BINATIONAL HIV CONFERENCE • SAN DIEGO • 2026

Immigration Policy and HIV Prevention and Care among Migrant Communities

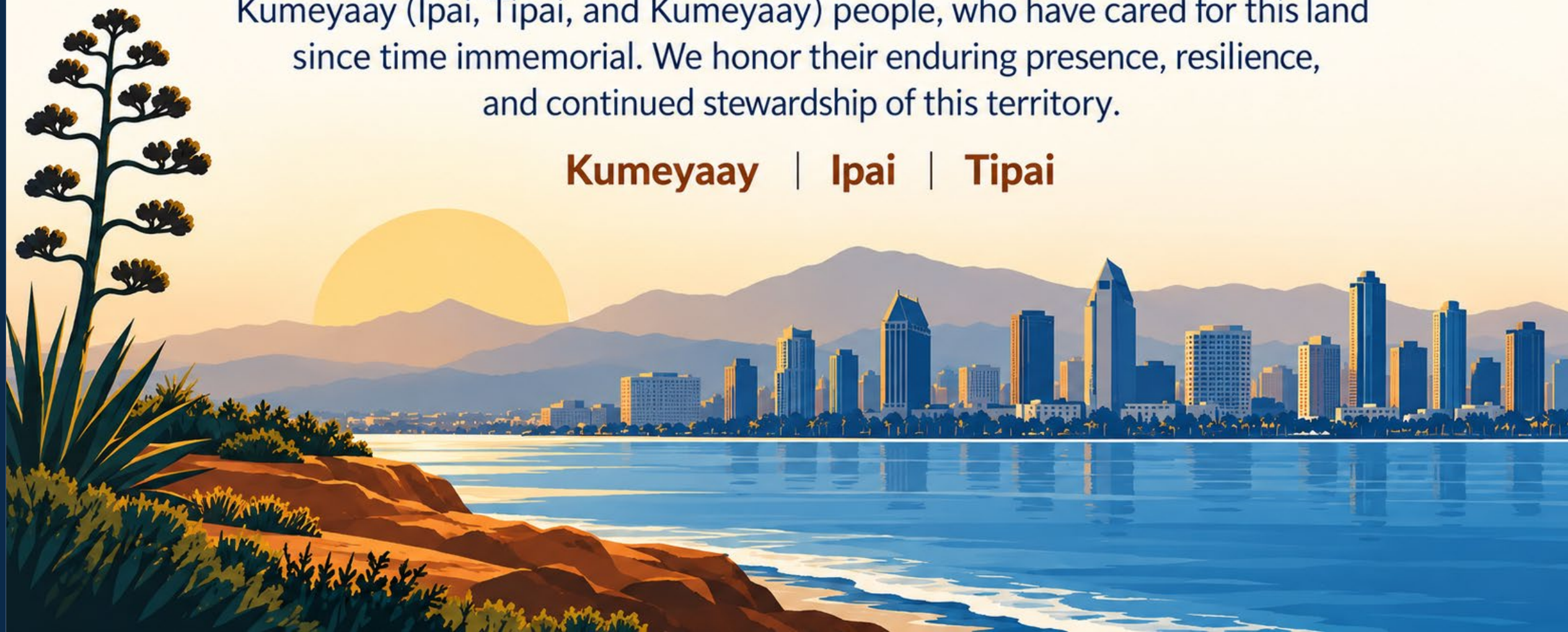
35-MINUTE SESSION

Higinio Fernández-Sánchez, PhD, RN, FAAN
Assistant Professor • UTHealth Houston Cizik School of Nursing

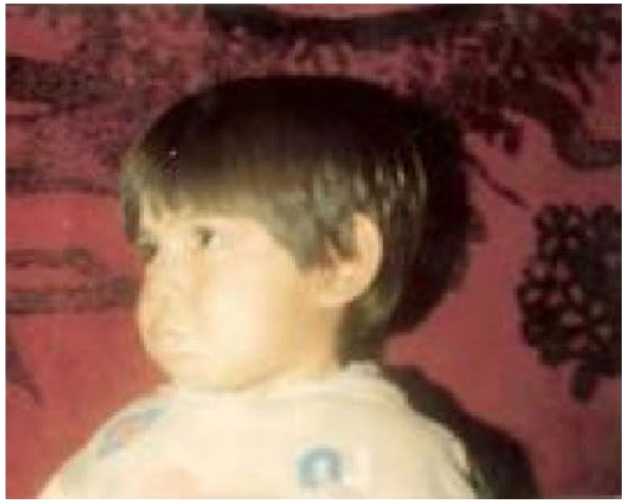
Land Acknowledgment

We acknowledge that San Diego sits on the ancestral lands of the Kumeyaay (Ipai, Tipai, and Kumeyaay) people, who have cared for this land since time immemorial. We honor their enduring presence, resilience, and continued stewardship of this territory.

Kumeyaay | Ipai | Tipai



Reflexivity/Positionality



Undocumented migrant:
México-USA-Canada



Professional experience



Activism work:
Migrant's and
Women's rights

The through-line

From migration context → patient behavior → HIV outcomes → practical response

01

What the preliminary data show

Three migrant groups; shared measures; stage-specific vulnerability.

02

What Public Charge means in 2026

What the rule does—and what it does not do—to health programs.

03

What HIV teams can do

Low-barrier workflows, precise messaging, and warm handoffs.

Audience lens: providers • researchers • case workers • PrEP navigators

Migrant communities are not a single population

People move through different pathways, legal categories, skills, timelines, and degrees of permanence.

Mobility patterns

Transit migration
- circular/temporary migration (H-2A, H-2B)
- return migration

Newcomer & mixed-status communities

Recent arrivals
- families with different statuses
- changing status over time

Humanitarian pathways

Asylum seekers
- refugees
- humanitarian parole / other protection pathways

MIGRANT COMMUNITIES

heterogeneous • dynamic • overlapping identities

Precarious or limited status

Undocumented migrants
- DACA recipients
- people with temporary or uncertain protections

Employment-based migration

Skilled/professional migration (TN, H-1B)
- employer-linked migration

Migration is a continuum

Categories can overlap and change across the life course, policy context, and migration journey.

Key implication Avoid treating "migrants" as a homogeneous group—health risks, access, rights, resources, and prevention needs differ substantially across communities.

My preliminary study

Young adult Latino migrants across three migration contexts (2025)

N = 325
Total participants

n = 125
Transit migrants • shelters in Mexico

n = 100
Circular migrants • agricultural sites, Texas RGV

n = 100
Newcomers • community settings, Houston

DESIGN

- Cross-sectional, 2025
- In-person, multi-site field data collection
- Validated Spanish-language survey instruments
- Descriptive statistics + cross-group comparisons



Measures included HIV/STI knowledge, risk perception, PrEP knowledge, testing, condom use, stigma, violence exposure, and human-trafficking indicators.

Three migration journeys, three access environments

Transit migrants

Mexico shelters

46% never HIV tested

66% never screened for STIs

22% always use condoms

56.8% reported violence

High mobility and interrupted care

Circular migrants

H-2A farmworkers • Texas RGV

89% never HIV tested

94% never screened for STIs

53% always use condoms

19% restricted mobility

Legal work status does not remove preventive barriers

Newcomers

Houston community settings

78% uninsured

67% did not seek care when sick

21% regular healthcare provider

40% job worse than promised

Significant barriers persist after arrival in the U.S.

Preliminary finding 1: HIV testing is especially thin in the circular-migrant group

11%

ever tested for HIV
among circular farmworkers

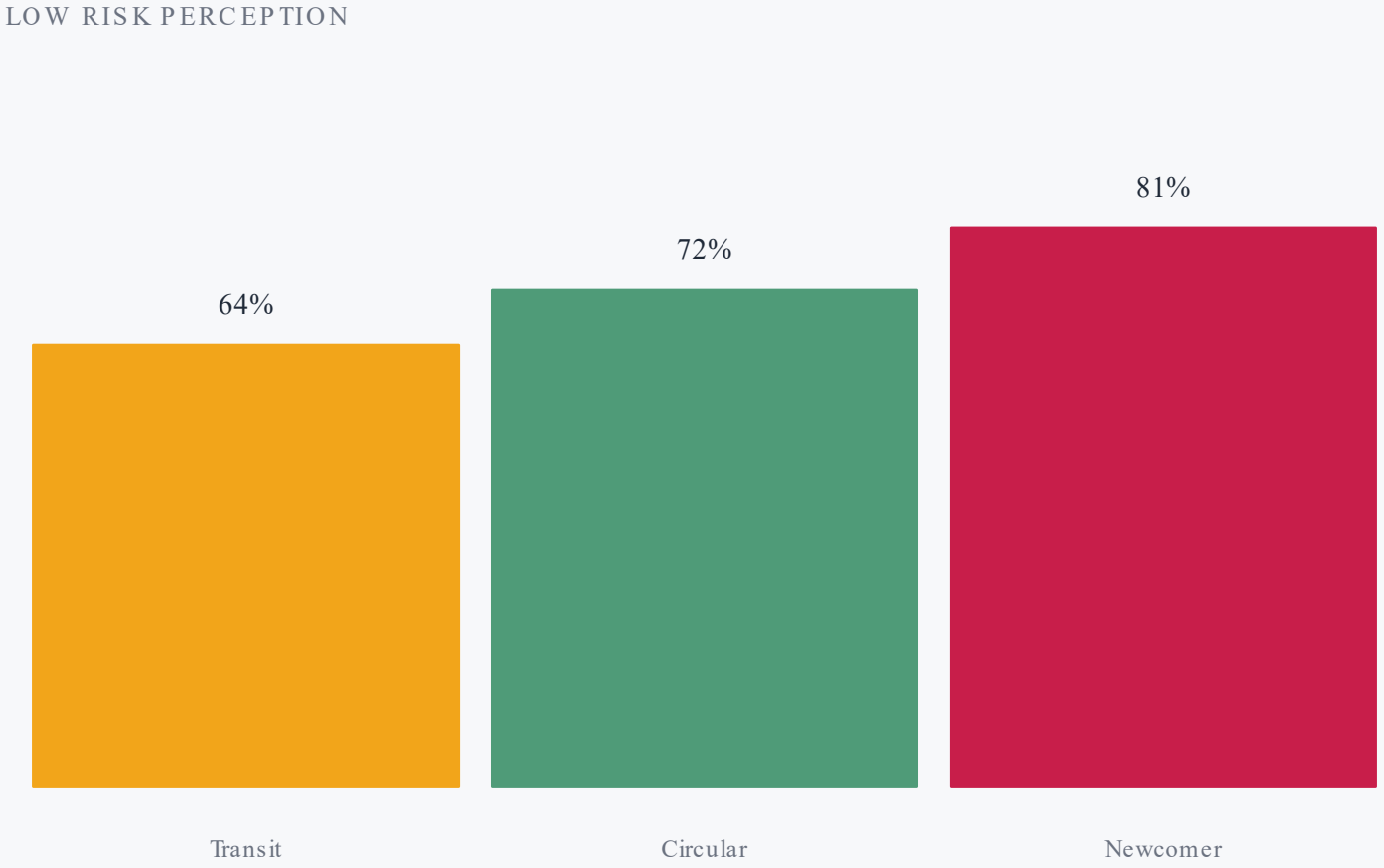
89%
never tested



WHY IT MATTERS

1. Legal work status ≠ automatic access to preventive HIV services.
2. Testing access appears intertwined with mobility, time, transportation, and clinic fit, not only immigration status.
3. For PrEP and prevention, the first bottleneck may be "getting through the door."

Preliminary finding 2: low perceived HIV risk is common across all three groups

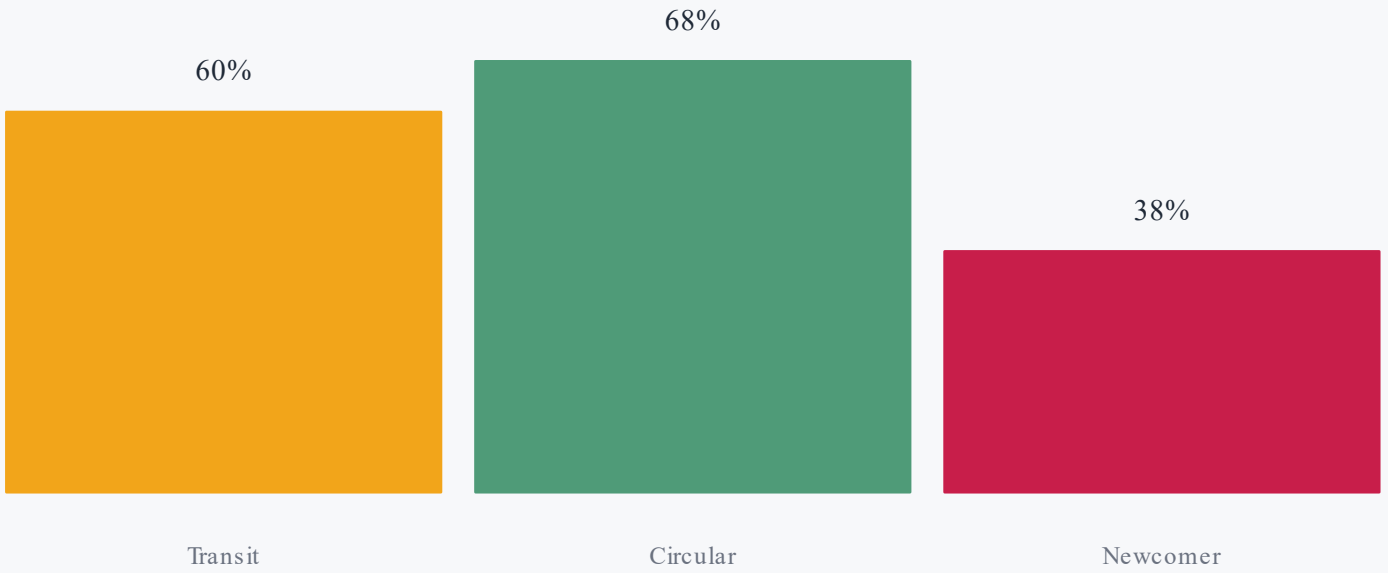


THE PARADOX

Low perceived risk + moderate-to-low HIV / PrEP knowledge can make prevention feel unnecessary, while structural exposure remains high.

This is a prevention communication problem, not simply a "risk behavior" problem.

Preliminary finding 3: PrEP knowledge is a concrete, addressable gap



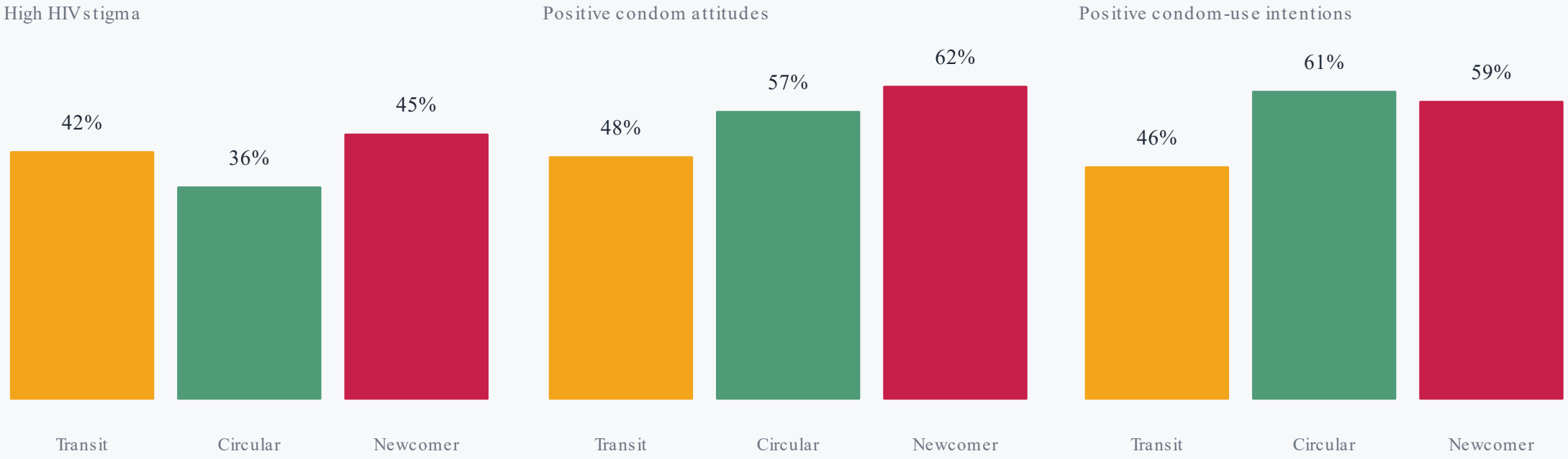
Percent with low PrEP knowledge

PRACTICAL RESPONSE

- Explain PrEP without assuming the patient already knows the vocabulary.
- Offer options that fit mobility and visit patterns.
- Make baseline testing + follow-up a navigation issue, not a gatekeeping issue.

Current CDC guidance: inform sexually active patients about PrEP and prescribe it to people who ask; pair PrEP with testing and prevention counseling.

Preliminary finding 4: stigma remains high even as condom attitudes are more positive



A prevention service can be technically available yet socially "expensive."

For HIV teams, stigma messaging should sit alongside practical access: privacy, language concordance, discrete navigation, and low-friction follow-up.

What the preliminary findings suggest

Same HIV goal; different barriers; stage-specific response

TRANSIT	**Testing + PrEP knowledge**	→	Rapid, trauma-informed, shelter-based services
CIRCULAR	**Testing + preventive care**	→	Mobile/outreach services at agricultural sites
NEWCOMER	**Insurance + exploitation + linkage**	→	Integrate HIV services with legal/social supports

Do not ask only "What is their status?" Ask "What barrier is operating here, and what can our system remove?"

Now: the question patients are actually asking

"Will getting HIV care, or using this program, hurt my immigration case?"

The chilling effect: fear changes healthcare behavior

Avoidance can extend beyond the people and programs technically targeted by immigration policy.

20.4%

avoided a public benefit

Adults in immigrant families with children, 2019 — because of green-card concerns.

15.6%

reported chilling effects

Adults in immigrant families nationally, 2019, avoiding noncash benefits.

25%

estimated to forgo programs

At-risk immigrant essential workers/households in one national analysis.

Spillover matters for HIV care

Among families reporting chilling effects, avoidance reached programs outside the policy's technical scope. Historical evidence also links public-charge announcements to reduced coverage and altered care-seeking.

For HIV teams: fear can become delayed testing • reluctance to ask about PrEP • coverage avoidance • missed follow-up

Public Charge: what it is, and when it matters

WHAT IT IS

An immigration inadmissibility standard.

The current rule governs certain applications for admission and adjustment of status by asking whether an applicant is likely at any time to become a public charge.

It is not a general rule that makes healthcare use illegal or automatically disqualifying.

CURRENT SCOPE

WHO	Applies to applicants subject to the public-charge ground, not everyone who uses benefits.
WHEN	Current final rule effective Sept. 18, 2026; applies to qualifying admission/adjustment applications on or after that date.
HOW	DHS may consider means-tested public benefits plus other individualized factors in a totality-of-the-circumstances assessment.
IMPORTANT	Receipt of a benefit is not, by itself, the outcome of the case.

The 2026 rule changed the “safe list” era

2022 REGULATORY FRAMEWORK

Bright-line exclusions for most noncash health, nutrition, and housing benefits.

Medicaid (except long-term institutional care), CHIP, SNAP, WIC, housing and several other benefits were outside the public-charge determination under the 2022 rule.

That is historical context, not the rule to teach as current law.

2026 FINAL RULE

DHS rescinded the 2022 regulatory framework and restored broader officer discretion.

The rule allows officers to consider means-tested public benefits, including benefits previously excluded, received/applied for on or after the effective date, as one part of the totality of the circumstances.

Translation for HIV teams: do not use an old “nothing counts” script.

What counts now? A safer way to teach it

Medicaid	2026: potentially considered if means-tested and received/applied for on/after Sept. 18, 2026.	Do not equate use with automatic inadmissibility.
CHIP	2026: DHS expressly declined to exclude CHIP when received by the applicant.	Child benefit use still requires individualized legal context.
SNAP	2026: DHS explicitly says previously excluded benefits such as SNAP can be considered prospectively.	Eligibility ≠ public-charge determination.
WIC	2026: DHS declined to exclude WIC; potentially relevant if means-tested.	Do not rely on the old "WIC never counts" script.
Housing assistance	2026: means-tested government housing assistance may be considered.	Program eligibility is a separate question.

Key distinction: "potentially considered" ≠ "automatically disqualifying."

What Public Charge does NOT do

Keep these concepts separate in every HIV encounter

01

Public Charge ≠ benefit eligibility

A person may be ineligible for Medicaid/SNAP because of a separate eligibility rule. The public-charge rule is an immigration inadmissibility analysis.

02

Public Charge ≠ “no healthcare”

DHS states the rule does not prohibit eligible people from receiving benefits or accessing medical treatment.

03

Public Charge ≠ automatic denial

Current DHS language says benefit receipt is one aspect of a totality-of-the-circumstances assessment.

04

Public Charge ≠ family member use

DHS says it generally focuses on the applicant; family-member benefit use is generally not treated as the applicant’s receipt, subject to case-specific evidence about support.

Three HIV questions clinicians are hearing

1

“Will PrEP hurt my green card application?”

Separate the questions: (1) Is the person eligible for PrEP? (2) Are they in a public-charge adjudication? (3) What does the current rule say about the relevant benefit?

PrEP is HIV prevention; public-charge analysis is an immigration-law question.

2

“Does Ryan White count?”

Do not improvise. Verify the specific funding/benefit pathway and route the immigration question to qualified counsel.

The 2026 final rule does not name “Ryan White” or “PrEP” specifically.

3

“Can I stop my HIV medicine until I know?”

Do not frame treatment interruption as a solution. Focus on continuity, adherence support, coverage options, and urgent linkage to legal help when needed.

In HIV care, uncertainty should trigger navigation, not medication abandonment.

Use a consistent line: “I can explain the health-care piece, but individualized immigration advice belongs with qualified immigration counsel.”

Strategies for the HIV workforce

Make trust and navigation part of the HIV service, not an extra referral

PROVIDERS

Name confidentiality limits and protections clearly
Use language-concordant care
Offer PrEP/HIV testing without status-based assumptions

CASE WORKERS

Separate benefit eligibility from immigration consequences
Document barriers that affect retention
Build warm legal/community handoffs

PrEP NAVIGATORS

Treat paperwork, transportation, cost, and fear as navigation barriers
Keep follow-up feasible for mobile patients
Use current program assistance resources

RESEARCHERS / PROGRAMS

Measure fear, trust, and policy knowledge, not only uptake
Design with trusted community partners
Return findings to communities in usable language

A low-barrier HIV workflow under immigration uncertainty

1. **Ask the health question first**
   "What do you need today, testing, PrEP, HIV treatment, STI care, refills?"
2. **Clarify confidentiality**
   Explain what the clinic protects and the limited circumstances when information may be disclosed.
3. **Address the actual barrier**
   Cost • transportation • time off work • language • fear • documentation • phone access.
4. **Keep HIV prevention/care moving**
   Offer the clinically appropriate service; do not make immigration uncertainty the reason for delay.
5. **Warm handoff for immigration questions**
   Qualified immigration counsel + trusted CBO/legal-medical partner.

The operational goal: preserve trust long enough for the patient to stay in prevention or care.

Five practices to take back next Monday

1. Replace “What is your status?” with “What barrier is affecting care today?”

2. Put confidentiality messaging where patients can see and hear it.

3. Keep PrEP, HIV testing, and ART continuity low-barrier, and make follow-up realistic for mobile lives.

4. Stop using outdated “nothing counts under Public Charge” language; teach the 2026 change accurately.

5. Build a standing warm-handoff pathway to trusted community + qualified immigration/legal partners.

Trust is not separate from healthcare access. It is part of healthcare access.

Gracias



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