficient nutrition during their journey, and starvation and malnourishment put not only the mother's life in danger, but also the

pregnancy. As a result, they arrive in the US after crossing the US-Mexico border in distress and in need of support. Many arrive with extensive sunburns and dehydrated from extreme heat exposure.<sup>9-12</sup> Often, these women have gone weeks without the ability to bathe and are caked with dirt.<sup>9</sup> Some have extensive bruising.<sup>9,10</sup> As a result of the immense challenges of pregnant migrants' journeys and the difficult circumstances that force them to migrate in the first place, many arrive traumatized physically and mentally but lack the resources to support their physical and mental health care on their own.

If the United States Customs and Border Protection (CBP) deems that someone seeking asylum is in urgent need of medical help, the agency may allow them to come across the border. Typically, pregnancy falls under this designation. Under the previous administration, the vast majority of pregnant migrants who were allowed to ask for asylum were in the third trimester of their pregnancies, though recent anecdotal evidence points to an increase in the acceptance of asylum seekers in their second trimester.<sup>9,10,13</sup> Most pregnant asylum seekers who cross the border have had little or no prenatal care, a trend which is particularly dangerous for people who are further along in their pregnancies.<sup>9-11, 14-16</sup> Few of the pregnant asylum seekers are aware of what kind of care is available or why it is important,<sup>9-11, 14</sup> a fact which only makes their health care access an even greater challenge.

## **Initial Processing of Pregnant Asylum Seekers**

When pregnant asylum seekers reach the border, they are typically given Title 42 exemptions because of their pregnancies and are accepted into the country on "humanitarian parole."<sup>13</sup> Under this designation, they may live within the US and travel anywhere within the country, but they are prohibited from working and thus cannot earn an income. Asylum seekers who enter under Title 42 exemptions typically hold this legal status for one year or until their court appearance for their asylum claim.<sup>13</sup>

If, during processing, CBP determines that a pregnant asylum seeker has a serious medical condition that needs immediate attention, she is sent to a nearby hospital where she receives care while in CBP custody.<sup>9, 12-16</sup> The definition of a "serious medical condition" is vague, but examples of conditions that would result in such a determination include spina bifida in a child or serious injuries requiring surgical intervention that the asylum seeker suffered during the journey.<sup>14</sup> If an asylum seeker goes to the hospital while in CBP custody, the agency covers the expenses.<sup>16</sup> However, CBP does not consider most pregnant asylum seekers to be in need of this immediate hospital attention. CBP releases most pregnant asylum seekers to shelters in the border region which results in the agency not bearing the responsibility to provide care or the liability of the pregnancy outcome. Additionally, the CBP does not provide resources or other connection services for the asylum seeker to find care on her own; the agency leaves the pursuit of care completely to the individual.

## **Limitations of Care at Shelters Along the Border**

Immigrant shelters, to which pregnant asylum seekers are released, are typically designed for short-term respite and travel coordination; many provide a shower and toiletries, a warm

meal, and assistance in purchasing a bus ticket. Most are run by volunteers and community members. Some provide overnight facilities for one- or two-night stays.

Most of these shelters do not offer medical services. Those that do typically provide minimal triage care in which a clinician screens migrants for emergency medical needs. At one shelter, a nurse midwife periodically provides a basic prenatal exam to ensure pregnant asylum seekers are healthy enough to continue their migration to their receiving community within the US. Other shelters lack capacity to provide care beyond a basic physical exam to all migrants, with limited staff, medical supplies and equipment, and facilities. Due to the short-term nature of their facilities, shelters that do provide medical care do not provide full solutions to pregnant asylum seekers' needs.

In an anonymous survey of seven shelters across three border states, three reported providing some kind of health care screening or services to the migrants it sees.<sup>25</sup> All seven, however, reported a need for more funding for crucial equipment and supplies as well as better coordination and cooperation with government entities. The strained conditions of the shelters limit their ability to support the migrants they seek to help, including for basic health screenings after detention.

## **Limited Support Systems for Asylum Seekers**

After asylum seekers leave shelters to travel to their respective final destinations around the country, they must find health care providers that can meet their health needs within their limited financial abilities—a task which is often unattainable due to numerous and substantial obstacles. Migrant Clinicians Network (MCN), a national not-for-profit that seeks to build practical solutions at the intersection of migration, health, and vulnerability, runs a program called Health Network that connects migrants with any ongoing health condition to care in their next destination, regardless of where they are moving. For pregnant asylum seekers, Health Network Associates, who act as case managers, mitigate obstacles to care by advocating for their care in medical facilities in their receiving communities, setting up medical appointments, transferring medical records if applicable, addressing logistical matters such as transportation to such appointments, and ensuring that the asylum seekers' access to care is continuous. However, for each patient with which the Health Network works, there are countless other pregnant asylum seekers who must fend for themselves without case management and support.<sup>9-12, 14, 15</sup> MCN is limited in funding and personnel for its initiatives and cannot connect with all the asylum seekers that need Health Network's support, and MCN does not have a formal relationship with any governmental immigration entity to communicate when and where pregnant asylum seekers are released into the country. Additionally, Health Network Associates encounter resistance from federally funded health centers and other prenatal care facilities to enroll late-term pregnant asylum seekers in care. Meanwhile, there are no federal or state programs that ensure asylum seekers are offered the care they need and deserve; the work of non-governmental organizations like MCN is the only safety net for pregnant migrant health care in the United States, and it only reaches a small number of the people who need it.

## Major Barriers to Health Care Access

**Education.** One of the most significant obstacles pregnant asylum seekers face in finding health care is understanding what care is available and why it is important. Several Health Network Associates report that one of the most significant tasks of their job is educating their patients about the US health care system since the patients are accustomed to the very different systems of their home countries.<sup>9-11</sup> Asylum seekers are generally unaware of the kind of care to which they have access and should pursue.<sup>9-11, 14</sup> Asylum seekers often do not understand the steps they must take to access the care they need.<sup>9-11,14,15</sup> “Sometimes, for example, migrants show up to appointments three hours late thinking the doctor can just take them whenever, so we have to make sure we explain everything to a T,” Brenda Ramirez, a Health Network Associate, explains.<sup>9</sup> Thus, asylum seekers who do not connect with such case managers are often ill-equipped to find and pursue the care they need, a fact which poses dangers to the pregnancy and the life and wellbeing of the mother.

**Cost.** Financial barriers are one of the most significant challenges pregnant asylum seekers face as they seek care.<sup>11, 14, 15</sup> Federally funded health centers are mandated to offer care for migrants and non-migrants regardless of patients’ ability to pay and to charge for services on a sliding fee scale.<sup>17</sup> However, many asylum seekers move to locations that are not close enough to health centers for them to be reasonably accessible.<sup>15</sup> At health centers, a patient’s fee is based on their household size and income,<sup>17</sup> yet those in the lowest fee category typically must pay a “nominal fee” which may be prohibitive even if it is only \$30 for a visit. While health centers may offer payment plans, migrants are often sufficiently intimidated by the asking price—even just the nominal fee—that they do not reach the point of establishing a payment plan.<sup>15</sup>

**Lack of insurance.** Many health clinics refuse to see patients without health insurance.<sup>9, 11, 15</sup> However, with no access to income, private insurance is impossible to pay for without a friend’s or family member’s assistance, and, in 25 states of the contiguous US, Medicaid is not immediately available to pregnant asylum seekers.<sup>18,19</sup> Without a social security number or other similar documentation, obtaining and utilizing insurance is made more difficult.<sup>10</sup> Moreover, language barriers add to the challenges of accessing insurance coverage.

**Transport.** Transportation often poses challenges as well.<sup>9,11,14,15</sup> Some health centers provide patient transport, but many others do not.<sup>11,15</sup> Health Network Associates frequently must set up and find a way to pay for their patients’ transportation to care providers.<sup>9-11</sup> For pregnant asylum seekers who are not enrolled in Health Network, transportation coordination is difficult in new settings, with limited finances, and no connection to community resources.<sup>11,15</sup>

**Refusal by health centers.** Many health care providers will not accept asylum seekers as new patients late in their pregnancies.<sup>9-11,14,15</sup> Health centers have not reported why they turn away late-pregnancy patients when it contradicts their mandate, but it may be due to liability concerns for patients who have had little to no prenatal care up to that point and have had suboptimal pregnancies due to difficult journeys.<sup>9,11,14,15</sup>

**Fear.** Many asylum seekers are fearful of sharing much about themselves or their medical history and drawing attention to themselves due to a lack of trust in the US immigration

system.<sup>15</sup> There may be a concern that accepting health care services may jeopardize their asylum-seeking status. Health Network Associates support fearful patients frequently.<sup>9-11</sup> As a result of pregnant asylum seekers' fear of and distrust in the system around them, they are more hesitant to take the necessary steps to access the care they need.

## **Dangers of Inadequate Prenatal Care**

Pregnancies without adequate prenatal care have significantly higher chances of fetal demise and neonatal death.<sup>20,21</sup> Low birth weight, another common effect of a lack of prenatal care, statistically leads to lower wages, worse educational attainment, and worse employment prospects in adulthood.<sup>22,23</sup> Inadequate prenatal care produces greater chances of preterm births,<sup>21</sup> and one study demonstrated that adequate prenatal care is linked to a reduction in postpartum hospitalization for people who deliver vaginally.<sup>24</sup> Without prenatal care, infants will not have the benefit of early screening and treatment of potentially life-threatening diseases and screening for congenital abnormalities, while in utero. Pregnancies without prenatal care may result in utilization of emergency services which produce unforeseen strain on the health care system.

## **Conclusions**

Safe pregnancies and births set the stage for healthy child development and strong mother-child bonds. The current US health care system, however, fails to provide the majority of pregnant asylum seekers who reside legally within the US with the support they need for their pregnancies and births to be safe. This failure leaves thousands in perilous, inhumane situations. A nationwide system of thorough, low-cost health insurance for pregnant asylum seekers must be established and streamlined to ensure that they can access the care they need anywhere in the country and regardless of their connection to a financial benefactor. This system must be held accountable for the health of the asylum seekers and of their pregnancies. The current migrant health care system provides care of various adequacy depending on numerous factors, but is insufficient for most. Comprehensive changes to the health care system must be made to ensure the humane treatment of all those whom the US accepts within its borders.

### **Case Study: A Pregnant Asylum Seeker's Pursuit of Care With MCN**

Esther, a Haitian asylum seeker, was pregnant when crossing the US-Mexico border with her husband. Her pregnancy was high risk, as she had had two prior miscarriages. Esther and her husband had tried to access prenatal care in Mexico during their migration but her husband reported that they were treated poorly. After crossing the border and a short detention, they moved to a state on the Eastern Seaboard, where they encountered a nonprofit focused on migrant emotional health. This nonprofit enrolled Esther into Health Network, Migrant Clinicians Network's bridge case management system for migrants. Health Network Associate Camila Velasquez was assigned to manage Esther's case. At the time of enrollment, Esther was in the 23<sup>rd</sup> week of her pregnancy.

Velasquez called numerous federally funded health centers in the area only for them to refuse to accept Esther as a new patient for unspecified reasons. Velasquez suspects that the centers did not want to deal with the liability or responsibility of a high-risk or complicated case with no prior prenatal care.

When Velasquez eventually did secure an initial appointment for Esther, the health provider

canceled the appointment just before it was scheduled to start and did not contact the family in advance. Esther and her husband had arrived at the clinic for a 10 AM visit. The clinic told them to return at 5 PM, but the couple did not have a means of personal transportation and thus were forced to wait for seven hours until the doctor could see them. They arrived back at their residence at approximately 9 PM.

After these concerning obstacles to secure an initial visit, the health center refused to give Esther a follow-up appointment, and the clinic did not inform her why she could not continue care there. Velasquez called the health center to ask for more information about their refusal, but upon mentioning the patient's name, the clinic representative shut down the conversation and ended the call. Velasquez called the clinic back and received no response. She ultimately called twelve other health centers before she could secure a second appointment for her patient. The earliest available date was nearly two months after the first. In the days after Velasquez scheduled the appointment, she searched for another way for Esther to access care sooner.

Velasquez and her colleagues connected with several doctors in Migrant Clinicians Network's physician network in a nearby state for advice about and assistance with the case. According to Velasquez, the doctors reported that a patient like the one in question could find care much more easily in the neighboring state, than the state in which Esther resided. In Velasquez's own experience, her communications with health centers in Esther's state felt rude and standoffish compared with those with health centers in the neighboring state.

Eventually, with the help of doctors in the neighboring state, Velasquez scheduled an appointment with a health clinic in that nearby state. The major challenge of transportation to the clinic immediately arose; Esther could not drive to the clinic, she and her husband were unfamiliar with the region, and the couple had very little money. Migrant Clinicians Network and their associates had to organize and pay for a ridesharing service to help Esther to the medical facility. Even when Esther reached her appointment, those at the front desk of the clinic refused to let Esther be seen because they lacked confirmation as to how she would pay for the appointment. Velasquez spoke with the clinic's staff and even had to connect the clinic with a medical doctor who works for Migrant Clinicians Network to assure the provider that the costs of the visit would be covered.

Ultimately, Esther had her appointment at the clinic in the neighboring state, and later went to the other appointment Velasquez had scheduled at a different health center in her own state. Esther and her husband are now in touch with a charity in the region to support their basic needs like food. Although the patient has established a steadier circumstance after the first few months than she had upon first arriving in the state, her pursuit of sufficient health care is not over. As her pregnancy continues and as she becomes a mother, she will undoubtedly have to navigate even more obstacles to access the further care and attention she needs.

Without such care advocacy and support, many pregnant asylum seekers forgo prenatal care. Without care records and relationships with providers, a pregnant asylum seeker who goes into labor would continue to the emergency department, where she would be higher risk because of a lack of prenatal care. Her emergency care would potentially be more expensive due to use of emergency services and the cost of treating any complications that could have been prevented with proper prenatal care, including preeclampsia and C-section. Therefore, case management would provide better care to the asylum seeker and lowered costs for the health system – if clinics accept the patients into their practices. As demonstrated in Esther's case, many federally funded clinics across the US are not prepared to provide mandated access to these services and reject pregnant asylum seekers.

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