Enhanced immigration enforcement in the USA and the transnational continuity of HIV care for Latin American immigrants in deportation proceedings

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In our work as clinicians, researchers, and immigrant rights advocates, we have noted increased anxiety about the possibility of deportation and disruptions in care among immigrants with HIV. Before the 2016 US elections, patients rarely asked about HIV treatment in their home countries. However, since the increase in anti-immigrant rhetoric and arrests by US Immigration and Customs Enforcement, patients have voiced concerns about the availability of HIV treatment in their home countries much more frequently. Although antiretroviral therapy is available throughout Latin America, access depends on economic, social, and political circumstances. Maintaining uninterrupted continuity of care among immigrants held in detention or deported to their home countries is challenging. In this Viewpoint, we identify periods of particular vulnerability for immigrants during deportation proceedings, from initial detention to deposition in their country of origin. We discuss the effect of enhanced immigration enforcement on the health and wellbeing of HIV-infected immigrants, and on public health. Finally, we also discuss recommendations for clinicians, immigration authorities, and public health institutions in the USA and in receiving countries.

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The continuity of HIV care among Latin American immigrants

Migration and travel have driven HIV transmission since the earliest days of the epidemic. Phylogenetic studies highlight the role of migration in bridging the HIV epidemic between North and South America[1] and suggest that most Latin American immigrants acquire HIV after arrival to the USA.[2] Economic, social, and political circumstances in the country of origin, during transit, and in the USA often put immigrants at risk of physical and emotional harm.[3,4] Undocumented immigrants travelling by land are often exposed to various forms of violence, including extortion, kidnapping, human trafficking, and sexual assault. Once in the USA, stressors related to their documentation status and the fear of family separation are prevalent, but can be especially harmful in states with more restrictive immigration legislation.[5] Isolation and loss of established social or family networks can lead to substance use and unprotected sex with casual partners.[6] Among gender and sexual minorities, changing behavioural norms and the opportunity to live more openly in the USA can lead to high-risk behaviours and social networks with high risk of transmission.[7] Additionally, language and cultural barriers, restrictive policies, and discrimination can reduce access to basic services, including health-care and preventive services.[8,9]

Since UNAIDS launched the 90-90-90 HIV targets for 2020, HIV care continuums have improved remarkably in many places worldwide. Among Latinos diagnosed with HIV in the USA, an estimated 75% are linked to care within a month, and 58% are virally suppressed.[10] Approximately 43% of Latinos diagnosed with HIV are born outside the USA, and among those, 66% are men who have sex with men.[11] Late diagnosis persists, but virological outcomes are good after engagement in care, especially among undocumented immigrants.[12–14]

These findings are not surprising to many physicians caring for HIV-infected Latino immigrants. Reduced English proficiency, lack of insurance, difficulty navigating the health-care system, fear of deportation, and stigma related to HIV status are barriers to health care.[15] Immigrants without health insurance often delay seeking medical care until they become symptomatic and unable to work.[12,14,16] The tangible impact of antiretroviral therapy (ART) can reinforce the importance of adherence, and viral suppression tends to be good if treatment is provided at no (or minimal) cost, by culturally competent health-care teams.[13,17] However, even the patients that are most adherent to treatment would have trouble maintaining viral suppression if detained and deported.

In this Viewpoint, Latino refers to anyone of Latin American descent residing in the US, regardless of where they were born. Latin American refers to a person born in a Latin American country.

Heterogeneity in immigration enforcement and implications for HIV care

Since President Trump issued executive order 13768, *Enhancing Public Safety in the Interior of the United States*, non-criminal immigration detentions have more than doubled.[18,19] Although a similar number of individuals were deported in 2016 and 2017, the Immigration and Customs Enforcement (ICE) proceeded with 143 470 administrative arrests in 2017, the highest number in the past 3 fiscal years.[18] The Trump administration's shift from prioritising removal of immigrants convicted of serious crimes to removing any immigrants believed to have committed any crime (including minor offences like

traffic violations or driving without a licence) has increased the fear of deportation among many undocumented immigrants. This fear is particularly evident in areas of the country where local law enforcement cooperates with the ICE or where state and municipal policies restrict undocumented immigrant access to driver's licences and other basic health and social services.

Exclusionary policies have been associated with poor mental health outcomes, enhanced risk of HIV infection, and delays in HIV diagnosis and treatment.[5,20–22] Heterogeneity in immigration policy enforcement in different areas of the country (eg, rural *vs* urban areas, or liberal *vs* conservative jurisdictions) can have a profound effect on the risk of detention and deportation, access to social benefits (including basic health care and identification cards), and the stress associated with undocumented status.[5,21] On the one hand, restrictive legislation has passed in states such as Alabama, Arizona, Georgia, Indiana, and South Carolina, allowing police to question people about their immigration status. On the other hand, states including California, Connecticut, Maryland, and Washington offer driver's licences and in-state tuition, regardless of immigration status.[23]

HIV care in detention facilities

Among patients engaged in HIV care, maintaining continuous access to treatment while in detention can be challenging. Studies in US correctional facilities show that prisoners can achieve good virological outcomes in detention using simple, well tolerated regimens and if structured protocols are implemented and followed.[24] However, the detention process for immigrants in deportation proceedings is complex and decentralised, leading to frequent lapses in access to appropriate medical care and essential medications.

Some individuals detained by ICE are housed at one of 21 federal detention centres, but most are housed in one of the more than 250 local detention facilities operating under intergovernmental services agreements, or in contract detention facilities provided by private sector operators. These local or contract detention facilities often cooperate with local law enforcement to detain immigrants and relieve overcrowded conditions in the federal detention centres. Transfers from one centre to another are frequent, often across jurisdictional boundaries, and lengths of stay for immigrants vary widely.[25]

ICE facilities adhere to 2011 Performance-Based National Detention Standards,[26] but these standards are non-enforceable in private detention facilities where poor living conditions are common and medical services vary depending on contractual agreements.[27] Most deaths in ICE custody between 2003 and 2013 occurred in local detention facilities operating under intergovernmental services agreements or in contract detention facilities provided by private sector operators.[28] According to Human Rights Watch, systemic substandard medical practice and unqualified medical staff contributed to preventable deaths, including suicide and HIV-related deaths.[25] In 2016, a report[29] by the Office of the Inspector General at the Department of Justice found that contract prisons had more safety incidents than those operated by the Federal Bureau of Prisons, prompting the Department of Justice to begin phasing out the use of private prisons.[30] However, the new Trump administration has reversed this decision and is relying more than ever on privately contracted facilities to house detained immigrants.[31] In an alarming move, the ICE has asked the National Archives and Record Administration for permission to begin routine destruction of records related to sexual assaults and deaths of people in their custody.[32]

ART is available to detainees who disclose their HIV status in the 21 federal detention centres operated by the Bureau of Prisons, but there are many disincentives for disclosure. In addition to the stigma associated with HIV infection, detained immigrants might be fearful that disclosure would negatively affect their immigration case. Although the ban on entry into the USA by HIV-infected individuals has been lifted,[33] reports of President Trump's anti-immigrant rhetoric about people from Haiti and HIV, since denied by the White House, might reinforce this fear. Gender and sexual minorities might be even less likely to disclose their HIV status, given their vulnerability to discrimination and sexual assault within correctional systems.[34] Interviews with 18 transgender immigrant women held in detention centres revealed that most are held in men's facilities and are subject to trauma and abuse.[35]

In 2009, the US Centers for Disease Control and Prevention (CDC) issued guidelines for HIV testing and linkage to care in correctional settings.[36] Implementation research at a state prison in Connecticut has shown high rates of virological suppression.[24] The successful transition back to the community, however, is often jeopardised by relapse into substance use, risky sexual behaviour, treatment interruption, and high mortality.[37] Maintaining HIV suppression after release from prison requires intensive case management, access to treatment of mental health and substance use disorders, adherence support interventions, and coordination of medical care.[38]

HIV care after deportation

None of these resources are routinely available to HIV-infected individuals deported from the USA (other than a 30 day supply of ART if they were receiving therapy while detained). Immigrants are typically released at the border between Mexico and the USA without identification and with few personal belongings.[39] Most find themselves in unfamiliar territory, far from their home communities, and for many, their immediate priority is how to re-enter the USA. Clinics capable of caring for HIV-infected individuals might not be easily accessible to those immigrants interested in seeking HIV care, because of distance or lack of health coverage.

Additionally, providers are often uncomfortable prescribing ART without previous medical records. The drugs used in the USA might not be available in immigrants' home countries. Patterns of drug resistance circulating in the USA might also differ, and the first-line regimen might be inadequate for patients with pre-existent resistance mutations.[40] Without access to previous medical records (including drug resistance profiles), health-care providers in the receiving country might make inadequate changes to drug regimens of immigrants with drug resistant HIV.

Vulnerable populations, such as gender and sexual minorities, face additional barriers to receiving appropriate HIV preventive services and treatment.[41] Immigrants who left their home countries because of their sexual orientation often experience social exclusion upon return.[42] Unfamiliarity with sexual diversity and lack of competency in LGBT care can lead to discrimination or even denial of care. The negative attitude of health-care providers can reduce patients' trust in the health-care systems and disrupt the continuum of care. Protective legal frameworks for sexual and gender minorities and HIV-infected individuals are not uniform in receiving countries. For example, Mexico has antidiscrimination legislation, and Mexico City has gender identity laws that allow transgender people to change their name and sex on legal documents. In contrast, no laws in El Salvador, Guatemala, and Honduras prohibit discrimination based on sexual orientation and gender identity.[41] In some countries in Central America HIV transmission is criminalised, or HIV testing is mandatory to obtain a marriage licence, adopt a child, or for particular groups of people such as sex workers.[43]

Stigma and discrimination associated with HIV also has consequences for public health. The fear of stigmatisation is a deterrent to disclosure, and might contribute to HIV transmission to sexual partners. Over 80% of individuals deported from the USA to Mexico and Central America are male.[44] A study[45] with Mexican indigenous women reuniting with their spouses after their return from the USA reported difficulties discussing condom use and HIV testing, because the women were fearful of being accused of infidelity or of not trusting their partners, which could have lead to disputes and domestic violence. Additionally, access to HIV care might be reduced in rural communities of Mexico and Central America.[46] This is particularly concerning for women who become pregnant after reuniting with migrant partners and have reduced access to prenatal HIV testing or treatment to prevent mother-to-child transmission.[47] Most Latin American countries have adopted the 2010 Pan American Health Organization recommendation to provide universal perinatal HIV testing and surveillance of perinatal HIV transmission.[48] As a result, maternal infant transmission of HIV has declined across Latin America, but gaps in care persist. In Guatemala, for example, a third of pregnant women do not deliver in a hospital and only 42% are tested for HIV.[48] In Mexico, most births occur in hospital settings, but only 56% of pregnant women are tested for HIV.[48] The enhanced risk of HIV infection among women with migrant partners has been documented in various settings.[47]

The public health implications of disruptions to HIV care are not limited to receiving countries. The intersectionality between the geographical, social, and political landscape at the border between Mexico and the USA has fueled an emerging HIV epidemic that affects both countries.[39,49] The crossing between San Diego and Tijuana is one of the busiest land borders in the world. Poverty, drug trafficking, sex work, and injection drug use place deportees at high risk of HIV infection. The extent of cross-border migration complicates public health efforts to control the HIV epidemic in both countries. Men who have sex with men and clients of female sex workers living in San Diego report crossing the border to Tijuana frequently for sex,[49,50] and phylogenetic analysis shows linkage of transmission networks between San Diego and Tijuana among men who have sex with men and people who inject drugs.[51]

Recommendations

The political debate about immigration grows, but the effect of deportations on public health and the transnational continuity of HIV care has received little attention. One reason is lack of data to assess the extent of the problem. The HIV prevalence among Latin American immigrants in the USA is low (0·5%), but the prevalence is much higher among gender and sexual minorities. More deportations could lead to thousands of HIV-infected individuals at risk of treatment interruption, poor health outcomes, and ongoing transmission in receiving communities and at the border between Mexico and the USA.

Thus, several key components of the continuity of HIV care must be put in place to address stigma, discrimination, and human rights (table). Within detention centres in the USA (where immigrants can be detained for prolonged periods of time), monitoring systems can ensure that all detention facilities adhere to performance-based national standards[26] for the delivery of appropriate medical care. To reduce the strain on detention centres to meet the needs of HIV-infected immigrants, community-based alternatives to detention centres and humanitarian parole could be offered to people with medical needs that cannot be adequately met in detention. Methods of data collection and identification of deportees infected with HIV (compliant with patient autonomy and protection of confidentiality) should be improved. The development of legally and ethically sound data-sharing policies to strengthen the coor-dination of linkage to care between countries is crucial to ensure transnational continuity of HIV care. These policy changes are not straightforward to

	Health-care providers	US Immigration and Customs Enforcement	General advocacy, communication, and social mobilisation	Local immigration administration	Receiving country
Health service delivery and HIV care	Follow National Immigration Law Center guidelines[52] and create safe spaces to discuss immigration concerns and risks of deportation; establish medical-legal partnerships that leverage the expertise of lawyers and non-governmental organisations to address immigration issues, including asylum eligibility[53]	Offer voluntary HIV testing at ICE intake with protection for the rights of patients to autonomy and confidentiality[54,55]	Advocate for collaboration between health-care providers and human rights organisations to create a human rights framework for the delivery of care to HIV-infected immigrants*	Provide access to health care, including free HIV counselling, testing, prevention, and treatment;[56] require health-care providers to complete training for culturally and linguistically appropriate services[57]	Implement reintegration services and provide legal identification to facilitate access to health and social programmes; offer voluntary HIV testing and access to programmes designed to help with reintegration into receiving country[56]
Data monitoring and surveillance	Enrol patients in the MCN or establish a way for the patient to communicate with the clinic that was caring for the patient in the USA, if deported;[58,59] use AIDS Education and Training Center resources to facilitate linkage to care[44]	Gather data about HIV prevalence and outcomes to monitor quality and continuity of care within the ICE and other detention facilities in the USA;[54] establish international agreements for sharing of data and medical records, perhaps coordinated by the PAHO and the CDC, leveraging existing infrastructures created by MCN and CureTB[60,59]	Advocate for human rights monitoring of compliance with PBNDS in detention facilities, especially those operating under intergovernmental services agreements, or contract detention facilities;[26] encourage human rights monitoring of evidence of stigma, discrimination, and violence against HIV-infected detainees and gender and sexual minorities[25]	Ensure compliance with national standards for Culturally and Linguistically Appropriate Services[57]	Gather data about HIV prevalence and outcomes to monitor quality and continuity of care for immigrants returning to their home countries;[56,61,62] establish international agreements for sharing of data and medical records
Policy	Inform patients of their right to receive medical care and report discrimination because of HIV status in correctional facilities;[26] discuss potential unintended consequences of HIV disclosure; partner with human rights organisations to monitor HIV-related stigma, discrimination, and violence in detention facilities*	Enforce compliance with PBNDS in all facilities, including those operating under intergovernmental services agreements, or contract detention facilities;[26] inform all detainees of their rights, including the right to HIV treatment, reporting of grievances, and legal rights advice;[26] allow external monitoring agencies to oversee compliance with PBNDS in all facilities;* comply with the Freedom of Information Act to not destroy records of sexual assaults or deaths in custody;[28,32] offer community-based alternatives to detention and humanitarian parole based on medical needs*	Encourage dissemination of clear information to the public to raise awareness about the effect of enhanced deportation on HIV-infected immigrants and public health[56]	Provide undocumented immigrants with access to driver's licences[5,20]	Establish specific policies for ART for immigrants returning to their home countries, to avoid failure from pre-existing resistance mutations (eg, using a dolutegravir backbone or targeted genotype resistance testing)[40]

ICE=Immigration and Customs Enforcement. MCN=Migrant Clinician's Network. PAHO=Pan American Health Organization. CDC=US Centers for Disease Control and Prevention. PBNDS=Performance Based National Detention Standards. ART=antiretroviral therapy. *Recommendations based on the authors' clinical and public health experience.

***Table*: Recommendations to strengthen the continuity of HIV care for people deported from the USA to Latin America**

implement, but there are models available that can be instructive.

For more on the **Migrant Clinicians Network** see https://www.migrantclinician.org/

WHO has developed a consensus document outlining recommendations for coordinating transnational continuity of care for patients with tuberculosis.[60] The document highlights key elements, including political commitment (eg, a legal framework for cross-border collaboration), adequate governance and financial mechanisms, surveillance and monitoring, and adequate health service delivery. In the USA, the Migrant Clinicians Network, a non-profit organisation that coordinates continuity of care for migrant populations through case management, technical assistance, and transfer of medical information, has facilitated care coordination for over 1500 migrants from the USA with active tuberculosis.[45,58,59] The CDC cooperate with the

ICE to coordinate care for tuberculosis cases across borders. The National Health Service Corps screen almost 200 000 detained immigrants a year with chest radiography to reduce the risk of tuberculosis transmission within facilities. Patients with chest abnormalities are evaluated for active tuberculosis and treated as needed. Continuity of care is then coordinated through the CDC CureTB Program,[63] which facilitates the transfer of clinical information and warm handoffs to treatment centres following deportation of detained immigrants.

Routine voluntary HIV screening is not offered in ICE facilities, which might be a lost opportunity.[54,55] Studies in US correctional facilities have shown that opt-out confidential HIV testing is feasible, acceptable, and cost-effective.[37] However, given the potential for serious adverse social consequences if the HIV test result is positive (which might be different to the consequences of a tuberculosis diagnosis), the human rights implications need to be considered before adapting the tuberculosis screening model to immigrants in detention facilities. For example, the effect of a HIV-positive result on immigration proceedings should be evaluated, in addition to the possibility of further discrimination of gender and sexual minorities. Before any guidelines are issued or HIV testing programmes are implemented, consultation with relevant stakeholders (including members of the affected communities), human rights organisations, and groups serving immigrant populations is required.

Receiving countries should also establish initiatives to facilitate the reintegration of patients into their health-care system. Confidential assistance for all HIV-infected deportees immediately upon their return is essential to link them to health and social programmes to which they might be entitled. The Mexican National Institute of Migration, for example, has implemented a repatriation strategy called Somos Mexicanos to provide personalised assistance to returning migrants, offering legal identification and facilitating their reintegration into economic and social structures.[64] Migrants from Central America, however, do not have access to this service.

The transnational continuity of HIV care is complex. Creating a robust public health approach to facilitate HIV care among immigrants will require political will and financial commitment from the USA and from receiving countries. Existing infrastructure and international agreements between public health agencies to control the spread of other infectious diseases such as tuberculosis and influenza could be leveraged to develop the logistics of HIV care across borders, enhance efficiency, and reduce cost.

Building this infrastructure will take time, so clinicians must do their best to assist patients at risk of deportation (table). The National Immigration Law Center[52] has developed "Know your rights, and know your patients' rights" factsheets with information for health-care providers and institutions to prepare for interactions with law enforcement or ICE that could affect their patients. Individuals with HIV should be informed of their right to receive medical care (including ART) while in custody, and of their right to formally report grievances and access representation from legal rights groups without reprisal, as outlined in the Performance-Based National Detention Standards.[26] Oversight and enforcement of compliance with these standards varies, especially in contract detention facilities, with reports from human rights organisations documenting serious lapses in care.[25,32,34]

To ensure rightful access to HIV care, detainees should be encouraged to disclose their HIV status to a health professional, but they should be informed of the possibility of a breach in confidentiality and attendant risks such as discrimination or violence while detained. Additionally, patients should be informed that discrimination by correctional officers as a result of their HIV status should be reported, and that legally, HIV infection should not affect deportation proceedings. Clinicians must also be sensitive to the stressors faced by people in detention centres. The detainees might have been suddenly removed from their everyday lives and families and might be wondering if they will ever see their children again, while navigating a system that feels hostile to them. Under these circumstances, HIV care could become a secondary priority to them, and detainees might feel understandably wary of disclosing their HIV status within a system they do not trust.

The extreme vulnerability of immigrants during deportation proceedings highlights the importance of a multidisciplinary approach to address these issues. Advocacy might push some clinicians beyond their comfort zone, but collaboration with human rights organisations, immigrant rights advocates, media, and health authorities could help raise awareness of suboptimal conditions in detention facilities. Academics can also contribute to this work, for example by collaborating with human rights organisations to implement monitoring procedures and examine the differences in living conditions and medical care depending on the type of detention facility, and its location. Hatzenbuehler and colleagues,[5] for instance, have highlighted the heterogeneity of local immigration enforcement and associated health outcomes. In clinical settings, health-care providers can establish medical-legal partnerships to clarify questions, assist victims of violence or discrimination, and assess asylum eligibility based on threats to wellbeing if deported, such as persecution due to sexual and gender orientation.[38,53]

However, this advocacy work must be done cautiously to avoid unintended consequences. Current anti-immigrant attitudes could be further exacerbated by bringing public attention to the needs of HIV-infected immigrants. Although there is strong evidence that the risk of HIV infection increases after migration to the USA and is exacerbated by exclusionary immigration

policies,[6,7,9,20,21] proponents of anti-immigrant policies might overlook this. The Trump administration has expanded deportation priorities to include undocumented immigrants who have abused public health benefit programmes;[65] this change raises concerns that HIV-infected immigrants receiving healthcare in the USA could be targeted. Although this conduct would be a violation of human rights of HIV-infected individuals as outlined by international standards,[66,67] the possibility of covert discrimination through the application of immigration policy must be considered and closely monitored.

Developing a plan of action in case of deportation can also give patients a sense of control and provide reassurance. Using the fact sheets developed by the AIDS Education and Training Centers to assist HIV-infected patients returning to Mexico and Central America is a good place to start.[44] Resources like the Migrant Clinicians Network provide a Health Insurance Portability and Accountability Act (HIPAA) compliant platform to share medical records with international providers (with patients' consent) and link patients to care through virtual case management. Providers should be familiar with existing and functional safety net organisations in Mexico and Central America that serve gender and sexual minority populations.

These are stressful times for undocumented immigrants. For those that are HIV-positive, clinicians can mitigate some of the uncertainty by providing accurate information and facilitating continuity of care. A systems approach to address the transnational continuity of HIV care would have broad benefits not only for undocumented immigrants, but also for global public health and for all HIV-infected individuals who choose to relocate abroad, regardless of country of origin or destination.

Contributors

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We declare no competing interests.

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