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Enhanced Immigration Enforcement in the US and the Transnational Continuity of HIV Care for Latinx Migrants in Deportation Proceedings

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Introduction

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 HIV-infected immigrants. Before the 2016 elections, patients rarely asked about HIV treatment in their home countries. But as anti-immigrant rhetoric and arrests by Immigration and Customs Enforcement (ICE) escalated, patients have brought up concerns about the availability of HIV treatment in their own country much more frequently. Although antiretroviral therapy (ART) is available throughout Latin America, there is heterogeneity in access depending on economic, social and political forces.¹ Maintaining uninterrupted continuity of care among immigrants held in detention and/or deported to their home countries is challenging, at best. In this article, we identify periods of particular vulnerability during deportation proceedings, from initial detention to deposition in the country of origin. We discuss the implications of enhanced immigration enforcement on the health and well-being of HIV-infected migrants, and on public health. We conclude with recommendations for clinicians, immigration authorities, and public health institutions in the US and in receiving countries.

The continuity of HIV care among Latinx 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 America², and suggest that most Latinx immigrants acquire HIV after arrival to the US³. Economic, social, and political forces in the country of origin, during transit, and in the US often put migrants at risk of physical and emotional harm^{4,5}. Undocumented immigrants traveling by land are often exposed to various forms of violence, including extortion, kidnapping, human trafficking and sexual assault. Once in the US, 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.⁶ Isolation and the loss of established social or family networks can lead to substance use and unprotected sex with casual partners⁷. Among gender and sexual minorities, changing behavioral norms and the opportunity to live more openly in the US can lead to high risk behaviors and entrance into high transmission risk networks⁸. In addition, language and cultural barriers, restrictive policies, and discrimination can limit access to basic services, including healthcare and preventive services^{9,10}.

Since the Joint United Nations Program on HIV/AIDS (UNAIDS) launched the 90–90–90 HIV targets for 2020, there has been remarkable progress in the HIV continuum of care worldwide. It is estimated that among Latinxs diagnosed with HIV in the US, 75% are linked to care within a month, and 58% virally suppressed¹¹. Approximately 43% of Latinxs diagnosed with HIV are foreign-born, and among them, 66% are men who have sex with men (MSM)¹². Late diagnosis persists, but virologic outcomes are good after engagement in care, especially among undocumented immigrants^{13–15}.

These findings are not surprising to many physicians caring for HIV-infected Latinxs immigrants. Limited English proficiency, lack of insurance, difficulty navigating the health

system, fear of deportation, and stigma related to an HIV status are barriers to healthcare¹⁶. Immigrants without health insurance often delay seeking medical care until symptomatic and unable to work^{13,15,17}. The tangible impact of antiretroviral therapy under these circumstances can reinforce the importance of adherence, and viral suppression tends to be good if treatment is provided at no or minimal cost and by culturally-competent healthcare teams^{14,18}.

Even the most adherent patients, however, may have trouble maintaining viral suppression if detained and deported.

Heterogeneity in Immigration enforcement and implications for HIV

Since President Trump issued Executive Order 13,768, “Enhancing Public Safety in the Interior of the United States,” immigration detentions have more than doubled. Although the number of individuals deported in 2016 and 2017 were similar, ICE conducted 143,470 administrative arrests in 2017, the highest number in the last 3 fiscal years¹⁹. The Trump administration’s shift from prioritizing removal of immigrants convicted of serious crimes to anyone believed to have committed any crime (including minor offences like traffic violations or driving without a license) has increased the fear of deportation among many undocumented immigrants. This is particularly evident in areas of the country where local law enforcement cooperates with ICE or where state and municipal policies restrict undocumented immigrant access to driver’s licenses 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^{6,20–22}. Heterogeneity in immigration policy enforcement in different areas of the country (for example, rural vs urban, or liberal versus conservative jurisdictions) can have a profound effect on the risk of detention/deportation, access to social benefits, including basic health care and identification cards, and the stress associated with undocumented status^{6,21}. On the one hand, restrictive legislation has passed in states such as Arizona, Alabama, Georgia, Indiana and South Carolina allowing police to question people about their immigration status, and on the other hand, states including California, Washington, Maryland and Connecticut offer driver’s licenses and in-state tuition regardless of immigration status.²³

HIV care in detention facilities

Among patients engaged in HIV care, maintaining continuous care access to treatment while in detention can be challenging. Studies in US correctional facilities demonstrate that prisoners can achieve good virologic outcomes in detention using simple, well-tolerated regimens and when structured protocols are implemented and followed²⁴. However, the detention process for migrants in deportation proceedings is complex and de-centralized, 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 Centers, but most are housed in one of the more than 250 local detention facilities operating under intergovernmental services agreements (IGSA) or contract detention facilities (CDF)

provided by private-sector operators. These facilities often cooperate with local law enforcement to detain immigrants and relieve overcrowded conditions in the Federal ICE Detention Centers. Transfers from one place to another are frequent, often across jurisdictional boundaries, and lengths of stay for immigrants vary widely ²⁵.

ICE facilities adhere to Performance-Based National Detention Standards 2011 (PBNDS)²⁶, but these are non-enforceable in private detention facilities where poor living conditions are common and medical services vary depending on contractual agreements.²⁷ The majority of deaths ICE Custody between 2003 and 2013 occurred in IGSA or CDF facilities 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 by the Office of the Inspector General at the Department of Justice (DOJ) found that contract prisons had more safety incidents than those operated by the Federal Bureau of Prisons prompted the DOJ to begin phasing out the use of private prisons. However, the new administration has reversed this decision and is relying more heavily than ever on privately contracted facilities to house detained immigrants ²⁹. In an alarming move, ICE has asked the National Archives and Record Administration (NARA) for permission to begin routinely destroying records related to sexual assaults and deaths of people in its custody ³⁰.

In the 21 Federal Detention Centers operated by the Bureau of Prisons, ART is available for detainees who disclose their HIV status, but there are many disincentives for individuals to disclose. In addition to the stigma associated with HIV infection, detained immigrants may be fearful that disclosure may negatively impact their immigration case. Although the ban on entry into the US by HIV-infected individuals has been lifted ³¹, President Trump's anti-immigrant rhetoric about people from Haiti and HIV may reinforce this notion. Gender and sexual minorities may be even less likely to disclose their status, given their vulnerability to discrimination and sexual assault within correctional systems ³². Interviews with 18 transgender immigrant women held in detention revealed that most are held in men's facilities and are subject to trauma and abuse ³³.

In 2009, the Centers for Disease Control (CDC) issued guidelines for HIV testing and linkage to care in correctional settings ³⁴. Implementation studies have demonstrated high rates of virologic suppression in prison ²⁴. The successful transition back to the community, however, is often jeopardized by relapse substance use, risky sexual behavior, treatment interruption, and high mortality ³⁵. Maintaining HIV suppression after release requires intensive case management, access to mental health and substance use disorder treatment, adherence support interventions, and coordination of medical care ³⁶.

HIV care after deportation

None of these resources are routinely available for HIV-infected individuals deported from the US (other than a 30-day supply of ART if they were receiving therapy in detention). Immigrants are typically released at the border without identification and few personal belongings ³⁷. Most find themselves in unfamiliar territory, far from their home communities, and for many, their immediate priority is how to re-enter the US. Among those

interested in seeking care, clinics capable of caring for HIV may not be easily accessible due to distance or lack of health coverage.

In addition, providers are often uncomfortable prescribing ART without prior records. Medications used in the US may not be available in the receiving country. Drug resistance patterns circulating in the US may be different from those in the receiving country and the first line regimen may be inadequate for patients with pre-existent resistance mutations³⁸. Without access to previous medical records (including drug resistance profiles), providers may make inadequate treatment change upon arrival.

Vulnerable populations, such as gender and sexual minorities, face additional barriers to appropriate HIV preventive services and treatment³⁹. Immigrants who left their country because of their sexual orientation often experience social exclusion upon return⁴⁰. Lack of familiarity with sexual diversity and competency in LGTB care can lead to discrimination or even denial of care. Negative healthcare provider attitudes can erode patient trust in the healthcare system and disrupt the continuum of HIV. 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, in Honduras, El Salvador, and Guatemala there are no laws prohibiting discrimination on the basis of sexual orientation and gender identity³⁹. Some countries criminalize HIV transmission, or mandate HIV testing to obtain a marriage license, adopt a child, or for particular groups, such as sex workers⁴¹.

Stigma and discrimination associated with HIV also has consequences for public health. The fear of stigmatization is a deterrent to disclosure and may contribute to HIV transmission to sexual partners. Over 80% of individuals deported from the US to Mexico and Central America are male⁴². Women reuniting with spouses returning from the US may have limited power to negotiate condom use or suggest HIV testing for their partners⁴³. In rural communities, access to HIV care may be limited⁴⁴. This is particularly concerning for women who become pregnant upon reunification with their migrant partners and have limited access to pre-natal HIV testing or treatment to prevent maternal to child transmission.⁴⁵ Most Latin American countries have adopted the 2010 Panamerican Health Organization recommendation to provide universal perinatal HIV testing and conduct surveillance of perinatal HIV transmission⁴⁶. As a result, the maternal infant transmission of HIV has declined, 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 HIV⁴⁶. In Mexico, most births are in hospital settings, but only 56% of pregnant women receive an HIV test⁴⁶. The enhanced risk of HIV infection among women with migrant partners has been documented in various settings.⁴⁵

The public health implications of disruptions in the continuum of care are not limited to receiving countries. The intersectionality between the geographic, social, and political landscape at the US-Mexico border have fueled an emerging HIV epidemic that impact both countries^{37,47}. The Tijuana-Mexico border is one of the busiest land border crossings in the world. Poverty, drug trafficking, sex work, and injection drug use place deportees at high

risk of HIV infection. High cross-border mobility complicates public health efforts to control the HIV epidemic in both countries. Men who have sex with men and clients of female sex worker living in San Diego report crossing the border to Tijuana frequently for sex ^{47,48}, and phylogenetic analysis demonstrates linkage of transmission networks between San Diego and Tijuana among MSM and people who inject drugs ⁴⁹.

Recommendations

As the political debate about immigration rages, the impact of deportations on public health and the transnational HIV continuity of care cascade has received little attention. One reason is lack of data to assess the extent of the problem. The HIV prevalence among Latinx immigrants in the US is relatively low (0.5%), but among gender and sexual minorities the prevalence is much higher. Increases in deportations could lead to thousands of HIV-infected individuals at risk for treatment interruption, poor health outcomes, and ongoing transmission in receiving communities and at the US-Mexico border.

To address this, several key components must be in place (Table 1). Within detention centers in the US, where immigrants can be detained for prolonged periods of time, monitoring systems can ensure that all detention facilities adhere to performance-based national standards for the delivery of appropriate medical care. The strain on detention centers to meet the needs of HIV-infected immigrants could be mitigated with expansion of community-based alternatives for detention and humanitarian parole for people with medical needs that cannot be adequately met in detention.

In addition, improvements in data collection methods and identification of deportees infected with HIV (compliant with patient autonomy and protection of confidentiality) are needed. The development of legally and ethically sound data-sharing policies and programs to strengthen the coordination of linkage to care between countries are critical to address the transnational continuity of HIV care. These changes are not straightforward to implement, but there are models available that can be instructive.

The World Health Organization (WHO) has developed a consensus document outlining recommendations for coordinating transnational continuity of care for patients with tuberculosis (TB) ⁵⁰. The document highlights key elements that must be in place, including political commitment (legal framework for cross-border collaboration), sound governance and financial mechanisms, surveillance and monitoring, and adequate service delivery. In the US, the Migrant Clinicians Network, a non-profit organization 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 US with active tuberculosis ^{43,51,52}.

In addition, the CDC cooperate with ICE to coordinate care for tuberculosis (TB) cases across borders. The Health Service Corps screen almost 200,000 detainees a year with chest radiography to reduce the risk of TB transmission within facilities. Patients with abnormalities are evaluated for active TB and treated as needed. Continuity of care upon removal is coordinated through the CDC CureTB Program ⁵³ which facilitates the transfer of

clinical information and coordinates warm hand-offs to treatment centers following deportation.

Offering routine voluntary HIV screening is not performed in ICE facilities. This may be a lost opportunity ^{54,55}. Studies in correctional facilities demonstrate that opt-out confidential HIV testing is feasible, acceptable, confidential, and cost-effective ³⁵. However, given the potential for serious adverse social consequences of a HIV-positive test result, which may differ from those of a TB diagnosis, the human rights implications need to be considered before adapting the TB model to immigrants in detention facilities. For example, it would be important to evaluate how an HIV-positive result may affect immigration proceedings or whether it could lead to further discrimination of gender and sexual minorities. Consultation with relevant stakeholders including members of the affected communities and engagement with groups serving immigrant populations and human rights organizations should be conducted in advance of issuing any guidelines or implementation of HIV testing programs.

In addition, receiving countries should establish initiatives to facilitate medical repatriation. Confidential assistance immediately upon repatriation for all HIV infected deportees is essential to link them to health and social programs to which they may have entitlements. The Mexican Institute of National Migration, for example, has implemented a repatriation strategy “Somos Mexicanos” to provide personalized assistance to returning migrants, provide legal identification, and facilitate reintegration to economic and social structures ⁵⁶. Central America migrants, 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 migrant populations will require political will and financial commitment from the US as well as receiving countries. But 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 facilitate logistics, enhance efficiency, and reduce cost.

This will take time. In the meantime, clinicians must do their best to assist patients at risk of deportation (Table 1). The National Immigration Law Center has developed “Know Your Rights, and Know Your Patients’ Rights” factsheets with information for healthcare providers and institutions to prepare for interactions with law enforcement or ICE that could have impact their patients ⁵⁷. 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 legal rights group representation without reprisal as outlined in the Performance-Based National Detention Standards ²⁶. Oversight and enforcement of compliance with these standards is variable, especially in Contract Detention Facilities, with reports from human rights organizations documenting serious lapses in care ^{25,30,32}.

Disclosure of HIV status to a health professional if detained should be encouraged to ensure rightful access to HIV care, but in the context of a realistic discussion about the possibility of a breach in confidentiality and attendant risks, such as discrimination or violence while in detention. For this reason, it is critical that patients be told explicitly that discrimination due to HIV status by correctional officers or other detainees must be reported, and that legally

HIV infection should not impact deportation proceedings. In addition, clinicians must be sensitive to the stressors faced by people in detention, who may have been suddenly removed from their lives and families, may be wondering if they will ever see their children again, and are navigating through a system that feels hostile to them. Under these circumstances, HIV care may be a secondary priority, and detainees may feel understandably weary of disclosing their status within a system they do not trust.

The extreme vulnerability of immigrants in deportation proceedings highlights the importance of a multidisciplinary approach to address these issues. Taking the role of advocacy may push some clinicians beyond their comfort zone, but collaboration with human rights organizations, immigrant rights advocates, media, and health authorities could help raise awareness of suboptimal conditions in detention facilities. Academicians can also contribute to this work by collaborating with human rights organizations to implement monitoring procedures and examine variability in conditions based on type and location of detention facilities, as has been previously done to highlight the heterogeneity of local immigration enforcement and health outcomes ⁶. Within clinical settings, providers can establish medico-legal partnerships to help clarify questions, assist victims of violence or discrimination, and assess asylum eligibility based on threats to wellbeing if repatriated, such as persecution due to sexual and gender orientation ^{36,58}.

This work, however, must be done cautiously to avoid unintended consequences. Prevailing anti-immigrant attitudes could be further exacerbated by bringing public attention to the needs of HIV-infected immigrants. While there is strong evidence that HIV risk increases after migration to the US and is exacerbated by exclusionary immigration policies ^{7,8,10,20,21}, these nuances may be overlooked by proponents of anti-immigrant policies. In addition, the new administration's expanded deportation priorities to include unauthorized immigrants who have abused public health benefit programs ⁵⁹ raises concerns that HIV-infected immigrants receiving health care in the US could be targeted. While this would be a violation of the human rights of HIV-infected individuals as outlined by international standards ^{60,61}, the possibility of covert discrimination in 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 AIDS Education and Training Center to assist HIV-infected patients returning to Mexico and Central America is a good place to start ⁴². Resources like the Migrant Clinicians' Network provides a HIPAA Compliant Platform to share medical records with international providers (with patient consent) and to link patients to care through virtual case management.⁶² In addition, providers should be familiar with existing and functional safety net organizations in Mexico and Central America that serve gender and sexual minority populations.

These are stressful times for undocumented immigrants. For those infected with HIV, clinicians can mitigate some of the uncertainty by providing accurate information and facilitating transitions 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.

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References

1. Pineirua A, Sierra-Madero J, Cahn P, et al. The HIV care continuum in Latin America: challenges and opportunities. *Lancet Infect Dis* 2015; 15(7): 833–9. [PubMed: 26122456]
2. Junqueira DM, de Medeiros RM, Matte MC, et al. Reviewing the history of HIV-1: spread of subtype B in the Americas. *PLoS One* 2011; 6(11): e27489. [PubMed: 22132104]
3. Dennis AM, Hue S, Pasquale D, et al. HIV Transmission Patterns Among Immigrant Latinos Illuminated by the Integration of Phylogenetic and Migration Data. *AIDS Res Hum Retroviruses* 2015; 31(10): 973–80. [PubMed: 26214548]
4. Alarcon RD, Parekh A, Wainberg ML, Duarte CS, Araya R, Oquendo MA. Hispanic immigrants in the USA: social and mental health perspectives. *Lancet Psychiatry* 2016; 3(9): 860–70. [PubMed: 27568273]
5. Weine SM, Kashuba AB. Labor migration and HIV risk: a systematic review of the literature. *AIDS Behav* 2012; 16(6): 1605–21. [PubMed: 22481273]
6. Hatzenbuehler ML, Prins SJ, Flake M, et al. Immigration policies and mental health morbidity among Latinos: A state-level analysis. *Soc Sci Med* 2017; 174: 169–78. [PubMed: 28043019]
7. Sastre F, Sanchez M, De La Rosa M. Changes in pre- to post-immigration HIV risk behaviors among recent Latino immigrants. *AIDS Educ Prev* 2015; 27(1): 44–57. [PubMed: 25646729]
8. Bianchi FT, Reisen CA, Zea MC, Poppen PJ, Shedlin MG, Penha MM. The sexual experiences of Latino men who have sex with men who migrated to a gay epicentre in the USA. *Cult Health Sex* 2007; 9(5): 505–18. [PubMed: 17687675]
9. Dolwick Grieb SM, Desir F, Flores-Miller A, Page K. Qualitative assessment of HIV prevention challenges and opportunities among Latino immigrant men in a new receiving city. *J Immigr Minor Health* 2015; 17(1): 118–24. [PubMed: 24158380]
10. Barrington C, Gandhi A, Gill A, Villa Torres L, Brietzke MP, Hightow-Weidman L. Social networks, migration, and HIV testing among Latinos in a new immigrant destination: Insights from a qualitative study. *Glob Public Health* 2017: 1–13.
11. CDC. HIV Care Outcomes Among Hispanics or Latinos with Diagnosed HIV Infection- United States, 2015. *MMWR* 2017; 66(40): 1065–72. [PubMed: 29023431]
12. Gray KM, Valverde EE, Tang T, Siddiqi AE, Hall HI. Diagnoses and Prevalence of HIV Infection Among Hispanics or Latinos - United States, 2008–2013. *MMWR Morb Mortal Wkly Rep* 2015; 64(39): 1097–103. [PubMed: 26448539]
13. Chen NE, Gallant JE, Page KR. A systematic review of HIV/AIDS survival and delayed diagnosis among Hispanics in the United States. *J Immigr Minor Health* 2012; 14(1): 65–81. [PubMed: 21773882]
14. Poon KK, Dang BN, Davila JA, Hartman C, Giordano TP. Treatment outcomes in undocumented Hispanic immigrants with HIV infection. *PLoS One* 2013; 8(3): e60022. [PubMed: 23555868]

15. Sheehan DM, Trepka MJ, Dillon FR. Latinos in the United States on the HIV/AIDS care continuum by birth country/region: a systematic review of the literature. *Int J STD AIDS* 2015; 26(1): 1–12. [PubMed: 24810215]
16. Garland JM, Andrade AS, Page KR. Unique aspects of the care of HIV-positive Latino patients living in the United States. *Curr HIV/AIDS Rep* 2010; 7(3): 107–16. [PubMed: 20526824]
17. Dennis AM, Napravnik S, Sena AC, Eron JJ. Late entry to HIV care among Latinos compared with non-Latinos in a southeastern US cohort. *Clin Infect Dis* 2011; 53(5): 480–7. [PubMed: 21844031]
18. Dang BN, Giordano TP, Kim JH. Sociocultural and structural barriers to care among undocumented Latino immigrants with HIV infection. *J Immigr Minor Health* 2012; 14(1): 124–31. [PubMed: 22012476]
19. ICE. Fiscal Year 2017 ICE Enforcement and Removal Operations Report. Available at <https://www.ice.gov/removal-statistics/2017> Last accessed on 1/26/18 2017.
20. Galeucia M, Hirsch JS. State and Local Policies as a Structural and Modifiable Determinant of HIV Vulnerability Among Latino Migrants in the United States. *Am J Public Health* 2016; 106(5): 800–7. [PubMed: 26985616]
21. Martinez O, Wu E, Sandfort T, et al. Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review. *J Immigr Minor Health* 2015; 17(3): 947–70. [PubMed: 24375382]
22. National HIV/AIDS Strategy for the United States. Available at <https://www.hiv.gov/federal-response/national-hiv-aids-strategy/nhas-update>. Last accessed 2-18 2017.
23. Park H Which States Make Life Easier or Harder for Illegal Immigrants. *The New York Times* 3 29, 2015 Available at <https://www.nytimes.com/interactive/2015/03/30/us/laws-affecting-unauthorized-immigrants.html>.
24. Meyer JP, Cepeda J, Wu J, Trestman RL, Altice FL, Springer SA. Optimization of human immunodeficiency virus treatment during incarceration: viral suppression at the prison gate. *JAMA Intern Med* 2014; 174(5): 721–9. [PubMed: 24687044]
25. Blunt M Systemic Indifference: Dangerous & Substandard Medical Care in US Immigration Detention. Available at <https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard-medical-care-us-immigration-detention-7072ac> Last accessed on 1-26-2018 2017.
26. ICE. 2011 Operations Manual ICE Performance-Based National Detention Standards. Available at <https://www.ice.gov/detention-standards/2011> Last accessed 1/26/18 2011.
27. Jorgensen C Immigrant Detention in the United States Violations of International and Human Rights Law. Human Rights Brief 2017.
28. Lists of Deaths in ICE Custody. October 2003 to December 2013. Available at <https://www.ice.gov/doclib/foia/reports/detaineedeaths2003-present.pdf> Last Accessed 1/26/18.
29. NPR. Big Money As Private Immigrant Jails Boom. Available at <https://www.npr.org/2017/11/21/565318778/big-money-as-private-immigrant-jails-boom> Last Accessed on 1/26/18.
30. ACLU. ICE Plans to Start Destroying Records of Immigrant Abuse, Including Sexual Assault and Deaths in Custody. Available at <https://www.aclu.org/blog/immigrants-rights/ice-and-border-patrol-abuses/ice-plans-start-destroying-records-immigrant> Last Accessed 1/26/18 2017.
31. Centers for Disease C, Prevention USDoH, Human S. Medical examination of aliens--removal of human immunodeficiency virus (HIV) infection from definition of communicable disease of public health significance. Final rule. *Fed Regist* 2009; 74(210): 56547–62. [PubMed: 20166276]
32. ACLU. Sexual Abuse in Immigration Detention. 2017 Available at <https://www.aclu.org/issues/immigrants-rights/immigrants-rights-and-detention/sexual-abuse-immigration-detention-0> Last accessed 1/26/18.
33. Stauffer B Human Rights Watch. Do You See How Much I'm Suffering? Abuse against transgender women in US immigration detention. 2016. Available at <https://www.hrw.org/report/2016/03/23/do-you-see-how-much-im-suffering-here/abuse-against-transgender-women-us> Last accessed 1/26/18 2016.
34. CDC. HIV Testing Implementation Guidance for Correctional Settings. Available at <https://www.cdc.gov/hiv/pdf/group/cdc-hiv-correctional-settings-guidelines.pdf> Last Accessed 1/26/18 2009.

35. Westergaard RP, Spaulding AC, Flanigan TP. HIV among persons incarcerated in the USA: a review of evolving concepts in testing, treatment, and linkage to community care. *Curr Opin Infect Dis* 2013; 26(1): 10–6. [PubMed: 23221766]
36. Springer SA, Spaulding AC, Meyer JP, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. *Clin Infect Dis* 2011; 53(5): 469–79. [PubMed: 21844030]
37. Strathdee SA, Magis-Rodriguez C, Mays VM, Jimenez R, Patterson TL. The emerging HIV epidemic on the Mexico-U.S. border: an international case study characterizing the role of epidemiology in surveillance and response. *Ann Epidemiol* 2012; 22(6): 426–38. [PubMed: 22626001]
38. Beyrer C, Pozniak A. HIV Drug Resistance - An Emerging Threat to Epidemic Control. *N Engl J Med* 2017; 377(17): 1605–7. [PubMed: 29069566]
39. Silva-Santisteban A, Eng S, de la Iglesia G, Falistocco C, Mazin R. HIV prevention among transgender women in Latin America: implementation, gaps and challenges. *J Int AIDS Soc* 2016; 19(3 Suppl 2): 20799. [PubMed: 27431470]
40. Carrilo H Sexual Migration, Cross-Cultural Sexual Encounters, and Sexual Health. *Sexuality Research & Social Policy* 2004; 1(3): 58–70.
41. Frautschi S Understanding HIV-Specific Laws in Central America. *International Journal of Legal Information* 2010; 38(1): 43–92.
42. AETC. Assisting HIV Patients Returning to Mexico and Central America / Asistiendo a los Pacientes que Regresan a México y Centroamérica. Available at <https://www.aidsetc.org/resource/umbast-factsheets> Last accessed 3/18 2016.
43. Hernandez-Rosete D, Garcia OM, Bernal E, Castaneda X, Lemp G. [Migration and ruralization of AIDS: reports on vulnerability of indigenous communities in Mexico]. *Rev Saude Publica* 2008; 42(1): 131–8. [PubMed: 18200350]
44. Lacey M Mexican Migrants Carry HIV Home. Available at <http://www.nytimes.com/2007/07/17/world/americas/17mexico.html> Last accessed 3/18 *New York Times* 2017.
45. Albarran CR, Nyamathi A. HIV and Mexican migrant workers in the United States: a review applying the vulnerable populations conceptual model. *J Assoc Nurses AIDS Care* 2011; 22(3): 173–85. [PubMed: 21185750]
46. PAHO, WHO, UNAIDS. Elimination of mother-to-child transmission of HIV and syphilis in the Americas. Available at <http://iris.paho.org/xmlui/bitstream/handle/123456789/34072/9789275119556-eng.pdf?sequence=4&isAllowed=y> Last accessed 1/26/2018 2017.
47. Espinoza L, Hall HI, Hu X. Increases in HIV diagnoses at the U.S.-Mexico border, 2003–2006. *AIDS Educ Prev* 2009; 21(5 Suppl): 19–33. [PubMed: 19824832]
48. Patterson TL, Goldenberg S, Gallardo M, et al. Correlates of HIV, sexually transmitted infections, and associated high-risk behaviors among male clients of female sex workers in Tijuana, Mexico. *AIDS* 2009; 23(13): 1765–71. [PubMed: 19584699]
49. Mehta SR, Wertheim JO, Brouwer KC, et al. HIV Transmission Networks in the San Diego-Tijuana Border Region. *EBioMedicine* 2015; 2(10): 1456–63. [PubMed: 26629540]
50. Dara M, de Colombani P, Petrova-Benedict R, et al. Minimum package for cross-border TB control and care in the WHO European region: a Wolfheze consensus statement. *Eur Respir J* 2012; 40(5): 1081–90. [PubMed: 22653772]
51. Dara M, Sulis G, Centis R, et al. Cross-border collaboration for improved tuberculosis prevention and care: policies, tools and experiences. *Int J Tuberc Lung Dis* 2017; 21(7): 727–36. [PubMed: 28633696]
52. Garcia D, Hopewell J, Liebman AK, Mountain K. The migrant clinicians network: connecting practice to need and patients to care. *J Agromedicine* 2012; 17(1): 5–14. [PubMed: 22191498]
53. CDC. Cure TB. Available at <https://www.cdc.gov/usmexicohealth/curetb.html>. Last accessed 3/18.
54. Venters HD, McNeely J, Keller AS. HIV screening and care for immigration detainees. *Health Hum Rights* 2009; 11(2): 89–100. [PubMed: 20845844]

55. Martinez-Donate AP, Rangel MG, Rhoads N, et al. Identifying opportunities to increase HIV testing among mexican migrants: a call to step up efforts in health care and detention settings. PLoS One 2015; 10(4): e0123631. [PubMed: 25860261]
56. Instituto Nacional de Inmigracion. Estrategia Somos Mexicanos. Available at <https://www.gob.mx/inm/acciones-y-programas/estrategia-somos-mexicanos>. Last accessed 3/18.
57. NILC. Healthcare Providers and Immigration Enforcement: Know Your Rights, Know Your Patients' Rights. Available at <https://www.nilc.org/issues/immigration-enforcement/healthcare-provider-and-patients-rights-imm-enf/> Last Accessed 1/26/18 2017. 2017.
58. Bowen Matthew D THE LAW AS HEALER: HOW PAYING FOR MEDICAL- LEGAL PARTNERSHIPS SAVES LIVES AND MONEY. Center for Health Policy at Brookins. Available at https://www.brookings.edu/wp-content/uploads/2017/01/es_20170130_medicallegal.pdf. Last accessed 3/18 2017.
59. Zamora L Comparing Trump and Obama's Deportation Priorities. Available at <https://bipartisanpolicy.org/blog/comparing-trump-and-obamas-deportation-priorities/>. Last accessed on 3/2018 2017.
60. United Nations Human Rights, Office of the High Commissioner. HIV and Human Rights. Available at <http://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx>. Last accessed 3/18.
61. UNDP. Global Commission on HIV and the Law. Available at <https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport-RisksRightsHealth-EN.pdf>. Last Accessed 3/18.
62. Migrant Clinicians' Network. Available at <https://www.migrantclinician.org/> Last accessed 3/18.

Table 1. Recommendations to strengthen the continuity of HIV care for people deported from the US to Latin America

	Service Delivery/ Care	Providers	US Immigration and Customs Enforcement	Advocacy, Communication, Social mobilization	Local Immigration Policies	Receiving Country
Address stigma, discrimination, and human rights		Understand NILC guidelines and create safe spaces to discuss immigration concerns and risks of deportation ⁵⁴ Establish Medico-Legal Partnerships leveraging the expertise of lawyers and NGOs that address immigration issues, including asylum eligibility ^{34,55}	Offer voluntary HIV testing at ICE intake with protection for the rights of patients to autonomy and confidentiality ^{51,52}	Collaboration between providers and human rights advocates to foster a human rights framework to the delivery of care for HIV-infected immigrants ⁷	Provide access to healthcare, including free HIV counseling, testing, prevention, and treatment ^{19-21,60,61} Require health care providers to complete training in culturally and linguistically appropriate services ⁶²	Implement reintegration services and provide legal identification to facilitate access to health and social programs ⁵³ Offer voluntary HIV testing and linkage to care and information in programs designed to help with reintegration into receiving country ⁶¹
	Data/Information	Enroll patients in the Migrant Clinician's Network (MCN) or establish a way for the patient to communicate with the clinic if deported ^{41,48,49} Use the AETC Resources to facilitate linkage to care ⁴⁰	Gather HIV prevalence data and outcomes to monitor quality and continuity of care within ICE and other detentions facilities in the US ⁵¹ Establish international data and medical record sharing agreements (perhaps coordinated by PAHO and CDC and leveraging existing MCN and CureTB infrastructure) ^{47,61}	Human rights monitors of compliance with PBNDS in detention facilities, with special attention those under IGSA's and CDFs ²³ Human rights monitors of evidence of stigma, discrimination, violence against HIV-infected detainees and gender and sexual minorities ²³	Ensure compliance with National Culturally and Linguistically Appropriate Service (CLAS) Standards ^{20,21,62}	Gather HIV prevalence data and outcomes to monitor quality and continuity of care for returning migrants ^{61,63,64} Establish international data and medical record sharing agreements (perhaps through MCN or leveraging existing CureTB infrastructure) ^{47,61}
	Policy	Inform patients of their right to medical care and non-discrimination due to HIV status in correctional facilities ²⁴ Discuss potential unintended consequences of HIV disclosure and partner with human rights organizations to monitor HIV-related stigma, discrimination, and violence in detention ⁷	Enforce adherence to PBNDS in all facilities, including those under IGSA's and CDFs ²⁴ Inform all detainees of their rights, including the right to HIV therapy, reporting of grievances, and legal rights advice ²⁴ Allow external monitoring agencies to oversee compliance with PBNDS in all facilities ⁷ Comply with Freedom of Information Act and do not destroy records regarding sexual assault or deaths in custody ²⁸	Dissemination of clear information to the public to raise awareness about the impact of enhanced deportation on HIV-infected migrants and public health ⁶¹	Provide access to driver's licenses for undocumented immigrants ^{19,20}	Establish specific policies for antiretroviral therapy in returning migrants to avoid failure from pre-existing mutations (such as using a dolutegravir backbone or targeted genotype resistance testing) ³⁶

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	Providers	US Immigration and Customs Enforcement	Advocacy, Communication, Social mobilization	Local Immigration Policies	Receiving Country
		Expand community-based alternatives for detention and humanitarian parole based on medical necessity /			

/ Authors' opinion based on clinical and public health experience

AETC= AIDS Education and Training Center

CDC= Centers for Disease Control

CDF= Contract Detention Facilities

CLAS= Culturally and Linguistically Appropriate Service

HIV= Human Immunodeficiency Virus

ICE= Immigration and Customs Enforcement

IGSA= Intergovernmental Service Agreements

MCN= Migrant Clinician's Network

NGO= non-governmental organization

NILC= National Immigration Law Center

PAHO= Panamerican Health Organization

PBND= Performance Based National Detention Standards