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Deportation of non-citizen military veterans: A critical analysis of implications for the right to health

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Abstract

Military personnel are commonly exposed to health-harming conditions during their service, resulting in higher rates of physical and mental health conditions compared with the general population. In an era of mass deportations, it is notable that non-citizen military veterans are not exempt from deportation. We utilised a human rights framework to conduct a critical analysis of potential health consequences of deportation for U.S. military veterans, identifying three ways in which veterans' rights to health may be constrained through deportation. First, honourably discharged deported veterans may be denied access to free or subsidised Veterans Affairs health services to which they would likely otherwise be entitled. Second, availability of and access to healthcare may be limited for reasons including barriers to enrolling in public insurance schemes, challenges navigating unfamiliar health systems and stigma and discrimination towards deported migrants. Finally, quality of available care may be sub-optimal due to limited expertise in service-related health issues and lack of evidence-based treatment for some health conditions (e.g. substance abuse/dependence). Binational multi-sectoral efforts are necessary to ensure that the rights to health of deported military veterans are adequately protected.

Keywords

migration; deportation; veteran's health; right to health; access to health care

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Author Contributions

All authors developed the initial concept for the manuscript. Dr. Horyniak led the analysis and drafting of the manuscript. All other authors contributed to the revision of the manuscript, and approved the final version for submission.

Conflict of Interest

The authors have no conflicts of interest to declare.

Introduction

The last decade has been characterised as an era of mass deportations (Golash-Boza, 2016b). Although a trend in numerous Western countries, nowhere is this more manifest than in the United States (U.S.), from where 1.6 million non-citizens, predominantly of Mexican origin, were deported in the past five years alone, and the current administration has made it a policy objective to not only continue, but further increase deportations (Trump, 2017; U.S. Department of Homeland Security, 2016). Deportation serves multiple functions, including a means of enacting citizenship (by virtue of the fact that only non-citizens can be at risk of deportation), a mechanism of extended border control, and a system of post-entry social control used to govern the behaviour of immigrants and enforce a 'tough on (immigrant) crime' agenda (Golash-Boza, 2015; Kanstroom, 2012). Deportation is an extremely stressful experience which can result in significant economic, social and psychological costs, both for deportees and for their families left behind. Many non-citizens are long-term U.S. residents who feel a strong sense of belonging to, and define themselves by, participation in American society; despite being deported to their country of origin, this is commonly a place to which they feel little connection (Golash-Boza, 2016a). Although legally not intended to be used as punishment, in this way deportation may also inadvertently serve a punitive purpose.

A growing body of evidence has found that deportation has significant detrimental impacts on health. In particular, deported migrants report poor psychological wellbeing and high rates of mental health disorders (Bojorquez, Aguilera, Ramirez, Cerecero, & Mejia, 2015; Brotherton & Barrios, 2009; Pinedo et al., 2016; Wheatley, 2011), harmful patterns of substance use (Horyniak, Pinedo, Burgos, & Ojeda, 2016; Zhang et al., 2015), engagement in behavioural risk practices which place them at risk of acquiring HIV or sexually transmitted infections (Martinez-Donate et al., 2015; Pinedo, Burgos, & Ojeda, 2014) and often face significant barriers to accessing healthcare (Fernández-Niño, Ramírez-Valdés, Cerecero-Garcia, & Bojorquez-Chapela, 2014; Rosales Martinez, Bojorquez Chapela, Leyva Flores, & Infante Xibille, 2017).

Deportation of U.S. military veterans

Numerous countries globally allow non-citizens to serve in their armed forces, including the U.S., where an estimated 70,000 non-citizens served between 1999 and 2008 (McIntosh & Sayala, 2011). In general, only legal permanent residents are permitted to enlist however under certain conditions other legal non-citizens (e.g. Deferred Action for Childhood Arrivals recipients) may do so (Vakili, Pasquarella, & Marcano, 2016). Additionally, despite significant safeguards to prevent fraudulent recruiting, anecdotal evidence suggests some undocumented migrants may enlist using false documentation as a way to 'give back' to the country they consider home (Vakili et al., 2016). Importantly, citizenship has long been touted as an incentive for enlistment (Vakili et al., 2016), with non-citizen service members entitled to expedited citizenship after one year of honourable service during peacetime or one day of honourable service during periods of hostilities (Immigration and Nationality Act §328 [8 U.S.C. 1439]; Immigration and Nationality Act §329 [8 U.S.C. 1440]). The process of obtaining citizenship does not occur automatically; the best available data suggests that despite the numbers gaining citizenship increasing, fewer than half of eligible service

members acquire citizenship (McIntosh & Sayala, 2011). Reported barriers to naturalisation include not receiving information about the application process, believing citizenship was conferred upon enlistment (the wording of the oath of enlistment is similar to the oath of naturalisation), and applications becoming lost in red tape, particularly in the context of multiple deployments or frequent transfers (Vakili et al., 2016). Additionally, non-citizens convicted of an aggravated felony (a category which includes several relatively minor non-violent crimes) are barred from naturalisation for life on the grounds of lacking “good moral character” (Immigration and Nationality Act §101b), even for military veterans who would otherwise meet citizenship requirements. This is particularly concerning given many veterans face significant challenges transitioning from military to civilian life, including unemployment, homelessness, poor mental health, and substance use, which may lead to criminal justice involvement (Greenberg & Rosenheck, 2009; White, Mulvey, Fox, & Choate, 2012).

Any non-citizen of the U.S., including legal permanent residents, may be subject to deportation for a number of reasons, including but not limited to, violation of immigration law, visa status or condition of entry, violation of criminal laws, and security-related grounds (for details see Immigration and Nationality Act §237 [8 U.S.C. 1227]). Although the U.S. Supreme Court has recognised that deportation has become linked to criminal law (*Padilla v. Kentucky*, 2010), Immigration and Customs Enforcement operates separately from the criminal justice system. As such, non-citizens convicted of a crime are routinely sentenced and incarcerated for their crime prior to removal proceedings being brought against them.

Non-citizen military veterans are not exempt from deportation and the elimination of judicial discretion means military service cannot be taken into consideration in deportation proceedings (Hartsfield, 2012; Kanstroom, 2012). Although deportation of military veterans is not solely a U.S. phenomenon (Gayle, 2016, 6 September; Gilligan, 2012, 1 December), in no other country has this occurred on such a large scale. Reliable estimates of the numbers of veterans deported or currently facing deportation are not available as U.S. Immigration and Customs Enforcement does not collect information on veteran status, however available information, based on cases documented by the American Civil Liberties Union (ACLU) suggest that to-date more than 200 military veterans have been deported to over 30 different countries (Vakili et al., 2016). Most have been deported as a result of criminal convictions (Vakili et al., 2016).

Despite some evidence of a ‘healthy warrior effect’ - that is, selection bias reflecting that individuals recruited into the military are healthier than the general population due to military entrance requirements, and within the military, healthier individuals have a higher likelihood of being deployed (Haley, 1998; Larson, Highfill-McRoy, & Booth-Kewley, 2008)-there is overwhelming evidence that military veterans are vulnerable to poor health. Poor health may arise as a result of military service, particularly for those who have experienced combat deployment, as well as in the context of challenges faced in the transition from military to civilian life. Studies have shown that military veterans report higher rates of many health conditions compared with the general population, including physical health symptoms (e.g. pain, fatigue), chronic conditions (e.g. diabetes), mental health disorders (e.g. post-traumatic stress disorder [PTSD], depression) and harmful substance use (Eibner et al., 2015; Golub,

Vazan, Bennett, & Liberty, 2013; Kramarow & Pastor, 2012; McCutchan et al., 2016; Nahin, 2017; Ramsey et al., 2016). In 2012, an estimated 3.5 million veterans had a documented service-connected disability (i.e. disease or injury incurred or aggravated during active military service), a 60% increase from 1990 (U.S. Department of Veterans Affairs, 2014a), and approximately six million veterans currently utilise healthcare services provided by the Department of Veterans Affairs (VA) annually (Eibner et al., 2015).

As noted earlier, deportation has potential negative effects on health for all those affected, however the deportation of military veterans is particularly concerning given the health vulnerabilities of this population and the moral and ethical considerations in the context of potential injuries and illness acquired in service to the country from which they are being deported.

The right to health

The right to health is internationally recognised as a fundamental human right (Table 1), with the United Nations (UN) Universal Declaration on Human Rights (UDHR) and International Covenant on Economic, Social and Cultural Rights (ICESCR) protecting the right to the “highest attainable standard of physical and mental health” (UN General Assembly, 1948, 1966). This can be understood as extending “not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition, and housing, healthy occupational and environmental conditions, and access to health-related education and information” (UN Committee on Economic Social and Cultural Rights, 2000). Significant progress has been made in recent years in understanding how the ‘highest attainable standard of health’ can be operationalised. Fundamental to achieving the highest attainable standard of health is an effective and integrated health system, with key features including transparency, active participation by individuals and communities, a high level of accessibility to all, particularly disadvantaged communities, and coordination between different levels of care, and within and across relevant stakeholders (Hunt & Backman, 2008). Accountability for the right to health is a complex issue. Although it is widely recognised that the right to health is subject to resource availability, states are obliged to have in place core components such as a comprehensive national health plan, and a minimum package of good-quality health-related services and facilities, as they progress towards the goal of a comprehensive, integrated health system (Hunt & Backman, 2008). Importantly, UN conventions (but not declarations) are legally binding for states that have ratified them, and “must be performed by them in good faith” (United Nations, 1969). The most prevalent mechanism of monitoring the right to health is through the use of health system indicators and benchmarks (Backman et al., 2008), although litigation approaches are becoming increasingly common (Yamin & Gloppen, 2011).

Not only do universal rights to health outlined in the UDHR and ICESCR apply to expelled and deported persons, but this population has particular vulnerabilities which must also be taken into consideration. Among other treaties which recognise the right to health (Table 1), two examples which may apply to deported migrants are the International Convention on the Elimination of All Forms of Racial Discrimination, which guarantees a variety of civil rights

including public health and medical care without distinction as to race, colour or national or ethnic origin (UN General Assembly, 1965), and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, which protects access to social and health services on the basis of equality of treatment with nationals of the state (UN General Assembly, 1990). The Draft Declaration on the Rights of Expelled and Deported Persons (Table 1), currently under development by immigration scholars, explicitly recognises the vulnerability of this population. This draft declaration acknowledges that current border control practices such as deportation can have harmful consequences and aims to articulate the legal, economic, social, cultural and other rights which must be protected at all stages of the deportation process (Kanstroom & Chicco, 2014). The draft declaration makes specific reference to rights to health, proposing that vulnerable persons, a category including those with physical or mental disabilities or serious medical conditions, should not be deported, however if deemed legal and necessary, additional protection, care and treatment should be provided. Consistent with ICESCR, it is proposed that all expelled and deported persons should have the right to the highest attainable standard of healthcare, and that sending and receiving states should coordinate to ensure continuity of medical treatment (Kanstroom & Chicco, 2014).

Aims and approach

The aim of this research was to present a critical analysis of the potential health consequences of deportation for U.S. military veterans and examine opportunities for a public health response to this phenomenon. Our analysis utilises veteran's health and migration literature, as well as a small but emerging body of literature specific to deported veterans. We utilised a human rights-based approach to this analysis, drawing on key protections pertaining to the right to health, universally, and specific to deported persons (as outlined above and in Table 1). Although the U.S. has not ratified ICESCR and the right to health is not recognised in the U.S. constitution, we frame our analysis with this perspective for two reasons. First, the right to health has been recognised by the U.S. both through ratification of the International Convention on the Elimination of All forms of Racial Discrimination, and through several Supreme Court decisions (albeit grounded in other constitutional rights) (Ruger, Ruger, & Annas, 2015). For example, *Roe v. Wade*, upheld the right to make reproductive decisions, and *Estelle v. Gamble* found that prisoners have the right to access adequate medical care (Estelle v. Gamble, 1976; Roe v. Wade, 1973). Recognising that the right to health remains limited in its realisation even for U.S. citizens and residents, we suggest that the right to health for deported veterans should be considered in terms of equity to this population, reflecting the standards attainable in the event they had not been deported from the U.S. Second, the deportation of military veterans is not solely a U.S. phenomenon; although our analysis was centred on the U.S. context, drawing on internationally recognised treaties enables these arguments to be applied to other settings and contexts.

We focused our analysis on Latin America and the Caribbean as the largest proportion of foreign-born U.S. military personnel are from this region (Batalova, 2008), the vast majority of deportations from the U.S. are of nationals from this region (specifically Mexico, Guatemala, Honduras and El Salvador) (U.S. Department of Homeland Security, 2016), and

available evidence suggests that Mexico is the primary receiving country for deported U.S. military veterans (Vakili et al., 2016). Although we recognise that some undocumented migrants may fall within the population of interest, given only legal permanent residents are legally entitled to enlist, our analysis focuses on this group. Although an important issue, exploring the military's obligations towards undocumented migrant veterans is beyond the scope of the current work.

We framed our analysis considering all military veterans as vulnerable persons due to their high risk of service-connected disabilities (although risk is highest among those with specific exposures such as combat duty, all are at elevated risk compared with the general population). Further, given the long latent period for development of some physical service-related conditions (e.g. those arising from exposure to chemicals such as Agent Orange), and the relapsing nature of some mental health conditions (e.g. depression, PTSD), it would be erroneous to ascertain who would and would not be considered vulnerable based on disease symptomatology prior to or at the time of deportation, particularly given that post-deportation stressors may exacerbate pre-existing health conditions.

Potential impacts of deportation on military veterans' rights to health

We identified three important ways in which veterans' rights to health are potentially constrained through deportation.

1. Deported veterans may be denied access to VA health benefits to which they would likely otherwise be entitled—Eligibility criteria for VA health benefits are complex (U.S. Department of Veterans Affairs), however in general, veterans who served on active duty and were discharged from the military under all conditions other than dishonourably may be eligible for some services. Citizenship is not an eligibility criteria, and non-citizen veterans residing in the U.S. have the same entitlement as citizen veterans to benefits including free or subsidised preventive care, primary and specialist medical care, mental health care and support in the transition from military to civilian life, and disability compensation for service-connected injury or disease (U.S. Department of Veterans Affairs, 2014b). For those who meet eligibility criteria however, deportation physically prevents access to services. The VA Foreign Medical Program also provides disability compensation and reimbursement for some medical care at local health facilities for those with VA-rated service-connected disabilities residing outside the U.S. (U.S. Department of Veterans Affairs), however obtaining such a rating requires attendance at a VA clinic. Again, for those who may be eligible, unless this assessment was completed prior to deportation this is impossible. For those who have obtained a rating, uptake may be constrained by lack of information about where services are located, how to access them, and how to seek reimbursement for services rendered. Thus, the denial of access to a healthcare system they are fully entitled to access is a clear contravention of these veterans' rights to health. Further, given that VA service providers have extensive expertise in working with veteran populations, and have been found to perform better with regard to effectiveness of care than non-VA health services (O'Hanlon et al., 2017), it could reasonably be argued that the denial of access to VA services specifically severely constrains veterans' right to the *highest attainable standard* of health.

2. Availability of and access to healthcare in post-deportation settings is likely to be limited—

As noted above, a fundamental component of achieving the highest attainable standard of health is healthcare. Availability and accessibility are recognised as crucial elements of good healthcare (UN Committee on Economic Social and Cultural Rights, 2000). With deportees being predominantly returned to middle-income countries (U.S. Department of Homeland Security, 2016) availability of healthcare is likely to be poorer than in the U.S., reflecting weaker health infrastructure. For example, in Mexico it is estimated that only around half the population have effective access to healthcare, with limitations resulting from a lack of health insurance coverage, particularly for low-income populations, a relatively small health workforce, inefficient use of health resources, and challenges in responding to rapidly changing patterns of morbidity (Gómez-Dantés et al., 2016; Gutierrez, Garcia-Saiso, Dolci, & Hernandez Avila, 2014; Lopez, Valle, & Aguilera, 2015). Weak health infrastructure is particularly evident in some specialties such as mental health, for which the estimated median mental health expenditure per capita is \$1-\$2 in middle-income countries compared with \$59 in high-income countries, and the number of mental health workers is 3–16 per 100,000 population compared with 52 per 100,000 population (World Health Organisation, 2015). In Mexico, availability of mental healthcare is extremely inadequate with only 2% of the total health budget allocated to mental health, and accessibility severely limited due to the fact that services are concentrated in psychiatric hospitals, rather than in the community (Berenzon Gorn, Saavedra Solano, Medina-Mora, Aparicio Basauri, & Galvan Reyes, 2013). Given the high rates of mental health conditions among both deported migrants (Bojorquez et al., 2015) and veteran populations (Ramsey et al., 2016), lack of mental healthcare is a major barrier to achieving health for deported veterans.

Healthcare accessibility can be considered through four key domains: non-discrimination, physical accessibility, economic accessibility and information accessibility (UN Committee on Economic Social and Cultural Rights, 2000), all of which are likely to impact deported veterans. For example, studies from diverse settings have found that deported migrants experience significant stigma and discrimination, commonly being perceived as criminals (Anderson, 2015; Brotherton & Barrios, 2009; Schuster & Majidi, 2015); deported veterans may potentially be even more stigmatised than their non-veteran counterparts as their military service may be interpreted as evidence of disloyalty to their country of origin. Stigma and discrimination are recognised as important drivers of health inequalities through their impacts on healthcare-seeking, access to resources, and underlying determinants of health such as housing, education and employment (Hatzenbuehler, Phelan, & Link, 2013). For military veterans who may be accustomed to being held in high esteem and respected by the public, experiences of stigma and discrimination within healthcare settings may be particularly important barriers to healthcare access. This may be especially concerning in relation to mental healthcare as low rates of help-seeking for mental health conditions have consistently been reported among military service members and veterans, reflecting a military culture which values resilience and self-sufficiency (Sharp et al., 2015). Further stigmatising experiences could be an additional deterrent against healthcare-seeking, as well as an important barrier to retention in care for those who have sought treatment. In relation to physical and economic accessibility, barriers may include lacking documentation required

to enrol in public health insurance resulting in low levels of health insurance coverage (Fernández-Niño et al., 2014; Horyniak et al., 2016), and economic barriers reflecting limited employment opportunities (Horyniak et al., 2016). Finally, with regards to accessibility of information, deported veterans (particularly those who may not be proficient in the primary language/s of their country of origin) are also likely to experience challenges navigating complex and unfamiliar health systems.

3. Quality of available care is likely to be sub-optimal—The third crucial way in which the right to health may be constrained relates to quality of care; even if healthcare is available and accessible in receiving countries (i.e. countries of origin), quality of available care is likely to be sub-optimal. There are two main reasons for this: lack of relevant expertise, and failure to implement evidence-based health policy. Veterans have highly specialised health needs, and may become even more vulnerable to poor health following a stressful deportation experience. Receiving countries' ability to provide the high-quality care needed is likely to be constrained. For example, in Mexico, quality of mental healthcare for veterans is likely to be poor, with few trained mental health workers (Berenzon Gorn et al., 2013) and access to psychologists with expertise in service-related mental health issues such as combat-related PTSD likely negligible. Another important example is substance abuse and dependence, health conditions which are prevalent among both veterans (Fuehrlein et al., 2016; Golub et al., 2013) and deported migrants (Horyniak et al., 2016). Mexico has not adequately implemented evidence-based responses to substance use, for example, there has been limited scale-up of medication-assisted treatments for opioid dependence, with the primary drug treatment available involving 12-step and residential rehabilitation programs, in which high levels of sexual, physical and psychological violence have been reported (Harvey-Vera et al., 2016). Deporting veterans to a setting where there is no possibility of receiving evidence-based high-quality care for prevalent service-connected health problems is another way in which rights to health may be constrained.

Call for a public health response

Numerous scholars have already delineated the legal, moral and ethical arguments against the deportation of military veterans, including the lack of adequate counsel provided in immigration proceedings, limited discretionary authority of immigration judges, and the military's failure to provide adequate information and to facilitate naturalisation for eligible service members, placing non-citizen veterans at risk of potentially avoidable deportation (Golash-Boza, 2015; Kanstroom, 2012; Vakili et al., 2016). The practice of deporting military veterans also raises important questions about notions of citizenship, rights, and belonging. These non-citizens risked not only their physical and mental health, but also their lives, protecting a country they consider home; it could be argued that this demonstrates the highest level of patriotism and loyalty, and it is reprehensible that the contributions of these veterans are not held in the same esteem as citizen veterans. Additionally, as noted above, in the context of having already served a prison sentence for their crime, it appears that deportation serves no purpose other than further punishment. In addition to these arguments, we argue that the breach of rights to health represents an additional means by which the deportation of military veterans could be seen as an unjust practice. We believe this adds

another compelling argument for immigration reform and advocate for a public health response to this emerging issue.

In framing this as a public health issue, and in order to develop a public health response, it is necessary to first consider a fundamental question: who is responsible for guaranteeing deported military veterans' rights to health? International human rights treaties promote equality for all, including non-citizens, noting that different categories of non-citizens (e.g. refugees, victims of trafficking) must be treated in a manner appropriate to their situation (UN High Commissioner for Human Rights, 2006). Although access to healthcare in the U.S. is not dependent on citizenship, studies have documented important health disparities between citizen and some non-citizen populations (Joseph, 2017; Vargas Bustamante, Chen, Fang, Rizzo, & Ortega, 2014). With respect to the right to health, deported veterans present a unique case as they may suffer from health issues acquired in the context of military service to the country where they do not hold citizenship (i.e. the sending state). We therefore argue that both the sending state (i.e. U.S.) and the receiving state (i.e. the country of origin, for example, Mexico) have obligations towards this population. Despite being deported from the sending country, as the state responsible for post-military-service care, we suggest that the sending country must continue to bear some ethical responsibility for ensuring the right to health. As the state in which citizenship is held and the state of current residence, the country of origin perhaps holds the greater burden of responsibility.

As noted earlier, it is also important to consider, in a context of global health disparities, against which markers the 'highest standard of health', should be measured. It has been noted that the right to health does not mean that health must be feasible to attain, but rather it is a "demand to take action to promote that goal" (Sen, 2008). We acknowledge that some unavoidable barriers to health arise simply from the poorer health infrastructure in receiving states compared with sending states such as the U.S., and that in many contexts the highest standard of health may not be feasible. Nonetheless, we propose that deported veterans' right to health must be measured relative to the highest standard of health in the sending state (i.e. the country for which they served). In this context, we have shown that the deportation of military veterans results in deprivation of universally protected rights to the highest attainable standard of health through several distinct mechanisms, with potentially serious consequences.

Supporting non-citizen military personnel to attain citizenship is without doubt the best way to prevent deportation and ensure access to evidence-based specialised healthcare, however efforts are nonetheless required to ensure non-citizen veterans rights to health are protected. Legislative responses to address this are underway; in March 2017, Rep. Raul Grijalva (D-AZ) and 40 co-sponsors introduced 'The Veterans Visa and Protection Act of 2017 [H.R. 1405]' in Congress (Grijalva, 2017). This bill aims to establish a veteran's visa program, which would facilitate the return of deported veterans, prevent future deportations for non-violent criminal offences and protect access to VA benefits. In April 2017, California Governor Edmund G. Brown granted pardons to three deported veterans, potentially paving the path to return for these individuals (Office of Governor Edmund G. Brown, 2017). Despite these positive actions, in the context of President Trump's hard-line position on immigration and deportation (Trump, 2017) legislative responses are unlikely to progress

easily. Facing continued, and potentially growing deportations, alternative strategies are urgently needed to ensure rights to health are adequately protected and the health needs of deported veterans (as well as all deported migrants more broadly) are met.

As we have noted, deportation is a binational process in which sending and receiving countries have shared responsibility to protect the rights of deported migrants. As such, public health responses must be implemented in both receiving and sending countries.

In deportee receiving states, there is a need for interventions to be implemented at the local level in migrant-receiving communities to address immediate health needs and ensure adequate access to health care. Such responses would be best implemented within existing health infrastructure, however appropriate modifications should be made to ensure cultural and linguistic acceptability. Given the numerous diverse challenges faced by deported military veterans, a participatory approach in which the population in need are engaged in planning, implementation and delivery of the intervention, is requisite. Such responses should also involve collaboration between government and local community-based organisations. In particular, organizations such as the Deported Veteran's Support House and Unified U.S. Deported Veterans, both run by deported veterans in Tijuana, have been instrumental in raising awareness of the deportation of military veterans, and have worked closely with political and civil organisations on both sides of the U.S.-Mexico border to facilitate change. Continued social mobilization efforts and collaboration with these grassroots organisations will be essential in future efforts to effectively implement health interventions for this population.

We also highlight an urgent need for high-quality research to inform the development and implementation of such health responses. Unanswered questions which should be prioritised in future research include elucidating the physical and mental health needs of deported veterans, identifying barriers and facilitators to health service utilisation, and exploring how health needs are situated within deported veteran's complex daily needs and impacted by marginalised and changing identities. Research addressing these questions will be integral to developing a timely, evidence-based response to this concerning issue.

On the sending side, the U.S. must collaborate with receiving countries to develop systems to facilitate access to VA health services for deported veterans. This should include protocols for facilitating temporary entry into the U.S. to attend VA health services at least for initial consultation to receive a VA rating and assessment of service-connected health issues, and preferably, for continuing care. Operationally, this would require collaboration within the receiving country, potentially through local community organisations, to help facilitate travel, potentially including escorting patients to their appointments and back. The U.S. must also make a concerted effort to facilitate access to VA care in receiving countries. As noted by the ACLU, there are provisions to do so through U.S. embassies, however little effort appears to have been made to facilitate such access (Vakili et al., 2016). In addition to through embassies, we propose temporary clinics as an additional means of providing such care. Such an approach could be easily implemented in border communities with relatively high numbers of deported veterans such as Tijuana, Mexico. Such clinics could be operated by local governmental and non-governmental organisations with support and guidance

provided by the VA and the U.S.-Mexico Border Health Commission, an established binational organisation tasked with providing leadership in addressing health along the entire U.S.-Mexico border region. In addition to providing medical care, such collaborations could also serve as a unique opportunity for local health systems strengthening, allowing local medical providers, including medical students, to build skills in veterans health care, as has been done in other binational health clinics (Ojeda et al., 2014).

Conclusion

Our analysis demonstrates that deportation constrains military veteran's rights to health through denial of access to evidence-based, specialised care to which they would otherwise likely be entitled. We highlight an urgent need for research to identify the health needs of deported veterans, and advocate for a binational multi-sectoral public health response to ensure that the rights to health of deported military veterans are adequately protected.

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Table 1.

Declarations pertaining to the right to health, universally, and specific to deported persons

Declaration	Status	Key protections
United Nations Universal Declaration of Human Rights (UN General Assembly, 1948)	Internationally recognised, non-legally-binding declaration.	Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. [Article 25]
International Covenant on Economic, Social and Cultural Rights (UN General Assembly, 1966)	Multilateral treaty ratified by 165 parties including Mexico. The U.S. is a signatory, but has yet to ratify this treaty.	The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness. [Article 12]
International Convention on the Elimination of All forms of Racial Discrimination (UN General Assembly, 1965)	Multilateral treaty ratified by 178 parties including the U.S. and Mexico.	States parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:... the right to public health, medical care, social security and social services. [Article 5]
International Convention on the Protection of the Rights of All Migrant Workers and members of Their Families (UN General Assembly, 1990)	Multilateral treaty ratified by 51 parties including Mexico. The U.S. has taken no action on this treaty.	Migrant workers and their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. [Article 28] Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to... access to health and social services, provided that the requirements for participation in the respective schemes are met. [Article 43]
Draft Declaration on the Rights of Expelled and Deported Persons (Kanstroom & Chicco, 2014)	Draft declaration in development ¹ . This declaration has not been formally adopted by any international legal body.	States should neither expel nor deport particularly vulnerable persons... If sending states deem it legal and necessary to deport such persons, certain expelled persons who require special attention, such as children, especially unaccompanied minors, pregnant and nursing women, persons with physical or mental disabilities, persons whose claims for asylum, withholding of removal, non-refoulement and similar forms of protection were denied, victims of human trafficking and other serious crimes, persons living with HIV/AIDS or other serious medical conditions, are entitled to protection and assistance required by their condition and to treatment which takes into account their special needs. Both sending and receiving States should coordinate protection, care, and treatment of such persons. [Article 8] All expelled and deported persons have the right to the highest attainable standard of health care. Sending and receiving States should coordinate to ensure continuity of medication and medical treatment upon arrival, such as transferring medical records upon the informed consent of the individual, and providing appropriate referrals. Whenever possible, sending and receiving States should coordinate to make special care available for individuals who have special needs. [Article 19]

¹ Led by Professor Daniel Kanstroom and Jessica Chicco, Boston College Center for Human Rights and International Justice, and developed through input from scholars, activists, non-government organisations and former government officials.