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Deportation along the U.S.-Mexico border: its relation to drug use patterns and accessing care

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Abstract

Since migration has been linked to new drug trends and risky behaviors, and deported individuals face unique economic and social stressors, we investigated behaviors of injection drug users (IDUs) from Tijuana, Mexico in relation to deportation history. In 2005, IDUs ≥ 18 years old who injected within the prior month were recruited by respondent-driven sampling, administered a questionnaire, and underwent antibody testing for HIV, HCV, and syphilis. Logistic regression compared IDUs who reported coming to Tijuana due to deportation from the U.S. versus others in the study. Of 219 participants, 16% were deportees. Prevalence of HIV, HCV and syphilis was 3%, 95% and 13%, respectively. Deportees had lived in Tijuana for a shorter time (median: 2 vs. 16 years), were more likely to inject multiple times/day (OR:5.52; 95%CI:1.62–18.8), but less likely to have smoked/inhaled methamphetamine (OR:0.17; 95%CI:0.17–0.86). Deportation history was inversely associated with receiving drug treatment (OR:0.41; 95%CI:0.19–0.89), recent medical care (OR:0.37; 95%CI:0.13–1.00), or HIV testing (OR:0.44; 95%CI:0.19–1.02). Deportees had different drug use patterns and less interaction with public health services than other study participants. Our study is an indication that migration history might relate to current risk behaviors and access to health care. More in-depth studies to determine factors driving such behaviors are needed.

Keywords

Mexico; HIV; drug use; deportation; border

Introduction

Illicit drug use has increased in Mexico over the past decade, especially in northern border areas where drugs are routed for attempted entry into the United States (U.S.). The 2000 mile porous border between the U.S. and Mexico is also characterized by a melding of political, cultural, and identity factors which may be contributing to higher risk of substance

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use among populations in these areas (1). These issues are reflected by the fact that the two largest border cities, Tijuana and Ciudad Juarez, now have the first and second highest prevalence of reported adult drug use in the country, with 14.7% and 9.2% of adults having ever used illicit drugs, respectively (2).

The region is also characterized by migration and mobility, with cross-border interactions common. Tijuana, Baja California, located just south of San Diego, California, U.S., is the northwestern-most city in Mexico and has over 1.3 million inhabitants. The San Ysidro border station between these cities is the busiest land border crossing in the world and accounts for 37% of the migrant flow between Mexico and the U.S. (3, 4). Recently, the number of persons deported from the U.S. has increased. In 2005, 1,171,428 undocumented migrants were expelled from the United States, with 126,909 from San Diego County (5). Although the U.S. and Mexican governments started a program in 2003 whereby deportees may be flown to Mexico City and bused to their town of origin, it is estimated that less than 1% of deportees of Mexican origin participate in this program (6). Instead, deportees are usually delivered by U.S. Customs and Border Protection Patrol agents to Mexican migration officials at deportation stations along Mexico's northern border. There are two such stations in Tijuana (7, 8).

Migration has been linked to lower socio-economic status, power inequalities, social and cultural alienation, a breakdown of family units, and fear of deportation and violence, which in turn may increase vulnerability to drug use and transmission of infectious diseases (9–11). Recently there has been some interest in issues such as maintenance of healthcare after deportation – with, for instance, the U.S. working with other governments to ensure more contiguity in tuberculosis treatment (12). There is, however, a paucity of data available on health concerns of deported migrants. An in-depth study of various categories of migrants suggests that deportees acutely lack economic resources shortly after deportation, with women deportees, in particular, sometimes resorting to selling sex in exchange for goods (13). Deportees also reported being subjected to violence in their past more often than other migrants, either at the hands of authorities or through interactions with others during the migration process (13). A possible consequence of the unique background and experiences of deportees on behavior was recently explored in a study of migrants and deportees in Tijuana which found that deportees were more likely to engage in certain high-risk practices, such as sex with an injection drug user (IDU) or transvestite, than other migrants (8).

We present here an analysis of data from a 2005 cross-sectional study of behavioral and social factors among IDUs in Tijuana, Mexico. While injection of illicit drugs comes with its own inherent medical, social, and legal ramifications, risky behaviors in IDUs, such as needle sharing, frequent injection, exchanging sex for drugs, and injecting with a high number of partners, have been associated with even greater risk of acquisition of infectious diseases. Given the unique economic and social stressors placed upon deported individuals, we hypothesized that IDU deportees might be engaging in higher risk sexual and drug using activities than other IDUs. We also hypothesized that IDU deportees might be more disconnected to health services due to unfamiliarity with resources or possibly economic constraints.

Methods

Study Population

Cross-sectional interviewer-administered surveys were conducted among 222 IDUs in Tijuana from February-April 2005, according to methods described elsewhere (14). This investigation was part of a binational study aimed at exploring risk behaviors and the spread

of infectious diseases among at-risk populations in the border region, in an effort to inform appropriate public health interventions. Eligibility criteria for the study included: having injected illicit drugs within the past month; aged 18 years or older; and willing and able to provide informed consent. Participants were recruited through respondent-driven sampling (RDS) in order to achieve a more representative sample of this hard-to-reach population and to be able to adjust for any recruitment bias (15).

A group of “seeds,” comprised of socially well connected injection drug users who fit the eligibility criteria of our study, was selected by local non-governmental organizations familiar with the drug use scene in the city (*Centro de Integración y Recuperación para Enfermos de Alcoholismo y Drogadicción “Mario Camacho Espiritu”, A.C. (CIRAD)*), which started in 1991 to work with drug users, and *pro-COMUSIDA*, which has been providing health education and services to injection drug users in Tijuana). Seeds were selected based on diversity of gender, location, and drug preferences. After providing informed consent, seeds underwent an interview, were educated on how to refer other eligible IDUs, and were given three uniquely coded coupons to refer their peers. Recruiters were themselves given coupons to recruit three IDUs in their social network until approximately 200 were recruited. The target sample size was based on available resources and an estimation of the number of participants that we believed would still provide enough waves of recruitment to effectively employ respondent-driven sampling techniques (15). Study methods were approved by the Ethics Board of the Tijuana General Hospital and the Institutional Review Board of the University of California, San Diego.

Data Collection and Laboratory Testing

Trained staff administered quantitative surveys in Spanish to IDU participants in order to collect information on domains such as socioeconomic and demographic profiles, drug-use practices, sexual behavior, and HIV testing history. Participants were asked about their lifetime drug use histories and current (past 6 months) drug use including the types of drugs used, routes of administration, age of first injection, and locations where they injected drugs (e.g., at their home, in a shooting gallery). Participants were tested for HIV, syphilis, and hepatitis C virus (HCV) using standard methods (14). Pre- and post-test counseling was provided to all participants. Those found positive for syphilis were provided with antibiotic treatment and counseling on risk behaviors, HIV-positives were counseled and referred to local care providers, and HCV-positives were provided with counseling on risk reduction, such as reducing alcohol intake, and referrals to the Tijuana General Hospital if symptomatic.

Variable Definitions and Data Analysis

Analyses were based on 219 participants who answered the question “How long have you lived in this city?” If the answer was less than lifetime, the participant was then asked “What was/were the reason or reasons that you moved here?” This was an open-ended question which was later hand coded based by two investigators and compared. Any discrepancies were discussed and then clarified for a subsequent round of coding. If any of the responses included deportation as the reason for moving to Tijuana, a person was categorized as having a self-reported history of deportation. Univariate logistic regression was used to compare IDUs who came to Tijuana due to deportation versus all other study participants. The small sample size precluded multivariate analyses. Two-sided P values < 0.05 were considered statistically significant.

Results

Characteristics of the study population

Most study participants were single males between the ages of 29 and 40, who had been injecting drugs for a median of 14 years (interquartile range (IQR) 9–20 years) (Table 1). Prevalence of HIV, HCV and syphilis was 3%, 95% and 13%, respectively. Few participants had completed secondary school and most earned less than 3000 Mexican pesos (approximately \$300 USD) per month. The most common drug injected was heroin, although this was usually taken in combination with methamphetamine (Table 1). Mobility was common in that most were born outside of the state of Baja California, approximately 2 out of 5 had worked outside of Mexico in the past 10 years (primarily in the U.S.), and nearly a quarter moved to Tijuana within the past 5 years (Table 1). Roughly 10% of participants had crossed the Mexico/U.S. border in the last 6 months. When asked why s/he had moved to Tijuana (n=219), deportation from the U.S. emerged as a common theme (16%), with responses such as “deportation from USA” and “I lived in Oregon and was deported to Juarez.” Other common themes included economic opportunities (13%), which included responses such as “to work,” “for a better life,” and “needed money”; intention to cross border to U.S. (14%), which included responses such as “father brought me as we were heading to USA but we stayed here” and “intended to cross border to USA”; born in area or family moved here (36%) including responses such as “to follow my family,” “my children live here”; and other (21%), which included such responses as “adventure” and “I like this city.”

Univariate associations with reported deportation history

Compared to other IDU participants, deportees were very recent arrivals to Tijuana (75% within the past 5 years); 79% had been employed outside of Mexico in the last 10 years (Table 2). Differences in drug use behaviors that reached or were near statistical significance are included in Table 2. Drug behaviors differed from other IDU participants in that deportees were more likely to inject multiple times per day ($p=0.002$) and to have snorted/sniffed heroin ($p=0.03$); they were somewhat more likely to have chased heroin (meaning, heated and inhaled vapors/smoke of heroin) ($p=0.05$) (Table 2). Smoking or inhaling methamphetamine, however, was less common (65% vs. 83%, $p=0.02$). Deportees were also less likely to have accessed public health services such as drug treatment, recent medical care, or HIV testing (Table 2).

Deportees had a much higher odds of having worked outside of Mexico (primarily in the U.S.) in the past 10 years than other study participants (OR 10.3, 95%CI: 4.20–25.1); therefore, we also explored the behavior of those who had worked outside of Mexico in the past decade but who had not reported deportation (n=50). These migrants with no reported history of deportation had lived in the city for a median of 16 years (IQR 6–29). Most associations seen in Table 2 lost significance in this sub-analysis; however, those who had worked in the U.S. were less likely to have ever received drug treatment than non-migrants. In comparing migrants versus the general population, migrants were more likely to have crossed the Mexico/U.S. border in the past 6 months (19% vs. 7%, OR:3.16, 95%CI:1.17–8.53) and to have injected cocaine and methamphetamine together (28% vs. 14%, OR:2.31, 95%CI:1.05–5.07).

Discussion

Our study of IDUs in a large Mexico-U.S. border city showed that mobility and migration was common; one-sixth cited deportation from the U.S. as their primary reason for being in Tijuana. Deportation history was associated with more frequent drug injection, different

patterns of drug use, and less interaction with medical or treatment services. These findings have important implications for drug use prevention and treatment in this border region, where substance use is a growing problem.

We found that only one-sixth of deportees had received medical care in the last six months and just a third had ever received drug treatment, despite the fact that most had injected drugs for over a decade. Both IDU deportees and IDU migrants to the U.S. who had not been deported were less likely than IDU non-migrants to have ever received drug treatment. It is unclear whether this has to do with treatment seeking or economic limitations. Likely a combination of factors are at play. As most deportees had only recently come to Tijuana, they may lack knowledge of local services or proper documentation to access services. Another factor relating to their lower health care utilization could involve mistrust of authorities. For instance, studies suggest that increased enforcement of migration laws in the U.S. have made accessing health services less common among migrant laborers (13).

Although HIV prevalence was low in this study compared to investigations of IDUs in other settings, virtually all IDUs (deportees and other IDUs alike) had been infected with Hepatitis C, underscoring a high prevalence of risky injection practices, such as sharing of injection equipment. This is especially concerning considering that treatment for HCV is lengthy, expensive, complicated, and not always effective (16). Further, it is generally agreed that drug abuse treatment should be a part of the treatment plan during and following treatment for HCV infection, placing deportees who appear to be less likely to enter drug treatment at a disadvantage in regards to HCV care. Also of concern are the results of a 2006 study that estimated that up to one in 125 adults aged 15–49 in Tijuana is likely to be HIV-infected and is on the rise in at-risk groups such as IDUs (17, 18). Increased frequency of drug injection among deportees, especially in an atmosphere where needle sharing is common, increases the probability of exposure to and transmission of blood borne infections. Considering their elevated risk status, it was concerning that one-quarter of deportees and less than one-half of other IDU participants had ever had an HIV test. A border probability survey recently conducted among a variety of migrant groups in Tijuana found that migrants deported from the U.S. also had the highest prevalence of risky sexual practices, including sex with IDUs and transvestites, compared to other migrants (8). Exploration into the impetus behind such risky behaviors warrants further study.

Migrant workers in the U.S. have demonstrated higher levels of stress and depression than the general population (20, 21). Stress is a strong predictor of increased drug use among migrants (22, 23). Migrants who have undergone deportation from the U.S. face additional stressors, ranging from time spent in detention to the stigma of being deported to unexpected loss of a job and separation from family and friends (24). Recently, there has been an increase in incarceration of undocumented migrants awaiting trial or repatriation to their home countries, from 57% in 1985 to 91% in 2000 (25, 26). During this same time period, the average time spent behind bars increased from 3.6 to 20.6 months. Future studies may help to better elucidate the possible relationship between high risk activities and stress.

Migrants can also play a unique role in dissemination of infectious diseases. A recent study of 600 Mexican migrant workers in San Diego and Fresno counties reported an HIV prevalence of 0.9%, three times the Mexican national average (19). Factors influencing vulnerability in the host country include language barriers, lack of knowledge of local resources, economic and survival issues, participation in high-risk sexual behaviors, and fear of deportation. When unstable migration status and drug use overlap, our study suggests that prevalence of risk factors for disease spread may be even greater.

Our study was limited in that it was not specifically designed to study deportation. We did not directly ask participants if they had ever been deported from the U.S., but rather categorized someone as having a history of deportation if they listed deportation in response to the question “What was/were the reason or reasons that you moved here?” Therefore, our numbers likely underestimate the number of participants who had ever been deported. Nevertheless, our analysis suggests that those who cited deportation as a main reason for coming to Tijuana are somehow different than those who came to the area of their own volition. Due to the cross-sectional design of this study, we cannot determine causality of associated variables. We also do not know the temporality of injection drug use in relation to deportation, frequency of deportation, or when the most recent deportation occurred. However, the short median time of residence in Tijuana (2 years) compared to other study participants (16 years) does give us some idea of a likely timeline of recent deportations. Sample size limitations precluded us from determining factors independently associated with deportation status in multivariate analyses, which should be explored in future research. It was also not possible to distinguish between deportations due solely to migration status versus criminal activity. Our study, nonetheless, suggests that IDUs who came to Tijuana due to deportation had unique risk behaviors and service needs that were not being met.

Our study indicates that cross-border migration history should be considered when developing harm reduction strategies in this border region. Approximately 94% of Mexican immigrants to the U.S. cross the Mexico/U.S. border at major border crossing points in just a handful of border cities, thus indicating the opportunity to concentrate health promotion efforts (4). Maintaining drug treatment regimens in a highly mobile population and determining how to best target education and services pose challenges to officials on both sides of the border. Since heroin was more and methamphetamine was less commonly used among deportees in Tijuana, these IDUs should benefit from methadone maintenance programs that are most effective for persons addicted to opiates. To effectively enroll and retain migrants, however, drug treatment programs might need to consider more flexible policies concerning attendance or how to better tap into such marginalized populations. Innovative programs providing job and educational assistance to deportees and migrants have been developed in a number of countries (13). These programs might also present the opportunity to provide migrants an introduction to local health services and provide health education, such as has been attempted in the “Ventanillas de Salud” program, where small health promotion information kiosks are located in the offices of the Mexican Consulate and are staffed by health educators or health advocates (27). Our findings also underscore the need for larger, more in-depth studies, preferably of longitudinal design, to explore the possible relationship between migration history and health risk behaviors.

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Table 1

Demographics and mobility among IDUs in Tijuana, Mexico (n=219)

Characteristic	%
% Male	92
Median age (IQR)	34 (29–40)
Median age of first injection (IQR)	19 (15–24)
Drugs most frequently used in past 6 months	
Heroin alone	37
Cocaine alone	0.5
Speedball	4
Methamphetamine + Heroin	53
Methamphetamine + Cocaine	1.6
Other	5
Needle Sharing in last 6 months	
Receptive Needle Sharing	76
Distributive Needle Sharing	71
Resided in Tijuana < 5 years	23
Born outside of Baja California	70
Worked outside of Mexico	
In past 10 years	38 (94% in US)
In past 1 year	17
Reason for coming to Tijuana	
Deportation	16
Born in Area or Family Moved here	36
Economic Opportunities in Tijuana	13
Intention to Cross Border to U.S.	14
Other	21

Table 2Univariate associations with deportation history among IDUs in Tijuana, Mexico (n=219)^a

	Reported History of Deportation (n=34)	No Reported Deportation History (n=185)	Odds Ratio	95% Confidence Interval
Mobility				
Time lived in Tijuana (Median years (Inter-Quartile Range))	2 (1–5)	16 (10–28)^b		
Worked outside of Mexico in past 10 years	27 (79%)	50 (27%)	10.3	(4.20–25.1)^b
Crossed border to U.S. (last 6 months) ^c	3 (9%)	18 (10%)	0.86	(0.24–3.10)
Drug Behaviors				
Frequency of Injection (multiple times/day)	(91%)	(65%)	5.52	(1.62–18.8)^b
Years of injecting (Median (IQR))	14 (9, 20)	13 (9, 20)		
Ever chased heroin ^d	7 (21%)	17 (9%)	2.55	(0.97–6.72)^e
Ever snorted/sniffed heroin	13 (38%)	38 (21%)	2.40	(1.10–5.22)^f
Ever smoked/inhaled methamphetamine	22 (65%)	152 (83%)	0.39	(0.17–0.86)^f
Smoked/inhaled meth. (last 6 months)	10 (29%)	95 (52%)	0.38	(0.17–0.84)^f
Sexual Behaviors				
Ever had sex with a man (males only) ^c	11 (32%)	80 (49%)	0.50	(0.23–1.08)
Casual sex without a condom (last 6 months)	8 (24%)	55 (30%)	0.72	(0.31–1.68)
Accessing Care				
Received medical care (last 6 months) ^c	5 (15%)	49 (32%)	0.37	(0.13–1.00)^e
Ever received drug treatment	11 (32%)	99 (54%)	0.41	(0.19–0.89)^f
Ever tested for HIV	8 (24%)	76 (41%)	0.44	(0.19–1.02)^e

^aBold face indicates a p-value ≤ 0.05^bp<0.01^cTotal n=178 for Crossed border, n=197 for Sex with a male, n=187 for Received medical care^dChasing involves heating heroin and then inhaling its vapors/smoke^ep=0.05^fp<0.05