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Abstract

Migrant smuggling is a humanitarian crisis that impacts public health. A limited number of studies have focused on the links between migrant smuggling and its impact on the risk of infectious diseases, including HIV, for those smuggled. To explore these links, we conducted in-depth interviews with 11 Asian and Pacific Americans (APA) living with HIV in New York and Los Angeles. Qualitative content analysis revealed that smuggled immigrants described their experience as one with opportunity and danger. Smuggled immigrants, who aimed to achieve their American dream, were influenced by hometown pioneers who successfully journeyed to the United States and by the prospect of gaining legal status through immigration policy similar to the 1986 amnesty. Unfortunately, the long and dangerous journey exposed the immigrants to health problems, including risk for HIV. Thus, health care providers for immigrants should assess their migration routes and screen for infectious diseases.

Keywords

Asian Pacific Americans, HIV, migrant smuggling, immigrants

Introduction

With the advent of antiretroviral therapy (ART), HIV infection has become a chronic condition (Teeraananchai et al., 2017) as opposed to a commonly fatal infection. The Centers for Disease Control and Prevention (CDC) reports that between 2013 and 2016, the Asian population increased by nearly 17% in the United States and experienced a 42% increase in HIV diagnoses (CDC, 2018). Even with this dramatic increase in HIV diagnoses, Asian Pacific Americans (APA) living with HIV (APALHIV) account for only 2% of the total population living with HIV in the United States (CDC, 2020a). However, the recorded number of APA cases might not reflect the actual number due to the misidentification of their ethnicity or race (CDC, 2019).

Currently, few studies have focused on the management of HIV-related psychological and physical discomforts, mental distresses, disease disclosure, and medication research among APALHIV (Takahashi et al., 2006; Tang & Chen, 2018). In addition, research on APA immigration experiences and how the immigration process is linked to HIV risk is even sparser (Huang et al., 2008; Kang et al., 2006). The lack of research on the APA population has resulted in few targeted intervention and prevention programs for this at-risk group (CDC, 2018).

Immigration is the main driver of Asian American population growth, especially undocumented immigration, which has led to APA becoming one of the fastest-growing undocumented racial groups in the United States, with a six-fold increase since 1990 (Kim & Yellow Horse, 2018). During the 1980s and 1990s, individuals from India, China, Japan, Vietnam, Philippines, Malaysia, and Korea sought covert

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entry into the United States due to the influence of perceived immigration policy in the United States (e.g., the possibility of future amnesties for undocumented immigrants) and the region's own complex socio-historical political contexts (e.g., strict family planning policy in China) (Chu,1984; Newsweek Archives, 2017). The Center for Migration Studies (2018) estimated that the Asian undocumented population was more than 1.7 million in 2018 in the United States (Center for Migration Studies, 2018). Studies on Asian Americans and Pacific Islanders have reported that nearly one in seven Asian American immigrants was undocumented (Ramakrishnan & Shah, 2017; Zong & Batalova, 2016).

Some of these undocumented immigrants came to the United States through migrant smuggling (Jawed & Yaqoob, 2018). Migrant smuggling is defined as "the procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a State Party of which the person is not a national or permanent resident" (United Nations Office on Drugs and Crime [UNODC], 2020). In contrast to human trafficking, which is broadly defined as the forced movement of individuals within and between nation-state boundaries (Musto, 2009), migrant smuggling is usually consensual (Laboratory to Combat Human Trafficking, 2017). When legal channels of migration cannot be achieved, migrant smugglers assist individuals who are willing to take risks during the smuggling process in order to achieve better lives (U.S. Immigration and Customs Enforcement, 2018). Smugglers most often move people (men, women, children, and family units) as part of cargo transports in land vehicles, boats, tractor-trailers, boxcars on trains, or automobiles or trucks that are transported on trains as cargo (UNODC, 2015; U.S. Immigration and Customs Enforcement, 2018). Legitimate transportation options also are utilized, such as commercial buses and airline flights (U.S. Immigration and Customs Enforcement, 2018). Typically, the relationship between the smuggler and the person being moved terminate upon arrival in the destination country (UNODC, 2020). In 2016, in the United States, the top three countries of origin of APA undocumented immigrants were India, China, and the Philippines (Wong, 2016).

Numerous media sources have covered migrant smuggling stories (e.g., Gentleman, 2019; Katz & Kirka, 2019). Especially after the 2019 British container truck tragedy, in which 39 smuggled immigrants died, the safety and health issues around migrant smuggling became part of the public discussion again (Mueller, 2019; Sundaram, 2020). During the process of smuggling, immigrants are exposed to unsanitary conditions that endanger their safety, health, and lives due to the territory and/or waters that are crossed and the methods used by smugglers (UNODC, 2015). The hazards include suffocating in containers, drowning at sea, and experiencing physical and sexual abuse at the hands of the smugglers (UNODC, 2015). These conditions may expose migrants to situations that could lead to behaviors that increase their risk for HIV or other potential illnesses, such as sex work, substance use, multiple sexual partners, and needle sharing (Keefe, 2009; UNODC, 2015). Studies suggest that human trafficking is associated with a profound burden of physical and psychological trauma (e.g., depression, anxiety, and post-traumatic stress disorder (Goldenberg et al., 2014; Ottisova et al., 2016; Sweileh, 2018), and, consequently, could exert a formative influence on immigrants' health care experiences, health care access, and health services engagement (Price et al., 2019).

Few studies have examined how the migrant smuggling process poses challenges to HIV screening, HIV testing, or other healthcare access. For example, a retrospective chart review conducted in the Boston area showed that only 36% of foreign-born immigrants had been screened for HIV (Waldorf et al., 2014). Pezzoli et al. (2009) reported that in Italy, 3,003 illegal immigrants were screened for HIV, of whom 29 (0.97%) tested positive. In the United States, many APA avoid HIV testing due to their lack of legal status, inadequate health care access, lack of insurance, poor financial status, language barriers, possible "loss of face" with their friends and family, and fear of discrimination and deportation (CDC, 2018). This prevents them from seeking healthcare and results in poor clinical outcomes, including the development of AIDS and severe levels of other diseases (Hacker et al., 2005).

As a vital public health framework, the HIV care continuum outlines the steps or stages that people living with HIV go through from diagnosis to engagement in medical care, antiretroviral therapy (ART) treatment, and, ultimately, suppression of the virus (CDC, 2019). Studies have shown that the HIV care continuum brings important health benefits for people living with HIV by suppressing their viral load (Hogg, 2018; Kay et al., 2016). For APALHIV, one of the most under-researched and hard-to-reach populations living with HIV (National Center for HIV/AIDS, 2019), there are limited studies on how accessible the HIV care continuum is to them.

Currently, few studies have focused on how migrant smuggling has affected APA undocumented immigrants with HIV. Thus far, the empirical links between immigrants who came to the United States via migrant smuggling and their HIV risk remain unknown. In this paper, we explore APALHIV's migrant experiences during smuggling, how the smuggling process exposed them to greater risk of HIV transmission, and their HIV experiences upon diagnosis.

Methods

Design

This was a qualitative study that used the content analysis approach to data analysis and adhered to the consolidated criteria for reporting qualitative studies (COREQ) checklist (Tong et al., 2007).

Settings and Participants

From September 2017 to January 2020, a purposive sample of 20 Asian Americans living with HIV was recruited in two cities (New York City and Los Angeles). Study participants were recruited from the Chinese-American Planning Council, Inc. (CPC) and the Asian/Pacific Islander Coalition on HIV/AIDS Community Health Center (APICHA Community Health Center) in New York City, and the CPC and the Asian Pacific AIDS Intervention Team (APAIT) in Los Angeles. Case managers in these agencies referred potential participants who were interested and willing to share their personal stories with the research staff. After staff explained the study purpose, answered questions, and secured study consent, the in-depth interviews were scheduled. The inclusion criteria for potential participants were that they were (a) living with HIV, (b) self-identified as Asian or Pacific American immigrants, (c) were at least 18 years of age, and (d) were willing to share their personal stories with the researchers. The sample size was determined by data saturation, defined as the point when "no new themes are observed in the data" (Faulkner & Trotter, 2017). In this study, after 20 in-depth interviews, the researchers felt there was no additional data being found and saw instances of similarities in responses over and over again; therefore, we determined that we reached a saturation point in the number of study themes. As we did not intent to recruit only smuggled migrants to the study, however, 11 out of the 20 (55%) of the study participants share their routes to come to the States via human smuggling. Therefore, we are only presenting these smuggled migrants' HIV experiences.

Qualitative Data Collection

The ethical review boards at the involved universities approved the study (#18-000025). APALHIV who were interested in the study met with the researchers, who explained the study, answered questions, and obtained consent. All of the in-depth interviews were audio-recorded and conducted in English or Asian languages (Mandarin, Cantonese, or Japanese) according to the study participants' preference. Bilingual nursing researchers with PhDs who had training and experience in qualitative studies conducted the in-depth interviews, and data analysis. Each face-to-face interview took about 1 to 2 hours and was carried out in private locations (a private conference room, the participant's house, or another location of choice). All study participants received a small payment in exchange for their participation. To enhance the reliability of the study, we first pilot tested the interview questions, which follow, on two participants, who were not included in the final study sample: "Tell me when and why you decided to come to the United States?" "How did you come to the United States?" "When and how did you know you were infected with HIV?" "Tell me the possible infection route of the disease (HIV)," "When did you start to take antiretroviral therapy?" and "How long did you stay in New York/San Francisco/Los Angeles?" Piloted participants said that they could understand these interview questions, and thus interview questions were unchanged. We then conducted the formal interview on the full sample and shared the de-identified transcripts of the interviews with them for reassurance, that is, to validate the transcripts.

Data Analysis

Two experienced qualitative nursing researchers used Atlas.ti software (Scientific Software Development Version 7.0, 2012) to conduct qualitative content analysis (Hsieh & Shannon, 2005). First, they inspected the transcriptions individually and coded the data. Three transcriptions were then randomly selected to check for coding consistency. For uncertain quotes, these two researchers met and discussed the code to achieve final consensus. Any disagreements would be adjudicated by a third researcher if needed to.

Second, they looked for concept categories from the code list related to the migration process and then themes were generated from these concept categories. Lastly, representative quotations related to the migration process were selected from the transcriptions. After all these processes were completed, the quotes were translated into English for publication. The dependability of this study was upheld by the performance of audits by external experts, who were familiar with APALHIV, throughout the process of collecting, thematizing, and analyzing the data to ensure the assigned themes were culturally tailored and appropriate to this population. This was done to confirm the accuracy of the findings and to ensure that the findings were supported by the data collected.

Results

Among the 11 APALHIV, ages ranged from 38 to 65 years, with an average age of 54.13 years ($SD = 9.72$). Average years of living with HIV was 21.22 ($SD = 5.19$). In this sample, the length of stay in the United States ranged from 14 to 40 years, with an average of 22.71 years. The average years of taking ART was 10.9 ($SD = 8.79$, range from 0 to 20 years). The other Socio-demographic characteristics of study participants were shown in Table 1.

Two main themes were discerned: namely "Migrant smuggling experiences" and "HIV experiences." The following is an exploration of each main theme and its related categories (see Figure 1).

Migrant Smuggling Experiences

The motivation to choose being smuggled. Several motivations were mentioned by participants to explain why they decided to be smuggled, with most of them saying they wanted to fulfill their American dream. Study participants said they

Table 1. Socio-Demographic Characteristics of Participants ($N = 11$).

Variables	AALHIV, *N* (%)
Gender	
Man	8 (72.7)
Woman	2 (18.2)
Transgender woman	1 (9.1)
Ethnicity	
Chinese	7 (63.6)
Malaysian	2 (18.2)
Vietnamese	2 (18.2)
Education	
11th grade or less	7 (63.6)
High school or GED	2 (18.2)
2 years of college/AA degree	2 (18.2)
Currently working status	
No	3 (27.3)
Part-time	6 (54.5)
Full-time	2 (18.2)

AALHIV = Asian Americans living with HIV.

perceived the United States as a place where they could pursue and achieve this dream. Several Chinese immigrants said they dreamt of owning their own restaurant. As one 53-year-old, Chinese man stated: "*I feel that America is good and have been wanting to come here for a long time. I thought it was my destiny to go abroad in this way*."

Second, many of them described financial reward as their major motivation. These APA spoke of their need for financial security for themselves and their families. For many of those who came to the United States in the 1980s and 1990s, the experience of poverty in their homeland was a prime motivator of their decision to come to the United States. One 49-year-old Chinese man noted that: "*It was easier to make money in the States. I can live a better life here than in my hometown, so I decided to leave. At that time, I could earn $2,000 dollars a month here.*"

Third was the influence of hometown pioneers who had successfully made the journey to the United States. Some of the participants came from Fujian province, a southeastern coastal area of China, where many of the migrant smugglers are from as well. Previously successful smuggled migrants had paved the way for their friends and families to follow. These early success stories were among the strongest incentives for those who followed. With preparations by friends and relatives in the United States and existing smuggling rings and transportation, these migrants successfully came to the United States. One 40-year-old Chinese man expressed it like this:

> *In the late '80s, at that time, we were on the coast, and one migrant smuggling ship was followed by another. It was a trend, and I just followed the flow. . ..my cousin prepared everything for me, including the housing, jobs, and the social networks.*

Fourth, sexual orientation was one of the major reasons for immigrants to leave their hometown. Some men living with HIV admitted that they recognized themselves as being gay, a fact that was very hard to disclose to their family members. In traditional Asian cultures, people are often forced to get heterosexually married; these individuals decided to start down the path of migration through migrant smuggling before that could happen. One 40-year-old male study participant stated:

> *Because I'm gay. And I know in my country, you can't have a life, an open life, and be respected [if you're gay]. That's my main issue. Uh, I like to, to respect people, and I, I don't think they respect gay people [in China]. I wanted to live with a guy, and, um, and I decided to move here because of that person.*

Fifth, immigration policy in Western countries also played a role in migrant smuggling. Some of the study participants mentioned that the U.S. immigration policy at that time encouraged them to take the risk of being smuggled. During the 1980s, the United States and some European countries legalized large numbers of undocumented immigrants through amnesties, which allowed undocumented immigrants who were already in-country to obtain resident status and apply for full citizenship. This act became one of the driving forces of migrant smuggling. One 53-year-old male study participant stated:

> *As soon as my brother got his status*, he sponsored me to come to the USA. But the important reason for my smuggling is the reform of immigration policy. My brother got the identity from the 1986 *amnesty. Before that, he had no identity, no tax return. Of course, he don't need to file a tax return every spring. So, he just need to work every day, see if the police come, and hide when they come. As soon as he got my status, he sponsored me to come.*

Last, the one-child policy was mentioned by some participants from China. One participant stated that since he has three children, he was often tortured because of the policy, and that was why he left the country. Other participants said they had wanted to have more than one child, since the more children there are in a family, the happier their lives would be. However, the domestic family planning policy in China did not allow them to bear more than one child. One 65-year-old Chinese man described it this way: "*I had two sons, and the second son was only a few months old. I wanted to keep trying until I had a daughter, so I needed to leave the country.*"

The process of migrant smuggling. Many immigrants said that their smuggling routes were arranged by the smugglers (whom they call "snakeheads") and recalled that there were long detours and uncertainty during the trip, with many last-minute changes to the itinerary. One 45-year-old study participant described his journey after he left his hometown. He

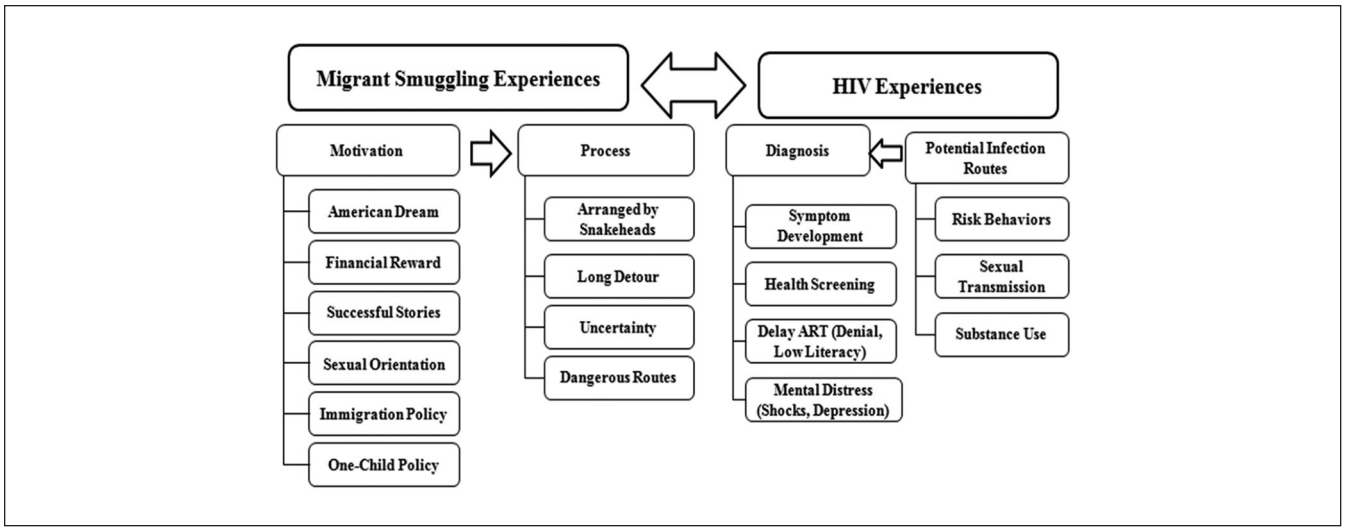

Figure 1. Themes and sub-themes of the migrant smuggling and HIV experiences.

took a 2-day bus to the border before getting on the smuggling route. Typically, the smuggling routes passed through several countries (e.g., Thailand, Cambodia, or Mexico), and ended in the United States after a series of trips by plane, bus, truck, and boat.

Several study participants came via a long mountain climb to Thailand, and they changed modes of transportation several times before arriving in the United States. The waiting times in these transit countries also varied, ranging from 1 week to 2 years. One interviewee (a 51-year-old man) came to the United States on the infamous "Golden Venture" ship. As he stated:

> *I climbed the border mountain from Yunnan to Thailand, which took 28 days. However, the one in charge of the smuggling process ran away; therefore, I had to stay in Thailand for another 2 years. Finally, I got on a ship to the United States. The cruise took more than 90 days.*

Others characterized the smuggling processes as being long and dangerous. Many migrant smugglers admitted that the journey had endangered their lives. One man (a 65-year-old) said:

> *I walked several days to Burma and waited there for 2 days. Then I climbed the mountain to cross the border to Thailand for 8 days. I walked on a single wooden bridge and sailed on a shaky sampan . . . I also walked through farm fields. I ran and followed the team, and we went through several fields of mud and a filthy, rocky trail. My feet went deep into the mud. The road was impossible to walk on, so I spent a couple hours slogging on it. Then, I had to go across several sand roads, which took at least 2 hours. At the end, my whole body and eyes were covered with dirt. Even now, I still can't see clearly. At that time, I couldn't see anything, but I just held onto brushes and climbed up to the top of the hill. Then, when I came down the hill, there was no grass on the way. I was so exhausted. I thought I might die.*

HIV Experiences

Diagnosis of HIV. After arriving at their destination, study participants needed to pay the smugglers. During their first few years in the United States, they not only needed to acculturate to the host culture but also had to work several jobs to pay back the money they owed to the smugglers. It took from 11 months to 4 years to clear the bill.

Within 2 to 9 years after arriving in the United States, study participants developed HIV or AIDS-related symptoms. Some of them were diagnosed during the legalization process, such as when applying for a green card, purchasing health insurance, getting premarital check-ups, or after being hospitalized for disease symptoms. When diagnosed with HIV, study participants were shocked and depressed. As one 61-year-old Chinese man said:

> *I went to the hospital to check on my lung issues. I got a blood test and the doctor told me that I had HIV. I stayed in the hospital for 1 month. I opened the window and wanted to kill myself. I could not accept that I have this. I just wanted to jump out the window.*

Regarding the ART experience, more than half of our participants started ART as soon as they had a confirmed HIV diagnosis. As one 60-year-old Chinese man said: "*The doctor called me and told me that there was a serious illness, then the Chinese-American Planning Council (staff) immediately contacted me, and helped me to pick up the medicine. I started taking medicine. . .*"

However, others delayed treatment until several years later due to a variety of reasons, such as low health literacy,

stigma, mental stress, or having mild symptoms. As one 49-year-old Chinese woman said: "*Well, there aren't many AIDS patients in China, and we didn't know anyone who has AIDS. For the first time, I didn't think that I had AIDS, so when I went for a checkup and they drew my blood, I felt like I was a healthy person. The doctor said that you have AIDS. AIDS – I did not know what that meant, so I did not take the medicine. He asked me to pick up the medicine, but I did not until I had issues with my eyes. . ..*"

Potential infection routes. When study participants tried to recall their possible infection route, many of them mentioned their risky behavior during the migrant smuggling journey. This behavior tended to happen while they were spending time waiting between different legs of their journey. Some of them had intercourse with "money boys," usually young males who earn money by offering sexual services. Some of them did sex work themselves to pay back the smugglers or for their use of substances (e.g., cocaine) during the smuggling process. As one 49-year-old Vietnamese transgender woman recounted:

> *The [smuggler] was trying to scare me. Before I could move away from him, he asked me for the money I owed. So the only way I could pay him back was to prostitute myself. But then he got caught and went to jail.*

Others acknowledged that they might have had the disease before they started the migrant smuggling process. One 65-year-old Chinese man admitted that "*Because HIV has a long incubation period, I don't know when I got it. Maybe it was in the process of smuggling, or maybe here. I am not sure; however, it was definitely sexually transmitted.*"

Discussion

Migrant smuggling is not only a humanitarian crisis but also an urgent public health issue (Langmagne et al., 2021). Although there are many indications of high incidences of migrant smuggling of APA, this topic is underrepresented in the health literature focused on migrant smuggling (Sweileh, 2018). By exploring the migrant smuggling experience of APALHIV, this qualitative study broadens the literature on migrant smuggling and HIV. The process of migrant smuggling might be a contributing factor to the exposure of immigrants to infectious diseases, including HIV.

As described by the APALHIV in this study, the migrant smuggling experience is a road with both opportunity and danger. Similar to previous studies on human trafficking (Gezie et al., 2019; Langmagne et al., 2021), the present study shows that socioeconomics are a major force influencing an immigrant's decision to be migrant smuggled. Many immigrants chose to be smuggled into the United States because of the hope of achieving the American dream and therefore providing better economic security for their families (Chen et al., 2015). Other immigrants chose the smuggling route because of the influence of hometown pioneers, and the idea of that they would eventually become legal residents in the United States. For example, studies have shown that people in Fujian, China began to migrate by being smuggled to developed countries, mostly the United States, on a large scale in the 1970s (UNODC, 2011). Later, in 1986, the U.S. Congress passed the Immigration Reform and Control Act, which granted amnesty to about 3.1 million undocumented immigrants (Jawed & Yaqoob, 2018; Library of Congress, 1986). In a way, the amnesty had encouraged migrants to come to the States and wait for the chance to legalize their status. Thus, to grasp the opportunities and realize their American dream, many immigrants stepped into the long journey of being smuggled.

On the other hand, unfortunately, the long, dangerous, and unsanitary smuggling routes exposed the immigrants to various health problems. During the process of smuggling, the immigrants were often deprived of necessities such as food, sleep, hygiene, and medical treatment, while being exposed to dangerous, poor, and unhygienic conditions. As a result, they were highly vulnerable to various health problems and human rights abuses. Moreover, immigrants engaged in risky behaviors during the smuggling process, such as sex work, violence, condomless sexual intercourse, or substance abuse. After arriving at their destination, immigrants also suffered from overwork and hazardous living conditions to pay back their smugglers. Keefe (2009) described migrant workers who were on the Golden Venture ship who subsequently became involved in kidnapping and extortion as well as ran sweatshops and massage parlors. The Golden Venture ship is a vessel carrying hundreds of smuggled immigrants from China that ran aground in Queens, New York, in 1993, leading to the deaths of 10 passengers (Fried, 1998). Some of the survivors lived in basements where dozens of people shared a few hundred square feet of space and slept in rotation. All these activities have numerous associations with negative health outcomes, including potential contact with infectious diseases, such as HIV (Gezie et al., 2019). Smuggled immigrants sacrificed all to gain their freedom and the American dream. From our study, participants developed HIV-related symptoms within the first 2 to 9 years after they arrived in the United States, and many of them went on to develop AIDS. This paper shares some insights into how migrant smuggling and HIV might be related.

Few of our participants started ART as soon as they had a confirmed HIV diagnosis; others delayed treatment up to several years due to a lack of health care access, low health literacy, lack of insurance, stigma, mental stress, the mildness of their symptoms, or financial hardship (CDC, 2018; Hacker et al., 2005). At the time of the study interviews, some of the participants had obtained their residency status, but others were still struggling to obtain legal residency. As the migrant smuggling process was completed and the immigrants settled into the new homeland, their spouses and

children in their home countries then started the next wave of migration.

There are several limitations to this study. First, the study participants were primarily Chinese immigrants, though some of them came from Vietnam and Cambodia. Therefore, the study should not be generalized to all APALHIV in the United States, especially undocumented immigrants. Additionally, the study's semi-structured interview guide, interviewers' abilities, and coding and analysis of the data may have been subject to researcher bias, which is important to acknowledge in qualitative research (Straughair, 2019). Another limitation could be recall bias, considering it had been decades since the participants arrived in the United States. Future similar studies should be conducted with a larger sample size to explore whether migration and migrant smuggling influence the spread of infectious diseases.

Relevance to Clinical Practice

As the sustainable development goals set by the United Nations for 2030 call for improving the health and human rights of immigrants (Sweileh et al., 2018), our findings have important implications for health care policy and intervention in support of migrant health. First, according to current CDC guidelines (CDC, 2020b), all people between the ages of 13 and 64 should be tested for HIV at least once and people at high risk should be tested at least once a year. Thus, infectious disease screening should be encouraged, especially when refugees and immigrants seek healthcare in clinics. To potentially increase the voluntary HIV testing among Asian immigrants, governmental and educational efforts should be made to dismantle barriers to HIV testing for this population; for example, culturally tailored and community-based programs should be developed that bundle HIV testing together with other regular health screenings, for example, diabetes screening and breast cancer screening.

In addition, people with undiagnosed HIV cannot obtain the care they need to stay healthy and may unknowingly transmit HIV to others. A lower percentage of APA have received a diagnosis compared to other races/ethnicities, which indicates that a significantly higher number of APA might be living with HIV in the United States than is accounted for by official reports (CDC, 2018). These findings could inspire an integrated disease prevention program aimed at raising awareness of migrant smuggling and its relationship to potential infectious disease transmission, including the transmission of HIV. Finally, our findings further emphasize the importance of expanding the continuum of care to APALHIV, including those who are undocumented immigrants, to ensure they are included in disease prevention and treatment programs and to protect the public health (Ross et al., 2017). During the era of the coronavirus disease 2019 (COVID-19) pandemic, people are increasingly aware that viruses as well as other infectious diseases can infect all humans, including immigrants.

Conclusions

This qualitative study provides insights into migrant smuggling experiences and reveals links between migrant smuggling and HIV susceptibility. Many immigrants started on the long journey along the migrant smuggling route with thoughts of potential opportunities and the hope of fulfilling the American dream. However, the long, dangerous, and unsanitary smuggling routes and risky behaviors of smuggled migrants are associated with negative health outcomes, including risk for HIV transmission and other potential traumas. For healthcare providers who work with immigrant populations, disease prevention programs should incorporate screening and treatment for infectious diseases during the provision of primary care. Specifically, healthcare providers should design integrated disease-prevention education programs aimed at promoting regular screenings in areas with large immigrant populations. Furthermore, healthcare providers should emphasize the importance of expanding provision of the HIV continuum of care to APALHIV and other immigrants living with HIV.

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