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Deportation Experiences of Women Who Inject Drugs in Tijuana, Mexico

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Abstract

Deportation from the United States for drug offenses is common, yet the consequences of deportation for women drug users are poorly documented. In 2008, in Tijuana, Mexico, we conducted an exploratory qualitative study of migration, deportation, and drug abuse by interviewing 12 Mexican injection-drug-using women reporting U.S. deportation. Women reported heavy drug use before and after deportation, but greater financial instability and physical danger following deportation than when in the United States. We identified an unmet need for health and social services among deported drug-using women, including HIV prevention, drug treatment, physical and mental health services, and vocational training. Binational coordination is needed to help deported women resettle in Mexico.

Keywords

addiction/substance use; health and well-being; HIV/AIDS; immigrants/migrants; Latino/Hispanic people; marginalized populations; Mexico; Mexicans; sex workers; sexuality/sexual health; vulnerable populations; women's health

Forced migration, including involuntary return migration (i.e., deportation), is highly prevalent in the U.S.–Mexico context, given the large unauthorized immigrant population residing in the United States. Notably, more than half of all undocumented immigrants in the United States, ~6 million persons, are Mexican born (Passel, 2006; Passel, Capps, & Fix, 2004). Although the majority of undocumented Mexican migrants living in the United States are men, women account for an increasing proportion of unauthorized border crossings (Donato, Wagner, & Patterson, 2008; Marcelli & Cornelius, 2001; Massey, Durand, & Malone, 2002), in part because of the growing demand for women's labor in the United States (Cerrutti & Massey, 2001; Curran, Shafer, Donato, & Garip, 2006; Donato et al.).

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Mexican-born persons account for the majority of deportations from the United States. In 2009, Mexican nationals accounted for 86% of the 613,003 persons apprehended in the United States, and ~72% of the 393,289 persons removed from the country (Department of Homeland Security, 2010). Deportees comprise a diverse population, which includes persons apprehended while crossing the border, during workplace raids, or during prosecution for other criminal charges, including drug offenses (Department of Homeland Security, 2001; Slevin, 2010). In 2010, ~11% of Mexicans who were deported to Mexico from the United States were women (National Migration Institute, 2010a).

Mexican migrants and return migrants, including deportees with drug-related criminal records, might experience increased risk for HIV transmission from continuing drug use and related risk behaviors such as syringe sharing (Mathers et al., 2008). Lifetime drug use is highest among Mexicans who have ever migrated to the United States (Borges, Medina-Mora, Breslau, & Aguilar-Gaxiola, 2007), possibly because of increased exposure to drugs through social networks in border communities and in the United States (Apostolopoulos et al., 2006; Sánchez-Huesca, Arellánez-Hernández, Pérez-Islas, & Rodriguez-Kuri, 2006). Specific subgroups of Mexican migrants in the United States, including injection drug users (IDUs), experience a documented risk for HIV (Magis-Rodriguez et al., 2004; Magis-Rodriguez et al., 2009). Although women who migrate exhibit lower rates of drug use than men, women experience additional vulnerabilities to HIV (Vega, Alderete, Kolody, & Aguilar-Gaxiola, 1998), including sexual exploitation (Miller, Decker, Silverman, & Raj, 2007). Among persons who inject drugs in Tijuana, Mexico, male deportees had four times the risk of HIV infection; this elevated HIV risk was not found among women (Strathdee, Lozada, Ojeda, et al., 2008). In contrast, another study found that Mexican women who injected drugs also reported frequently trading sex for money or drugs (Patterson et al., 2006). Significant gaps in the literature prevent a thorough understanding of how involuntary migration, including deportation, can shape HIV risk among vulnerable groups, including drug-using women.

Little is known about the relationships between deportation, social and economic vulnerability, drug abuse (i.e., continued drug use despite persistent social or interpersonal problems), and engagement in HIV risk behaviors among women who inject drugs. Thus, we conducted an exploratory qualitative study of deportation experiences among women who inject drugs in Tijuana. Many Mexican deportees are returned or travel to border cities such as Tijuana, Baja California, which is adjacent to San Diego, California. Together, both cities form the busiest land border crossing in the world. In 2010, ~40% of Mexicans deported from the United States arrived to ports of entry in Baja California, with Tijuana receiving the largest share of deportations, at >126,000 persons (National Migration Institute, 2010a). Tijuana is the largest and fastest-growing city on Mexico's northern border with the United States, with an estimated 1.4 million people in 2005. The city lies on drug-trafficking routes for heroin, cocaine, and metham-phetamine destined for the United States (Bucardo et al., 2005). Tijuana supports a large population of injection and noninjection drug users (Brouwer et al., 2006; Strathdee et al., 2005). Increasing HIV prevalence, particularly among high-risk populations of IDUs, female sex workers (FSWs), migrants, and deportees, is a significant concern for health officials in Tijuana (Strathdee & Magis-Rodriguez, 2008). HIV among substance-using migrants is also concerning because of the potential for "bridging" otherwise unconnected populations via their sexual and drug use practices, which may occur in diverse geographic regions. Among women in a cohort of IDUs in Tijuana, the adjusted HIV prevalence was recently estimated at 3.1%; notably, in the larger cohort, the majority of IDUs diagnosed as HIV positive were unaware that they were HIV positive (Strathdee, Lozada, Pollini et al., 2008). Persons who are unaware of their HIV serostatus are at high risk of transmitting HIV (Campsmith, Rhodes, Hall, &

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Green, 2010), implying that the sexual and substance-using networks of undiagnosed binational populations, such as deportees, might experience heightened risk for infection.

Given this setting and the lack of research on deported women who inject drugs, we drew on Rhodes' risk environment framework (2002, 2009) for understanding the social and structural production of HIV risk. Within this framework it is posited that drug users' risk for HIV is shaped by exogenous physical, social, economic, and policy risk factors at the macro-, meso-, and micro levels (e.g., drug availability, social norms, lack of economic opportunities), in addition to endogenous individual characteristics (e.g., sex, race, age) and risk behaviors such as unprotected sex and sharing of syringes (Rhodes, 2002, 2009). Using this framework, in our exploratory study we aimed to describe the experiences and risk environments within which deported, drug-using women in Tijuana lived throughout their migration and drug-use trajectories.

Methods

Study Population & Recruitment

We recruited women from a prospective study examining HIV risk behaviors among IDUs living in Tijuana, Mexico. As previously described (Strathdee, Lozada, Pollini, et al., 2008), in April, 2006, outreach workers used respondent-driven sampling (Heckathorn, 1997) to recruit participants >18 years old with evidence of recent injection drug use (i.e., track marks that were visible to study personnel). For our exploratory study sample, we first generated a list of IDUs in the prospective study who reported U.S. deportation. Of the 1,056 prospective study participants, 15% ($n = 157$) were women, 36 of whom reported U.S. deportation. In October, 2008, outreach workers invited all women who were not lost during the follow-up period (i.e., did not leave Tijuana and were alive) to participate in our exploratory study. After obtaining voluntary and informed consent, we enrolled 12 women in our exploratory study. We reimbursed women with US $20 for their time for undergoing qualitative interviews. The Human Research Protections Program of the University of California–San Diego and the Ethics Board of the Tijuana General Hospital approved the study protocols.

Data Collection

During October and November 2008, trained bilingual interviewers conducted semistructured qualitative interviews in private interview rooms in Tijuana's *zona norte* (northern district), an area of the city where drug use is widespread. Based on our theoretical framework, we developed a semistructured interview guide to query women on their migration, deportation, drug, and sexual experiences within various risk environments in the United States and Mexico. Sample questions included "Tell me about your drug use in the United States," and "Describe what happened the most recent time you were deported." Because many participants experienced multiple deportations, we asked women to focus on their most recent deportation, a strategy that the study team developed to increase the participants' ability to recall the conditions surrounding this event. Interviews ranged in duration from 60 to 120 minutes, and were conducted in English, Spanish, or both languages, according to women's preferences. We digitally recorded and transcribed interviews but did not translate the transcriptions because we wanted to preserve participants' language, which was often bilingual and contained terminology specific to the economic and drug subculture of Tijuana.

Data Analysis

We analyzed data for concepts by identifying major categories in participants' experiences (Corbin & Strauss, 2008). We created an initial coding scheme based on the major themes

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and concepts in the interview guide. Next, we read several cross-sections of interviews, revising the coding scheme to include emergent concepts and categories. We independently applied these codes to five interviews and discussed and resolved all discrepancies between coders by refining code definitions. We continued applying codes and memos to the transcripts. When new codes emerged, we updated the coding scheme and reread all transcripts according to the new structure. We employed ATLAS.ti, a qualitative data analysis computer software program, to attach codes and memos to transcripts (Muhr & Friese, 2004). Throughout the analysis, we discussed emergent themes and compiled quotations illustrative of key concepts. Quotes presented in this article were translated from Spanish to English as necessary by the first and last authors, and follow the original wording of the participants' statements.

Results

We identified several important themes relating to the various social and physical risk environments surrounding women's drug use before, during, and following U.S. deportation. We found that most (*n* =10 out of 12) women's social risk environments in the United States (e.g., family and social networks) contributed to their initial drug use (i.e., initiation), escalating drug abuse, and injection drug use. Drug-abuse experiences in the United States were intertwined with women's criminal histories and eventual deportation to Mexico. Following U.S. deportation, women reported heightened social and physical risk environments in Tijuana, including lack of social networks, greater financial and physical insecurity, emotional distress, increasing drug dependence (i.e., inability to cut down on drug use, increasing tolerance, and continued use despite knowledge of harm caused by drugs), and lack of access to drug treatment and other health services. In the following sections, we review these themes in greater depth and provide illustrative examples of women's experiences.

Migration Experiences

The median age and educational attainment in our sample were 37.5 years [interquartile range (IQR): 32–41] and 9 years (IQR: 6–14), respectively. Women were born in four states in Mexico, including Baja California (*n* = 7), Jalisco (*n* = 3), Chihuahua (*n* = 1), and Guerrero (*n* = 1). Women arrived in the United States as children (median 6 years; IQR: 2–12), either migrating with parents or being sent by parents to live with U.S. relatives. Most women completed primary and secondary education in the United States and spoke English proficiently or fluently at the time of the interview (*n* = 7). Women lived in cities in Southern California (*n* = 7) and suburban or rural areas (*n* = 3), and rural areas in Northern and Central California (*n* = 2). Participants reported a median of 2.5 lifetime deportations (IQR: 1–3), with the most recent deportation occurring a median of 5 years before the interview (IQR: 3–10).

Drug Use Initiation in the United States

Women reported first consuming alcohol and marijuana during adolescence (median age 15 years), when most were already living in the United States. Three women who traveled to the United States during later adolescence recalled seeing family members in Mexico use alcohol or drugs, but initiated their use of illicit substances after migrating to the United States. Several women reported trying cocaine (*n* = 6) or heroin (*n* = 5) in high school in the United States, and began injecting these drugs during late adolescence.

Women's social risk environments in the United States facilitated their initial drug use. Women explained how family members (e.g., siblings,) friends, and boyfriends in the United States introduced them to drugs (*n* = 7). Women also attributed early

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experimentation with drugs to an underlying curiosity because of the high prevalence of drug use in their communities and social networks, as described by a woman who migrated to California as a young child:

> When I was sixteen, I wanted to see how it felt. My whole family [used], well not my whole family, but my brothers and sisters. … I used to see them get high or whatever, and I wanted to know how it felt, I wanted to join the club. I thought it was cool. … Anything that they had I used. … PCP, acid, rock, heroin, crystal, coke.

Some women recalled experiencing pressure to use drugs by gang members ($n = 2$), sex partners ($n = 2$), and acquaintances. One woman who used cocaine and methamphetamine in the United States explained, “My husband’s friends introduced me [to drugs]; they were very possessive people who wanted me to use, even though I didn’t want to.” Although women attributed much of their initial drug use to social relationships, two women also described practical or employment-related reasons for starting to use drugs. One woman described how methamphetamine could help her maintain sufficient energy for two factory shifts: “I felt enthusiasm, strength. … I was no longer sleepy [or] in pain, and I worked well.”

Drug Abuse in the United States

For nearly all women in our sample, occasional drug use during adolescence in the United States transitioned into regular, daily consumption of drugs, eventually contributing to physical dependence on heroin and/or crack cocaine ($n = 10$). Experiences with methamphetamine in the United States were limited, and alcohol use was likely underreported because it was not a focus of our interviews. Some women discussed periods of polydrug use in the United States, particularly in the context of social relationships and parties. Women described how friends, spouses, and sex partners enabled their continued drug abuse. For example, one woman attributed her increasing dependence on heroin to a close friend who regularly supplied her with the drug:

> She would give me a bit more, and more, and several months passed by, and I felt shivers. My bones in my arms ached, and she would tell me, “Maybe you are addicted to that stuff [heroin],” because I was using more and more.

Despite increasing drug abuse and dependence, five women described using drugs in the United States within an environment of relative stability and social support. When asked about daily life in the United States before deportation, one woman explained,

> It was good because I was working to pay my bills, help my mom. … I wasn’t ripping nobody off. I was doing good, living a normal life. Not so normal because I was using drugs, you know what I mean? But I was stable in my life.

While living in the United States, family members provided economic and childcare support despite women’s escalating social and legal problems resulting from drug abuse: “My husband supported me, gave me money. … My family saw I was crazy [from drugs], but they helped me with the rent, helped me with my daughters and everything.”

Despite the economic stability and social support in the United States, four women described negative consequences of their increasing use of heroin, crack cocaine, and methamphetamine. Losing control over one’s life was a theme reported in many interviews; for example, one participant lost her job when caught with illicit drugs at work, and another described selling and trading sex for drugs at night in a dangerous neighborhood. Women also described social problems resulting from their drug abuse. For example, one woman hid her drug use from friends and family in the United States out of fear of being ostracized or

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punished, and two women described having to "live on the streets" after being kicked out of families' homes.

Injection Drug Use in the United States

Nearly all women reported injection drug use in the United States ($n = 10$). Eight women injected regularly for many years, and two reported injecting in the United States occasionally or "just to see what it was like." Similar to the social risk environment influencing their initial drug use and experimentation, women reported that friends ($n = 6$), boyfriends ($n = 3$), and family members ($n = 2$) in the United States taught them how to inject drugs. Seven women explained that they regularly shared injection equipment with friends and boyfriends because of physical dependence and withdrawal, apathy or not caring about the consequences, and not knowing where or how to access sterile injection equipment. One woman who started injecting heroin in the United States when she was 16 years old explained that she knew sharing syringes could be dangerous but did so anyway, "out of necessity, because I didn't care, you know? … Because it's a pretty ugly feeling when you're sick." Women bought syringes in the United States from drug dealers or at liquor stores, and one respondent reported obtaining syringes from her mother, a nurse:

> I know it broke her heart, supplying me with [syringes]. "If you're going to be using that shit, at least promise me that you're going to use clean needles. And if you run out, please don't use nobody else's needle." It was something that I was raised with. I mean, raised, no, that's not the word. I got used to, you know, clean needles.

Two women reported rarely sharing syringes because they typically injected alone, hiding their drug use from their social networks or avoiding other IDUs for safety concerns.

Deportation and Criminal Justice System Experiences

For all participants in our sample, women's most recent deportations were preceded by lengthy criminal histories that often included "serving hard time" in U.S. federal and state correctional facilities. Several women served lengthy prison sentences (e.g., >10 years). Reasons for women's most recent deportations included being arrested, violating parole, and having a record of unauthorized entries into the United States. Criminal charges ranged from minor drug possession charges to armed robbery, auto theft, and assault.

Some women experienced feelings of defeat and hopelessness with regard to U.S. criminal justice and immigration systems, particularly when contesting their immigration charges became more difficult because of past drug offences. One woman explained that she was prohibited from ever returning to the United States because of her accumulated drug and immigration charges:

> Immigration is hard on drug trafficking, which is why I got so much [prison] time [before deportation]. … I fought my case with a public defender, but they don't really care, you know? Because they all work together, the judge and the others, you know? So by the time you get there, they already know what they're going to do with you. … Your lawyer tells you what you're going to say, and that's it. You're not even there like five minutes.

Several women recalled being informed by immigration officials that they were prohibited from reentering the United States for periods of 10 to 20 years, or that they were "banned for life." Another respondent remarked that she was assumed to be Mexican and perhaps was singled out for being Mexican, despite having little connection to or knowledge of the country:

> [Immigration] started looking for Mexicans. … They interviewed me, and they told me that because of my drug history, I couldn't be in the United States. I had to get deported, you know? They asked me, "Are you afraid that somebody's going to hurt you in your country or something?" And I told them no, because I consider the [United States] as my country, you know? Not anywhere else. … I don't know anybody [in Mexico].

Women described "waiving" their rights and agreeing to voluntarily return to Mexico in exchange for an expedited removal process without additional prison time.

Women described different levels of drug accessibility in prison and detention facilities, with 9 women using drugs in prison and only 1 woman using drugs in an immigration detention center. Women described obtaining drugs and injection equipment from visitors or other inmates while in prison, and 1 woman sold drugs. Many women described intense physical withdrawal symptoms and "getting clean" in prison and detention facilities, followed by relapse or bingeing upon release. One woman who served consecutive federal sentences for drug charges and unauthorized reentry into the United States, an immigration offense, noted, "Two or three years before I got out [of prison] I stopped [using drugs] completely. I wanted to get clean, you know, but I didn't last very long after I got out."

Postdeportation Milieu

Following their most recent deportations, women were released into Tijuana ($n = 8$) or migrated to Tijuana from other Mexican ports of entry ($n = 4$) in search of economic opportunities, drugs or the local party scene, or existing social networks in the city. Women experienced heightened physical risk environments immediately following deportation, including difficulty communicating with family and friends in the United States and Mexico, finding shelter and safety, and securing employment. Some women shared the cost of temporary housing (e.g., rented rooms) with other deportees in the zona norte. Women lacking social networks in Tijuana described feelings of fear, isolation, and disorientation with the neighborhoods or street culture of Tijuana and other border cities into which they were released.

Some women were deported and released into Mexico very late in the evening and experienced increased physical vulnerability immediately following deportation, including lacking money and shelter ($n = 9$). Although some women shared the cost of hotel rooms with other deported women, one woman described immediately engaging in sex work because she needed money for food and shelter, and her deportee acquaintances "showed [her] the ropes." Another woman met a man in the zona norte who initially offered help but actually abducted her. For several months, the man injected her with heroin, which she had never injected regularly, and forced her to sell sex. She eventually escaped, but remained dependent on heroin and continued sex work. At the time of the interview, half of our sample reported that sex work was their primary source of income ($n = 6$); others were underemployed in the informal sector. Four women reported an average monthly income of less than US $250, indicating high levels of financial need.

Another immediate postdeportation concern was reentering the United States. Several women expressed an interest in returning to the United States for family reunification and improved financial stability ($n = 5$), but women who were "banned" from returning to the United States worried about additional criminal charges and incarceration. None of the women had attempted to return to the United States following their most recent deportation because they lacked the resources to hire a coyote (professional smuggler), or were afraid. One woman explained, "A lot of people die when they cross into the United States and it makes me scared, and I no longer want to return."

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Postdeportation Drug Abuse

Locating drugs was a major concern for many women immediately following deportation (*n* = 7). Two women described meeting men who were willing to provide them with shelter or drugs, at least temporarily, in exchange for sex. One woman explained how this quickly led her back into a life of "working the streets" to support her drug use:

> When I was sent here, I was unfamiliar with Tijuana. Well, I knew Tijuana, but not this drug scene. So I arrived with a little money; it ran out and I had to convince a man here and it was simple [to trade sex] to get high. … And I fell lower and lower.

Many women relapsed into old drug "habits" (i.e., patterns of drug abuse); some immediately began using the same drug(s) they had used in the United States, and others experimented with new or rarely used drugs. Methamphetamine, a new drug for many women postdeportation, was injected in combination with heroin ($n = 5$) or by itself ($n = 1$). Two women tried to abstain from drugs because they had been "clean" in prison or detention before their deportation. They reported that they were unsuccessful in abstaining from drugs because of the ubiquitous presence of drugs in the zona norte. Women described increasing drug dependence in Tijuana following deportation, which several women attributed to the lack of control over their lives.

Postdeportation Injection Drug Use

Several important themes emerged regarding injection drug use in women's postdeportation risk environments. First, the 4 women who rarely or never injected drugs in the United States began injecting regularly following deportation. Women described beginning to inject because of drug dependence, lack of self-control, and the influence of their social networks and neighborhoods, in which drug abuse was pervasive. Second, women reported frequently sharing syringes in Tijuana, particularly with people from whom they sought help injecting, including boyfriends and "hit doctors" (i.e., other IDUs who inject others with drugs for a small fee or share of drugs). Although many women described efforts to avoid sharing injection equipment because of fear of acquiring HIV/AIDS or developing abscesses (i.e., skin infections that can become serious without access to medical care), sharing injection equipment was common with sex partners. Two women described their need to be high on drugs "when it's business," or to make sex with clients easier.

A final emergent theme relating to injection was the fear of being apprehended or harassed by police for carrying syringes, "being a known user," or lacking proof of identification (e.g., driver's license, voter cards). Even though carrying syringes and having track marks are legal in Mexico (Pollini et al., 2008), some women reported never carrying syringes because they were afraid of or had experienced police harassment or detention. Instead, women reported injecting in the same locations (i.e., *picaderos*, or shooting galleries) where they bought drugs, hoping that sterile syringes would be available. One woman described how she tried, unsuccessfully, to hide her track marks from the police, which she showed the interviewer:

> I [used to] inject my arms and everywhere. My legs [were] all fucked up, you know? See all those black spots? I used to burn myself so there wouldn't be [anything], no tracks or whatever, and the cops wouldn't see it. But I'm still "track looking" because they've got holes, see? I burned myself. They hurt a little bit, but I didn't care at the time.

Respondents bought sterile syringes from pharmacies and liquor stores, obtained free syringes from a local organization, or borrowed used syringes from other drug users in picaderos.

Postdeportation Drug Treatment

Seven women in our sample had experience with drug treatment programs in the United States or Mexico. At the time of the interview, nearly all women ($n = 10$) wanted to “get clean,” and several described strategies to reduce their drug consumption or frequency of injecting. However, only 5 women had attended drug treatment programs in Tijuana, which they described as unsanitary, strict, involuntary, and overly religious. Four women felt fearful or skeptical of existing programs in Mexico because of their poor reputations. Financial access was a major barrier to drug treatment. Six women who were interested in starting drug treatment did not know how to afford entrance fees. Four women had knowledge of a methadone clinic in the zona norte that charged a prohibitive daily fee; of these, 2 women ultimately found long-term methadone treatment to be unaffordable. One woman described purchasing methadone once a week or less, depending on how much money she could save.

Postdeportation Emotions

Nine women described feeling lonely and sad following their most recent deportation, often because they were separated from children and other family members in the United States and elsewhere in Mexico. Several women discussed “losing everything,” as exemplified by a woman who was deported 10 years prior to the interview and was unable to return to the United States:

> I felt alone. I felt abandoned. …. Before my deportation, I did use drugs but not like right now. …. I had my house, my children. My children were young. I still have my children but they are older now, married. … Well, the deportation affected me a lot since in the past, I did not use drugs on the street. I feel humiliated.

Women also believed that they had been rejected by family members in the United States, and reported feeling ashamed about their current lives and struggles with drug dependence:

> I mean, right now, I haven’t seen [my family] in about a year already, because my habit is getting too much, you know? And I don’t want them to see me like this because I don’t want them to lose the little respect they still have for me, you know? And that’s why I don’t want to bring them here. They want to come and live with me, but no, no, no, no. I tell them, “No, I’m not ready for you guys, yet.”

Women described wanting to discontinue sex work, although supporting themselves was perceived to be much more difficult in Tijuana than in the United States. One participant characterized life in Mexico as a daily struggle to earn enough money for food and drugs. Two respondents mentioned their desire for a stable routine, although they did not believe they could achieve such stability without help. One woman described her hope “to find a good man” who could help her “get a job, get clean, and live in a house.”

Discussion

Our exploratory study, which was guided by a risk- environment framework (Rhodes, 2002, 2009), provides an important characterization of the range of migration and drug use experiences, physical and social vulnerabilities, and HIV risk factors among women who are deported from the United States to Mexico. We identified several key themes relating to the social and physical environments that influence women’s drug abuse and engagement in other risk behaviors for HIV transmission (e.g., selling sex). Overall, women described that social networks influenced their initial drug use in the United States, which was followed by escalating drug abuse, incarceration, and eventual deportation to Mexico. Key themes supported the notion of heightened risk environments following deportation, including

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greater financial and physical insecurity, increasing drug dependence, emotional distress, and lack of access to drug treatment and other physical and mental health services.

Overall, we found that deported drug-using women in Tijuana reported extensive experiences with U.S. migration, drug use, incarceration, immigration detention, and deportation. Previous studies have found drug use among Mexican American adolescents and young adults to be associated with the "Americanization" process, particularly among young women with high levels of acculturation (Amaro, Whitaker, Coffman, & Heeren, 1990; Vega et al., 1998; Warner et al., 2006). Most women in our study immigrated involuntarily to the United States as minors and thus had little or no exposure to drugs in Mexico. Mimicking drug-initiation trends among adolescents born in the United States, women began experimenting with drugs with friends and family members during their middle- and high school years. In our sample, all women became heavy drug users by early adulthood while living in the United States.

In addition to exposure to U.S. culture, the social and physical risk environments of women's lives in the United States facilitated their drug initiation and continued use. Our study findings support arguments by Valdez and coauthors that culturally relevant theories of social networks and drug use must consider the influence of family members in addition to that of peers and sexual partners within social networks (Valdez, Neaigus, & Kaplan, 2008). Our study supports previous findings that characteristics such as *familismo* (emphasis on the family) and *collectivismo* (collectivism) can influence behaviors within drug-involved Mexican American families (Valdez et al., 2008). Women in our study also described supplementing their family's financial support by engaging in criminal activities in the United States, including drug selling, theft, and occasional sex work. Women's U.S. social networks might have encouraged or accepted these criminal activities (Latkin et al., 2009; Miller, Miller, Zapata, & Yin, 2008). However, exchanging sex for drugs could simultaneously increase autonomy from families and traditional gender roles (Valdez, Kaplan, & Cepeda, 2000), suggesting complex relationships between social and economic influences on women's drug abuse in the United States.

Women's legal problems relating to drug abuse were often described as the primary causes of their deportations. Women developed extensive criminal records in the United States, often starting in adolescence and resulting in lengthy periods of incarceration and detention. Drug use continued during incarceration (excluding immigration detention centers), but injection behaviors were rare, and some women described "getting clean" during these periods of their lives. Following deportation, women described struggling with drug dependence and quickly relapsing into drug abuse and other risky behaviors. These findings are consistent with research on the economic, social, and drug-related challenges that incarcerated drug-using women face when released into communities where they lack social support and financial opportunities (Karberg & James, 2005; Richie, 2001; Robbins, Martin, & Surratt, 2009; Van Olphen, Eliason, Freudenberg, & Barnes, 2009; Yasunaga, 2001). The experiences of women in our sample support arguments that the U.S. criminal justice system needs evidence-based drug treatment services for minority women (Adams, Leukefeld, & Peden, 2008; Chandler, Fletcher, & Volkow, 2009; Gordon, Kinlock, Schwartz, & O'Grady, 2008), including drug treatment and other health and social programs for parolees reentering communities (Prendergast, 2009; Richie; Robbins et al.; Sarteschi & Vaughn, 2010). Our findings suggest that women could have benefitted from sustained drug treatment services in U.S. prisons/detention centers, and following their deportations; however, none of our respondents had accessed drug treatment or other reentry services in the United States or Mexico.

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The women’s stories highlight the need for programs to recognize the multiple risk environments that deportees experience, and identify ways to integrate or reintegrate deported women into Mexican communities. It is unsurprising that women described postdeportation life in Tijuana as being more difficult, uncertain, and dangerous than in the United States, because many of the respondents were unfamiliar with Tijuana or Mexico before deportation. Despite the lack of programs for return migrants and deportees globally (Hagan, Eschbach, & Rodriguez, 2008; Ruben, van Houte, & Davids, 2009), existing programs for Mexican migrants in the United States could be expanded to include deported women and drug users. Mexico currently sponsors a diverse set of programs, including *Ventanillas de Salud* (Health Windows/Stations), which operate in Mexico’s consulates in the United States (Secretary of External Relations, 2009). In Mexico, programs serving or resources for migrants include *Vete Sano, Regresa Sano* (Leave Healthy, Return Healthy; Secretary of Health, 2002), *Guía del Migrante* (Guide for Migrants; Secretary of External Relations, 2005), *Manual Para la Prevención del VIH/SIDA en Migrantes Mexicanos a Estados Unidos* (HIV/AIDS Prevention Manual for Mexican Migrants in the United States; Secretary of Health of Mexico, 2007), and the *Programa de Repatriación Humana* (Humane Repatriation Program; National Migration Institute, 2010b); these programs could refer deported women to local drug treatment and other physical and mental health services.

In addition to drug treatment, we learned from the women that they could benefit from services to help them cope with their emotional distress and physical and financial insecurity following deportation. Participants in a qualitative study of traumatized refugees in Switzerland held positive views of medical treatment and expected that they would benefit from services to help them cope with distress (Maier & Straub, 2011). Women in our sample also lacked formal economic opportunities and social connections following deportation, highlighting a need for social reentry programs for return migrants. For example, Mexican migrant and deportee programs could systematically provide deported women with assistance in locating affordable housing and obtaining identification cards necessary for securing formal employment. Access to legal employment opportunities might be particularly useful for deported drug-using women because migrants in Tijuana and other regions of Mexico have reported substantial migration- and drug-related stigma and exclusion from communities into which they enter (Infante, Aggleton, & Pridmore, 2009; Philbin et al., 2009; Pollini et al., 2008; Strathdee, Lozada, Pollini et al., 2008). Finally, programs for deported drug-using women could also include Spanish-language education, assistance navigating financial and legal institutions in Mexico, and the development of positive social networks (e.g., through deportee support groups).

Our data illustrate multiple, overlapping social and structural vulnerabilities to HIV and other physical and mental health concerns experienced by deported women. Overall, we found that women in our sample experienced heightened vulnerability to HIV in their postdeportation risk environments because of their disadvantaged status as (a) parolees, (b) involuntary return migrants (i.e., deportees), (c) IDUs with significant drug dependence, and (d) women who trade sex for money or drugs. An additional source of HIV vulnerability might result from the release of deportees in an international border region, which Rhodes and coauthors described as including increased population movement, drug trade and transport, social disruption created by language and economic difficulties, exploitation, fear of authority, and mixing of economically and socially disadvantaged populations (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005). For women, being released late in the evening in a dynamic border region might result in physical and sexual violence that further contributes to their vulnerable status and marginalization over the long term. Furthermore, although women in our sample did not specifically remark on the recent drug violence in Mexico, more than 34,000 people have died as a result of Mexico’s drug conflict since December, 2006 (Miglierini, 2011), suggesting important impacts of violence on Mexican

communities. The social and structural factors of the postdeportation risk environment warrant additional research so that public health resources can be efficiently directed toward services that serve vulnerable deportees and other return migrants.

Our exploratory study findings must be interpreted in light of the following limitations. First, our data on migration, deportation, and drug use were based on self-report, and could have been affected by recall bias. We asked participants to focus on their most recent deportation because many women had lengthy migration histories. Second, we selected participants based on self-reported deportation, and cannot confirm actual U.S. removal events. Third, the shame and fear regarding certain experiences could cause social desirability bias, or a reluctance to report certain events. Fourth, we did not specifically inquire about alcohol use, and believe that additional research is needed. Finally, the small number of women in the prospective study who reported deportation and could be located limited our sample size to 12 women. Although theoretically data saturation can be achieved within 12 interviews (Guest, Bunce, & Johnson, 2006), the objective of our exploratory study was to describe the range of experiences of a highly vulnerable and understudied population. We believe that the 12 women's stories provide a powerful basis for future investigation of risk environments within migration and deportation trajectories. Although we give examples of potential services for return migrants in Mexico–U.S. border cities, additional research with a larger sample is needed to develop concrete policy and programmatic recommendations.

Conclusion

We found that deported, drug-using women in Tijuana, Mexico have complex migration and drug use trajectories. Special efforts are needed to help these women avoid or cope with the negative health and social consequences of involuntary return migration. A multitude of factors contribute to the unique postdeportation risk environments of deported drug-using women, including their injection drug use and drug dependence, release from incarceration, lack of social and economic resources, unfamiliarity with the postdeportation society, stigma and policing practices, gender, and engagement in sex trade. Our study findings indicate that binational coordination is needed to help deported women resettle in Mexico, especially when they emigrated involuntarily (i.e., as minors), are unfamiliar with the country to which they are returning, and are struggling with drug dependence and relapse. Women could benefit from assistance in accessing quality drug treatment services, locating safe and affordable housing, reestablishing citizenship, and securing employment. Additional research is urgently needed to help understand how such programs could help reduce vulnerabilities to HIV while improving the general health of deported migrants and their sexual and drug using partners in the U.S.–Mexico border region, and the communities in which they reside.

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