THE EUROPEAN SOCIETY OF MEDICINE

Medical Research Archives, Volume 14 Issue 5

EDITORIAL ARTICLE

Immigration-Related Stress Among People with HIV in the United States

Swati Kumar BS[1]; Melanie Francis MD[2]; Claudia Bonilla, MPH[3]; Elena Cyrus, PhD[4]; Lunthita M. Duthely, EdD[2]

[1]University of Miami Miller School of Medicine, Department of Medical Education, Miami, FL

[2]University of Miami Miller School of Medicine, Department of Obstetrics, Gynecology and Reproductive Sciences

[3]Nova Southeastern University, Medical Education, Fort Lauderdale, FL

[4]University of Central Florida, Department of Population Health Sciences, Orlando, FL

OPEN ACCESS

PUBLISHED

31 May 2026

CITATION

Kumar, S., Francis, M., et al., 2026. Immigration-Related Stress Among People with HIV in the United States. Medical Research Archives, [online] 14(5).

COPYRIGHT

© 2026 European Society of Medicine. This is an open- access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

ISSN

2375-1924

ABSTRACT

Ending the HIV epidemic remains a public health priority. Immigration-related stress is an important yet overlooked factor influencing HIV outcomes among migrant populations. In an ever evolving and complex sociopolitical landscape, characterized by restrictive immigration policies and limited access to health insurance, migrants face significant challenges in maintaining consistent healthcare. For people with HIV, these challenges contribute to poor antiretroviral therapy adherence and inadequate viral suppression, increasing the risk of undesired outcomes associated with an uncontrolled HIV infection. Immigration-related stressors can lead to delayed testing, progression of disease and declining mental health among these individuals. Lack of health coverage is a critical factor, as it often discourages migrants from seeking care, whether due to fear of legal consequences or anticipated prejudice. It is essential to address not only the health-related issues but the legal challenges associated with their current immigration status. This editorial argues that addressing immigration-related stress is crucial to improving HIV outcomes in underserved communities. It is not only important for migrants to receive the care they need, but also to feel safe while accessing needed services, thereby promoting a more consistent follow-up. Interventions must be tailored to diverse migrant populations and this requires a coordinated approach that includes appropriate cultural and linguistic care, stigma reduction and targeted involvement.

Key Words; Immigration-related stress; HIV; healthcare access; mental health; stigma reduction

Introduction

Individuals with Human Immunodeficiency Virus (HIV) living in the United States (US) who are simultaneously navigating uncertain or hostile immigration environments face a compounded, destabilizing burden. In addition to managing a chronic, stigmatizing medical condition, they contend with structural barriers involving legal precarity, social exclusion, and limited access to healthcare. Current evidence suggests immigrants/migrants with HIV frequently experience disrupted care, delayed diagnosis, and poorer treatment continuity, which prevents people living with HIV (PLHIV) from achieving viral suppression, a key community prevention strategy which also improves healthcare outcomes for PLHIV at the individual level.[1] These intersectional pressures create a uniquely challenging landscape in which maintaining consistent engagement in HIV care becomes not only a medical issue, but a sociopolitical one that impacts structural factors.[2]

Sustained engagement in HIV care is essential for achieving viral suppression, which serves as both an individual health benefit and a cornerstone of prevention. The HPTN 052 trial demonstrated that immediate ART initiation reduced HIV transmission by 96%, while the PARTNER studies documented zero phylogenetically linked transmissions among serodifferent couples when the partner with HIV maintained viral suppression.[3,4] However, persons undiagnosed or not retained in care account for over 90% of all HIV transmissions despite representing approximately 60% of people with HIV.[5] This is particularly relevant for immigrant populations: approximately 13.6–18.9% of adults with diagnosed HIV in the US are foreign-born, with the highest proportions among Hispanics (42.2%) and Asians (64.3%).[6,7] Notably, a larger percentage of non-US-born individuals present with AIDS at diagnosis (31.2% vs. 23.9%), suggesting delayed testing and care engagement.[6] Surveillance data define "foreign-born" broadly as persons born outside the US and its territories (inclusive of naturalized citizens), though HIV risk varies significantly by migration type: asylum seekers demonstrate the highest HIV prevalence ratios compared to native-born populations, while longer-term residents may face increased risk over time due to adoption of local socio-cultural norms.[6,8] Thus, addressing immigration-related barriers to sustained care engagement is both a matter of health equity and a public health imperative for reducing HIV incidence.

Immigration-related stress, therefore, represents a critical yet underrecognized barrier to achieving HIV care continuum goals in the US While substantial progress has been made in population-level viral suppression due to the availability of highly effective antiretroviral therapy in multiple modalities, these advances are unevenly distributed, particularly among marginalized immigrant/migrant populations living with HIV. Structural determinants, including fear of deportation, language barriers, socio-economic exclusion and poverty, and restricted access to insurance or public benefits, can undermine each step of the care continuum, from testing and establishing care to long-term adherence.[1] Despite this, initiatives that address immigration-related stress are often insufficiently integrated into HIV clinical and public health strategies, limiting the effectiveness of interventions aimed at improving HIV outcomes for these communities.

Policy shifts in the US between 2024 and 2025 have further compounded these challenges. Globally, the world is experiencing unprecedented migration and changes in socio-economic paradigms. The COVID-19 pandemic underscored and heightened inequities faced by migrants, immigrants, and refugees with HIV, including reduced access to care, increased socioeconomic instability, and heightened psychosocial stressors.[9] These are exacerbated by the ongoing impact of increasingly restrictive and hostile immigration policies and underscore the importance of recognizing immigration-related stress as a central factor that destabilizes effective HIV care. Net-migration of healthcare workers also destabilizes

both source and recipient healthcare systems, creating workforce shortages in LMICs while high-income countries become dependent on international recruitment to maintain adequate provider availability, especially in primary care.[10,11] It is important, therefore, to direct local and national efforts to develop responsive, structurally-informed interventions that address both health and legal vulnerabilities of HIV patients and mitigate resource-constrained and shifting healthcare systems.[1,9] Examples of structurally-informed initiatives are: cross-border cooperation, including development of health passports and centralized HIV databases to ensure care continuity for migrants, integrating HIV testing services with non-stigmatizing services such as hypertension or cervical cancer screening, and training health professionals in immigration policies and resources to build trust and offer referral to legal support.[1,12]

While prior reviews have catalogued barriers to HIV care among migrants globally,[1] this editorial aims to synthesize the impact of the rapidly shifting 2024–2025 US policy landscape on immigration-related stress as a determinant of HIV care continuum outcomes and to propose a multi-level framework, spanning clinical, policy, and community domains, for mitigating these effects. To this end, the editorial examines the current policy landscape, mental health implications, impacts across the HIV care continuum, intersectional vulnerabilities, and evidence-based interventions.

Current Policy Landscape

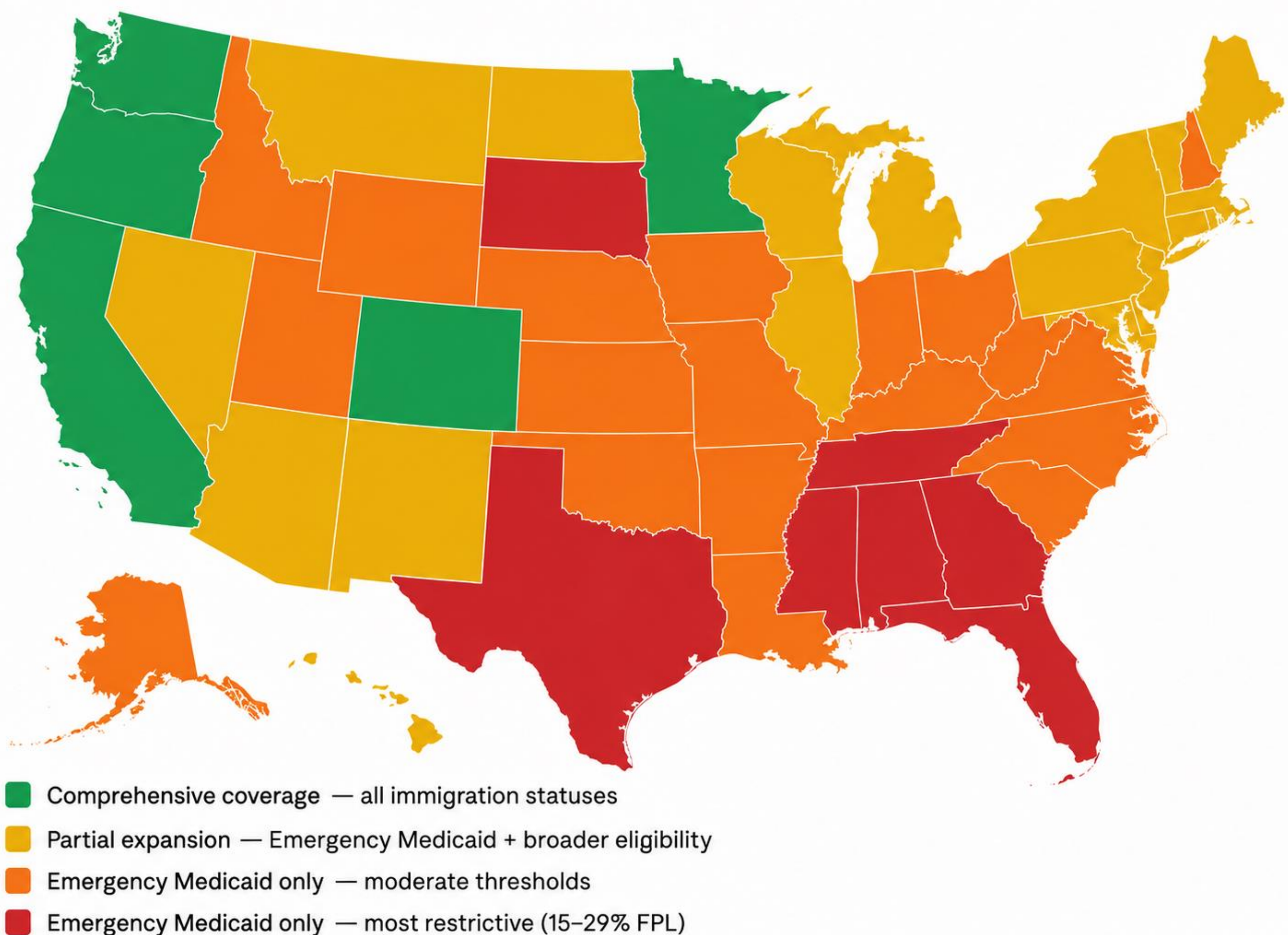

Figure 1: US Map of State-Level Healthcare Coverage for Undocumented Immigrants. Data derived from Santos et al., JAMA Internal Medicine, 2025 (reference 15).

Recent federal policy changes between 2024 and 2025 have significantly reshaped the healthcare landscape for immigrant/migrant populations, with direct implications for people with HIV. The 2025 Department of Health and Human Services (HHS) policy banning the use of tax-funded health

services for undocumented immigrants/migrants restricted access to essential components of HIV care, including testing, treatment, and preventive services.[13] Additional federal actions, including budget reconciliation measures, have stripped Medicaid eligibility from certain categories of refugees and asylees, while Deferred Action for Childhood Arrivals (DACA) recipients have lost access to Affordable Care Act Marketplace coverage.[14] Further, a new agreement allowing the Centers for Medicare & Medicaid Services (CMS) to share Medicaid enrollment data with Immigration and Customs Enforcement (ICE) has introduced heightened fear and mistrust among immigrant/migrant communities, potentially deterring individuals from seeking or maintaining care.[13] These policies limit federal support structures that are critical for sustaining engagement along the HIV care continuum.

At the state level, responses reflect both expansive and restrictive measures. At the time of this writing, several states have expanded access to care, including California, Washington, Oregon, Minnesota, Colorado, and the District of Columbia, offering comprehensive health coverage regardless of immigration status, representing important efforts to mitigate federal exclusion policies.[15] However, this progress has been tempered by California, Illinois, and Minnesota scaling back previously expanded coverage due to fiscal and political pressures.[13] In more restrictive contexts, legislative efforts such as Idaho's House Bill (HB) 135 sought to limit access to the Ryan White HIV/AIDS Program for undocumented individuals, though this measure was blocked by a federal judge.[13] These variations demonstrate the inconsistency individuals face in accessing care across jurisdictions.

This evolving policy landscape has resulted in a highly fragmented system, as evidenced by the variability of Emergency Medicaid programs across the 50 US states. While Emergency Medicaid remains one of the few safety nets available to undocumented immigrants/migrants, its scope, eligibility criteria, and covered services differ widely, leading to inconsistent access to care depending on geographic location.[15] This geographic variation is particularly pronounced in the Southeastern United States, where states maintain among the lowest income eligibility thresholds (15-29% FPL for parents, 0% for childless adults in states like Florida, Georgia, Alabama, Mississippi, Tennessee, and Texas) and restrict coverage to the duration of the emergency only, with no state offering Medicaid-equivalent programs for comprehensive care.[13,14] For individuals with HIV, whose health outcomes depend on continuous and coordinated treatment, such inconsistency poses substantial barriers and risks. While comprehensive data on healthcare-driven interstate migration among immigrants with HIV remains limited, state-level disparities in coverage create conditions where sustained HIV care depends heavily on geographic location.[15,16] Comprehensive coverage concentrated in only 5 states plus DC (serving up to 30.4% of undocumented immigrants) creates a "patchwork safety net," where access depends on location rather than medical need (Figure 1).[15,16] The interplay between restrictive federal policies and inconsistent state-level policies reinforces disparities and complicates efforts to deliver equitable, sustained HIV care to immigrant/migrant populations.

Immigration Stress and Mental Health

The psychological burden experienced by immigrants/migrants with HIV in the US arises from several compounding stressors that extend beyond the clinical management of the disease. These include the fear of deportation and immigration enforcement as well as the dual stigma of navigating both HIV-related discrimination and the marginalization associated with immigration status, often within communities and institutional settings that may not fully support either identity.[9,17] Many immigrants/migrants with HIV also carry the psychological sequelae of pre-migration trauma, including exposure to violence,

persecution, or forced displacement, while concurrently facing post-migration adversities such as discrimination, legal uncertainty, and structural barriers to care.[17,18] Immigration-related stressors are further exacerbated by economic instability, precarious employment, and social isolation stemming from disrupted family and community networks, all of which heighten vulnerability to psychological distress.[9,17,18]

These co-occurring stressors result in substantial mental health consequences, with immigrants/migrants with HIV experiencing disproportionately high rates of depression, anxiety, post-traumatic stress disorder, and substance use disorders.[2,17,18,19] Despite this elevated burden, mental health conditions amongst immigrants/migrants are frequently underdiagnosed and undertreated, reflecting both structural barriers to care and persistent cultural or linguistic gaps within the healthcare system.[17] Notably, psychosocial stress has been identified as a mediating factor linking HIV-related stressors to the onset and severity of depressive symptoms, thereby amplifying the overall impact on mental health and well-being.[19] These findings highlight that immigration-related stress is not merely an external pressure, but a central determinant of psychological health that directly influences the broader trajectory of HIV care and outcomes.

Immigration-related Stress: Impact on the HIV Care Continuum

Approximately 18.9% of people living with HIV in the US are foreign-born.[20] Among those unaware of their HIV status, immigration-related stressors disrupt engagement across every stage of the HIV care continuum, undermining progress from diagnosis to long-term viral suppression. At the earliest stage, fear of stigma and immigration-related consequences contributes to delayed HIV testing, as individuals may avoid healthcare settings due to concerns about exposure or discrimination.[1,21] Additionally, many immigrants arrive unaware of their HIV status; less than half of African immigrants with HIV reported prior negative testing, while others who knew their status pre-migration face barriers to re-establishing care and documentation in the destination country.[1,22] Even after diagnosis, persistent fear and structural instability can lead to missed clinic appointments and interruptions in antiretroviral therapy, particularly when immediate concerns of safety or economic survival take precedence over consistent care.[23] These disruptions accumulate over time, resulting in poor retention in care and increased loss to follow-up.[24,25] Consequently, rates of viral suppression remain suboptimal among immigrant populations and reflect failure in sustained access and engagement rather than treatment efficacy.[24] For those unaware of their status, delayed diagnosis drives excess morbidity and mortality: non-US-born persons are disproportionately diagnosed at Stage 3 (AIDS) compared to US-born persons. Certain immigrant sub-groups, for example African-born males and Asian-born females, have the highest proportions of late-stage diagnosis, underscoring that structural barriers to timely testing translate directly into preventable disease advancement.[26]

Immigration status, in particular, drives many of the disruptions experienced in care. Undocumented status consistently emerges as a primary obstacle, limiting insurance access, eligibility for services, and willingness to seek care.[21,24] Language and/or cultural barriers and the complexity of navigating the US healthcare system further hinder effective engagement, particularly for individuals with limited health literacy or access to culturally competent services.[24] Fear of encountering immigration authorities in or around healthcare facilities remains a major deterrent, reinforcing avoidance behaviors even when care is urgently needed.[21,23] Concerns about unintended disclosure of HIV status can also heighten mistrust and discourage participation in care.[1,21] These challenges are further reinforced by structural barriers including inadequate insurance coverage, poverty, transportation difficulties, and housing

instability, all of which interfere with consistent treatment adherence and follow-up.[7,23,27]

Intersectional Vulnerabilities faced by Immigrant/Migrant Communities

Immigration-related stress and its impact on HIV care are not experienced uniformly but, rather, are shaped by intersecting identities, with gender representing an important point of vulnerability. Women with HIV living in immigrant communities frequently face intimate partner violence and economic insecurity, both of which can limit autonomy in seeking and maintaining care.[17] Fear of a partner's reaction, including violence, abandonment, or financial loss, may discourage timely HIV diagnosis and disclosure.[1] For refugee women, prior trauma and resettlement stressors contribute an additional mental health burden that further complicates engagement in care.[18] However, these vulnerabilities must be understood within a broader syndemic framework, where multiple co-occurring conditions, including poverty, housing instability, substance use, mental health disorders, incarceration history, and experiences of violence, interact synergistically to undermine HIV care outcomes.[28] Research demonstrates that each additional syndemic factor is associated with significantly greater odds of poor ART adherence and viral non-suppression.[28]

Race and ethnicity further shape these experiences. Among Hispanic populations, HIV-related stigma remains substantial, with reported median stigma scores in current literature reflecting persistent negative attitudes and social marginalization.[29] Within this group, Black Hispanic individuals report higher rates of healthcare discrimination compared to their White Hispanic counterparts, highlighting the effects of racial and ethnic identity on healthcare experiences.[29] African-born immigrants face distinct challenges as well, including culturally specific stigma surrounding HIV and additional barriers related to migration history, language, and community perceptions that can deter healthcare engagement.[17,21] American Indian, Alaska Native, Native Hawaiian, and Pacific Islander populations remain critically underrepresented in HIV surveillance data due to small sample sizes and racial/ethnic misclassification, leading to exclusion from targeted interventions despite significant disparities; an estimated 1 in 5 AI/AN adults with HIV are unaware of their status, and only 64% achieve viral suppression.[30,31]

For LGBTQ+ immigrants with HIV, homophobia, when combined with HIV-related stigma and immigration precarity, creates a multilayered burden that limits access to supportive services and affirming care environments.[24] Latino men who have sex with men often navigate simultaneous discrimination based on sexual orientation, ethnicity, and immigration status, all of which can hinder testing and sustained engagement in care.[1] These findings show that racial and ethnic identities do not operate in isolation but intersect with immigration status, leading to distinct patterns of disadvantage and highlighting the need for tailored, culturally responsive interventions that address the specific needs of diverse subpopulations within this community.

© 2026 European Society of Medicine

Evidence-Based Interventions and Best Practices

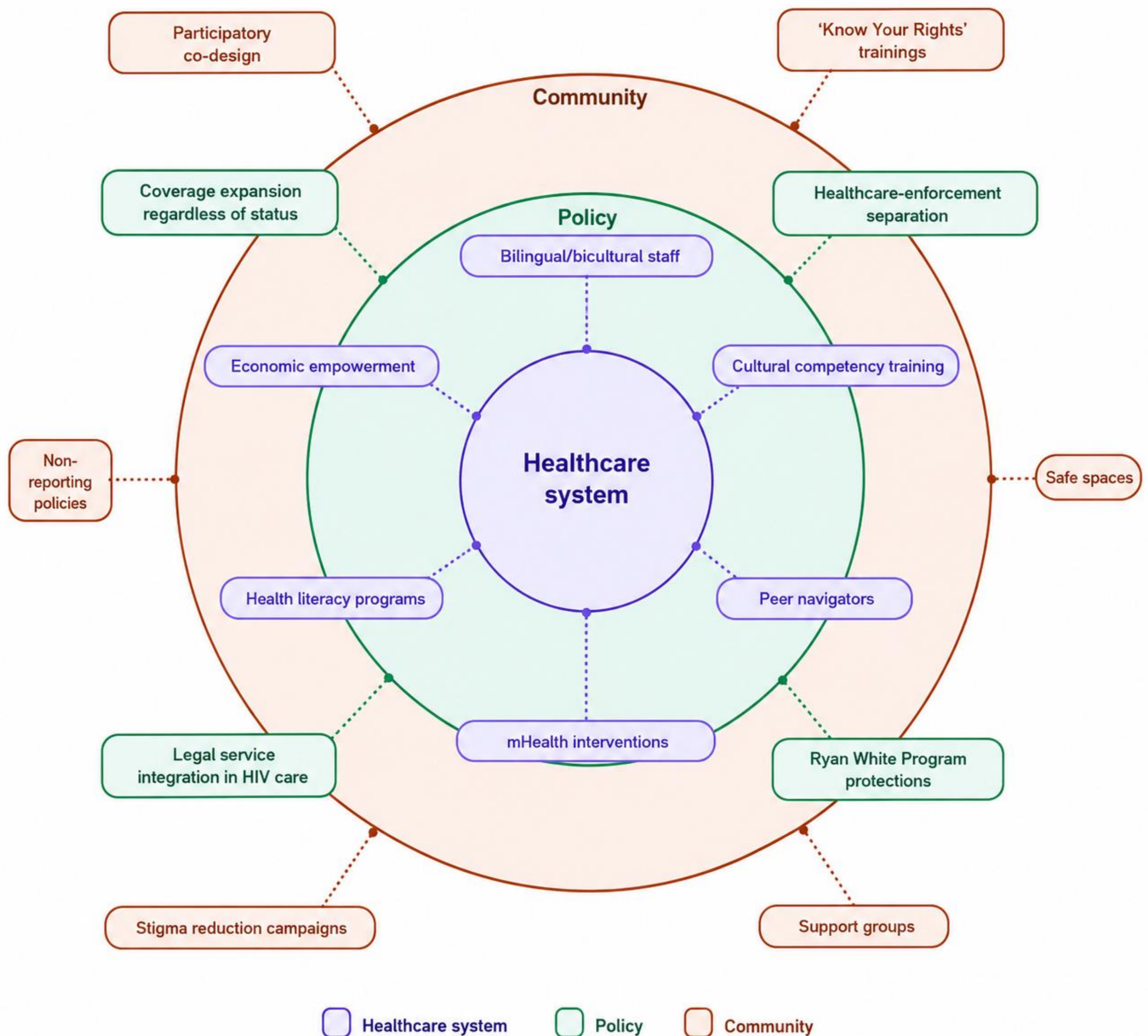

Figure 2: Multi-level intervention framework for addressing immigration-related stress among people with HIV. Intervention components derived from evidence reviewed in this editorial (references 1, 17, 21, 23, 27, 32–34).

Addressing immigration-related stress among people with HIV requires coordinated interventions across healthcare systems, policy frameworks, and community networks (Figure 2).

At the healthcare system level, evidence supports the implementation of culturally and linguistically responsive care models. This includes hiring bilingual and bicultural staff who can bridge communication gaps and foster trust, as well as providing cultural competency training for all healthcare workers to ensure sensitivity to the unique experiences of immigrant populations.[1,23] Peer navigators and cultural mediators have also emerged as effective strategies, helping patients navigate complex healthcare systems while providing social and emotional support.[1,23] Health literacy interventions, including culturally adapted self-management programs, can improve HIV-specific knowledge and self-efficacy, addressing the educational barriers that impede care engagement.[32] Economic empowerment strategies, including conditional incentives for viral suppression, savings programs, and financial literacy training, have also demonstrated efficacy in improving ART adherence and viral suppression by addressing the underlying economic drivers of

poor outcomes.[33,34] Integrating HIV testing into broader health services can reduce stigma by normalizing care-seeking, while mobile health (mHealth) interventions offer flexible solutions for highly mobile or hard-to-reach populations, improving continuity and engagement in care.[1,27]

At the policy level, expanding health coverage regardless of immigration status is a foundational step toward equitable access to HIV prevention and treatment.[1] Clear separation of healthcare systems from immigration enforcement can alleviate fear and encourage individuals to seek care without risk of legal consequences.[1] Integrating legal services within HIV care settings can also address immigration-related challenges that directly impact health outcomes.[1,23]

At the community level, participatory co-design of interventions ensures programs are tailored to the needs and values of affected populations.[1] Community outreach, support groups, and faith-based initiatives help reduce stigma and isolation, while "Know Your Rights" trainings and clear non-reporting policies within healthcare settings can reduce fear-based avoidance of care.[17,21,23] Collectively, these multi-level interventions underscore the importance of building systems that are not only accessible, but trusted and responsive to the lived realities of immigrant populations with HIV.

Actionable Measures

Addressing immigration-related stress as a determinant of HIV outcomes requires coordinated action across clinical, policy, research, and community domains.

ROUTINE SCREENING FOR HIV:

For clinicians and healthcare systems, routine screening for immigration-related stress and associated mental health needs is an essential first step in identifying patients at risk of disengagement from care. Equally important are routine HIV screenings; since 2010, HIV is no longer a required component of immigration medical examinations, meaning many immigrants arrive without knowledge of their HIV status and must rely on voluntary post-arrival testing, facing significant barriers with healthcare access, privacy concerns, and anticipated stigma.[12,35]

TRAUMA-INFORMED AND CULTURALLY COMPETENT CARE:

Implementing trauma-informed and culturally competent care models can help mitigate the effects of stigma, discrimination, and prior trauma while improving patient-provider relationships.[1,23]

HEALTHCARE SYSTEM ADVOCACY:

Clinicians and health systems play an important advocacy role within their institutions, working to establish policies that protect patient confidentiality and reduce fear of immigration enforcement in healthcare settings.[23] These efforts are critical to ensuring care environments are perceived as safe and accessible by immigrant patients and their providers.

HIV-RELATED POLICIES:

For policymakers, the current evidence underscores the urgent need to protect and expand healthcare access regardless of immigration status. Ensuring that safety-net programs, including the Ryan White HIV/AIDS Program, remain accessible to all individuals with HIV is vital for continuity of care and preventing adverse outcomes.[23] Policies that explicitly separate healthcare systems from immigration enforcement can reduce fear-driven avoidance of care and improve population-level public health outcomes.[1] In the context of the evolving 2025 policy landscape, such protections are increasingly necessary to counteract the destabilizing effects of restrictive federal and state measures.

RESEARCH AND INTERVENTIONS:

Further research is needed to better capture the heterogeneity of immigrant populations with HIV. Existing evidence highlights significant variation by ethnicity, race, migration history, and gender, yet gaps persist in understanding how these factors interact to shape health outcomes.[1,23] Evaluating

© 2026 European Society of Medicine

the effectiveness of interventions within the current policy climate is also essential, particularly as new restrictions and uncertainties emerge. Systematically assessing the impact of recent policy changes on HIV care engagement, treatment adherence, and viral suppression will be essential for informing future evidence-based responses.

COMMUNITY TRUST BUILDING AND EDUCATION:

For advocates and community organizations, building trust through sustained engagement, culturally grounded programming, and "Know Your Rights" education can empower individuals to seek care despite immigration-related fears.[23] Peer navigation and community-based interventions further support establishing and sustaining care, while efforts to reduce both HIV-related and immigration-related stigma remain important factors in improving health outcomes.[1,23]

Conclusion

Immigration-related stress among PLHIV is a public health issue and must be recognized as such. It is a factor that directly undermines efforts to control the HIV epidemic in the US. The persistence of structural barriers across the care continuum highlights that biomedical advances alone are insufficient to achieve equitable outcomes. In the context of an increasingly restrictive policy environment, there is an urgent need for compassionate, evidence-based approaches that center the dignity and safety of all individuals with HIV living in the US.

Conflict of Interest

The authors declare no conflicts of interest.

Funding Statement

There was no funding of this research.

Acknowledgements

None.

References

1. Kamenshchikova A, Peters CMM, Nöstlinger C, et al. Interventions to ensure access to and continuity of HIV care for international migrants: an evidence synthesis. *Lancet HIV*. 2024;11(12):e873-e884. doi:10.1016/S2352-3018(24)00175-9
2. Frost DM, Meyer IH. Minority stress theory: Application, critique, and continued relevance. Curr Opin Psychol. 2023;51:101579. doi:10.1016/j.copsyc.2023.101579
3. Gulick RM, Pau AK, Agwu A, et al; Office of AIDS Research Advisory Council. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV. Revised 2024.
4. Rodger AJ, Cambiano V, Bruun T, et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. Lancet. 2019;393(10189):2428-2438. doi:10.1016/S0140-6736(19)30418-0
5. Skarbinski J, Rosenberg E, Paz-Bailey G, et al. Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States. JAMA Intern Med. 2015;175(4):588–596. doi:10.1001/jamainternmed.2014.8180
6. Kerani RP, Satcher Johnson A, Buskin SE, et al. The Epidemiology of HIV Among People Born Outside the United States, 2010-2017. Public Health Rep. 2020;135(5):611-620. doi:10.1177/0033354920942623
7. Demeke HB, Luo Q, Beer L, Weiser J. Antiretroviral prescription, retention in care and viral suppression by place of birth among adults with diagnosed HIV in the United States-2015-2017, medical monitoring project. AIDS Care. 2021;33(1):86-91. doi:10.1080/09540121.2020.1738007
8. Santoso D, Asfia SKBM, Mello MB, et al. HIV prevalence ratio of international migrants compared to their native-born counterparts: A systematic review and meta-analysis. EClinicalMedicine. 2022;53:101661. Published 2022 Sep 17. doi:10.1016/j.eclinm.2022.101661
9. Marriette N, Dhungel R, Karki KK, Tovillo JB. Challenges and Resiliency: Social Determinants of Health, COVID-19, and the Disproportionate Impact on Immigrants and Refugees Living with HIV. *Int J Environ Res Public Health*. 2025;22(1):114. Published 2025 Jan 15. doi:10.3390/ijerph22010114
10. Eaton J, Baingana F, Abdulaziz M, Obindo T, Skuse D, Jenkins R. The negative impact of global health worker migration, and how it can be addressed. Public Health. 2023;225:254-257. doi:10.1016/j.puhe.2023.09.014
11. GBD 2019 Human Resources for Health Collaborators. Measuring the availability of human resources for health and its relationship to universal health coverage for 204 countries and territories from 1990 to 2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2022;399(10341):2129-2154. doi:10.1016/S0140-6736(22)00532-3
12. Cortes CP, Sued O, Wong WCW, et al. Humanising and optimising HIV health care for refugees and asylum seekers. *Lancet HIV*. 2024;11(12):e861-e872. doi:10.1016/S2352-3018(24)00233-9
13. Schneider L. HHS Bans Tax-Funded Health Services for Undocumented Immigrants. JAMA. 2025;334(10):845–846. doi:10.1001/jama.2025.12999
14. Sommers BD, Santos PMG. Rhetoric vs Reality on Immigrants' Health Care Spending. JAMA Health Forum. 2025;6(12):e256539. doi:10.1001/jamahealthforum.2025.6539
15. Santos PMG, Narayan A, Hong AS, et al. Landscape of Emergency Medicaid and Health Care Coverage for Undocumented Immigrants in the US. JAMA Intern Med. 2025;185(7):866–873. doi:10.1001/jamainternmed.2025.0604
16. Flynn MB, Stobb M, Palacios AM, Rodriguez D, Pinilla-Herrera A, Gonzalez Campos D. Migrant Barriers and Facilitators To Access Medical Services and Engage in Healthcare-seeking

© 2026 European Society of Medicine

Behaviors in the Southeast United States: A Mixed-Methods, Exploratory Study. J Immigr Minor Health. Published online November 16, 2025. doi:10.1007/s10903-025-01824-5

17. Ojikutu BO, Nnaji C, Sithole-Berk J, et al. African born women living with HIV in the United States: unmet needs and opportunities for intervention. *AIDS Care*. 2018;30(12):1542-1550. doi:10.1080/09540121.2018.1497767
18. Vitale A, Ryde J. Exploring Risk Factors Affecting the Mental Health of Refugee Women Living with HIV. *Int J Environ Res Public Health*. 2018;15(10):2326. Published 2018 Oct 22. doi:10.3390/ijerph15102326
19. Noh MS, Rueda S, Bekele T, et al. Depressive symptoms, stress and resources among adult immigrants living with HIV. *J Immigr Minor Health*. 2012;14(3):405-412. doi:10.1007/s10903-011-9515-0
20. ACOG Committee Statement No. 25: Advocating for Safe and Equitable Obstetric and Gynecologic Care for Immigrants. Obstet Gynecol. 2026;147(4):598-607. doi:10.1097/AOG.0000000000006213
21. Ross J, Akiyama MJ, Slawek D, et al. Undocumented African Immigrants' Experiences of HIV Testing and Linkage to Care. *AIDS Patient Care STDS*. 2019;33(7):336-341. doi:10.1089/apc.2019.0036
22. Kerani RP, Lugg A, Berzins B, et al. Post-migration HIV Acquisition Among African Immigrants in the U.S. J Immigr Minor Health. 2022;24(6):1459-1468. doi:10.1007/s10903-022-01356-2
23. Arnold EA, Fuller SM, Martinez O, Lechuga J, Steward WT. Documenting best practices for maintaining access to HIV prevention, care and treatment in an era of shifting immigration policy and discourse. *PLoS One*. 2020;15(2):e0229291. Published 2020 Feb 18. doi:10.1371/journal.pone.0229291
24. Ramírez-Ortiz D, Seitchick J, Polpitiya M, et al. Post-immigration factors affecting retention in HIV care and viral suppression in Latin American and Caribbean immigrant populations in the United States: a systematic review. Ethn Health. 2022;27(8):1859-1899. doi:10.1080/13557858.2021.1990217
25. Segala FV, Di Gennaro F, Frallonardo L, et al. HIV-related outcomes among migrants living in Europe compared with the general population: a systematic review and meta-analysis. *Lancet HIV*. 2025;12(12):e873-e882. doi:10.1016/S2352-3018(25)00301-7
26. Kajese Mawokomatanda TT, Singh S, Valverde EE. HIV Care Outcomes Among Non-US-Born Persons with Diagnosed HIV Infection, 2019. J Immigr Minor Health. 2024;26(3):443-452. doi:10.1007/s10903-023-01568-0
27. Thompson MA, Horberg MA, Agwu AL, et al. Primary care guidance for persons with human immunodeficiency virus: 2020 update by the HIV Medicine Association of the Infectious Diseases Society of America. *Clin Infect Dis*. 2021;73(11):e3572-e3605. doi:10.1093/cid/ciaa1391
28. Glynn TR, Safren SA, Carrico AW, et al. High Levels of Syndemics and Their Association with Adherence, Viral Non-suppression, and Biobehavioral Transmission Risk in Miami, a U.S. City with an HIV/AIDS Epidemic. AIDS Behav. 2019;23(11):2956-2965. doi:10.1007/s10461-019-02619-0
29. Padilla M, Patel D, Beer L, et al. HIV Stigma and Health Care Discrimination Experienced by Hispanic or Latino Persons with HIV - United States, 2018-2020. *MMWR Morb Mortal Wkly Rep*. 2022;71(41):1293-1300. Published 2022 Oct 14. doi:10.15585/mmwr.mm7141a1
30. Baugher AR, Beer L, Bradley HM, Evans ME, Luo Q, Shouse RL. Behavioral and Clinical Characteristics of American Indian/Alaska Native Adults in HIV Care - Medical Monitoring Project, United States, 2011-2015. MMWR Morb Mortal Wkly Rep. 2019;67(5152):1405-1409. Published 2019 Jan 4. doi:10.15585/mmwr.mm675152a1
31. Moore A, Williams W, Marano-Lee M, Williams N, Xu S, Uhl G. CDC-Funded HIV Testing and Linkage to HIV Medical Care Among American

Indian and Alaska Native People in the United States, 2014-2020. Public Health Rep. 2023;138(5):782-787. doi:10.1177/00333549221121672

32. Baumeister A, Aldin A, Chakraverty D, et al. Interventions for improving health literacy in migrants. *Cochrane Database Syst Rev.* 2023;11:CD013303. doi:10.1002/14651858.CD013303.pub2
33. Keene CM, Sabin LL, Jennings L, et al. Oral antiretroviral adherence interventions in the era of U=U. Lancet HIV. 2025;12(8):e587-e595. doi:10.1016/S2352-3018(25)00096-7
34. Tozan Y, Capasso A, Sun S, et al. The efficacy and cost-effectiveness of a family-based economic empowerment intervention (Suubi + Adherence) on suppression of HIV viral loads among adolescents living with HIV: results from a Cluster Randomized Controlled Trial in southern Uganda. J Int AIDS Soc. 2021;24(6):e25752. doi:10.1002/jia2.25752
35. Ojikutu B, Nnaji C, Sithole-Berk J, Bogart LM, Gona P. Barriers to HIV Testing in Black Immigrants to the U.S. J Health Care Poor Underserved. 2014;25(3):1052-1066. doi:10.1353/hpu.2014.0141

© 2026 European Society of Medicine