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Beyond Documentation: Racialized Legal Status as a Political Determinant of Health Among Latines with HIV in the United States

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Abstract

Objective: Latines in the United States (US) experience disproportionate HIV-related inequities, exacerbated by immigration-related legal precarity and exclusionary policies. This study explores how racialized legal status (RLS), a mechanism by which race-neutral legal classifications disproportionately burden minorities, impacts the lived experiences of Latines with HIV (LWH) across the HIV care continuum. **Methods:** We conducted a secondary qualitative analysis of in-depth interviews with 21 LWH, 15 healthcare providers, and 10 key informants in Prince George's County, Maryland. Drawing on RLS framework, data was analyzed thematically, focusing on emergent themes related to immigration, politics, and legal status and their impact on LWH. **Results:** Policies linking access to health and social services to legal status intensified economic instability and social exclusion, thus leading to suboptimal disease management. Fear of deportation, institutional mistrust, discrimination, and intersectional stigma contribute to healthcare avoidance, disrupting continuity and engagement across the HIV care continuum. Institutions providing services to LWH struggle to circumvent barriers caused by RLS, straining local and community-based resources. **Conclusions**: RLS erodes whole-person care by creating barriers for healthcare and social services access. Addressing inequities among Latines requires multi-level responses that reduce exclusionary policies and support the well-being of individuals at the intersection of immigration status and chronic disease management.

Keywords: immigration; HIV care continuum; Latin America; social exclusion

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1. Background

Latine people comprise nearly one-fifth of the United States (US) population, a country historically built and shaped by migration [1,2]. Yet, despite their cultural, social, and economic significance, Latine immigrants experience persistent inequities in health and healthcare access that are patterned by immigration legal status and exclusionary policy environments [3,4]. These dynamics motivate a focus on racialized legal status (RLS) as a political and structural determinant of health [5].

Racialized legal status (RLS) captures how immigration law operates as a mechanism of social stratification, producing and sustaining racial and ethnic health inequities [5,6].

RLS describes a socially stigmatized position created through immigration laws that are formally race-neutral but, in practice, are differentially enforced against racial and ethnic minority groups, such as Latines [5]. This lens emphasizes that legal stratification and racialization are co-constituted and together shape health [5,6]. Among Latine immigrants, RLS encompasses a wide spectrum of legal conditions, including undocumented/unauthorized status, referring to individuals living without federal immigration authorization; Temporary Protected Status (TPS), which provide temporary and revocable protections to remain in the US; lawful permanent residency ("Green card" status); citizenship; and mixed-status family arrangements, in which members of the same household hold different legal statuses [7–9]. While these statuses differ in formal rights and protections, Latines may experience precarity, surveillance, and uncertainty because racial profiling and the presumption of foreignness can intensify immigration scrutiny and restrict access to social and political resources [10,11]. Thus, RLS shapes how individuals navigate and access the conditions that affect their quality of life, including employment, housing, healthcare, and social belonging in ways that compound racial inequities [9,12,13]. As a result, Latine immigrants across diverse legal statuses may experience chronic legal insecurity, fear of status loss, constrained healthcare access, and heightened psychosocial stress [8,9,13].

RLS shapes health through both the healthcare system and the broader social-policy environment, producing and maintaining inequity. State and local immigration policy climates determine access to resources and to the institutions that govern healthcare, particularly health insurance and safety-net service delivery systems (e.g., community clinics and publicly funded HIV care programs) [14]. Non-citizen Latine individuals face persistent gaps in usual sources of care and insurance, alongside barriers such as language and discrimination [13,15]. Beyond formal eligibility, immigration enforcement climates discourage engagement with routine services. For example, higher local Immigration and Customs Enforcement (ICE) activity and restrictive enforcement policies are associated with reduced healthcare access and utilization among Latine immigrants, including lower odds of routine medical checkups [16]. Experiences of discrimination and immigration enforcement are also associated with adverse health impacts, underscoring how enforcement and social marginalization can shape health and care seeking [17]. Together, these pathways illustrate how RLS can translate legal vulnerability into healthcare avoidance, distrust, and delayed care [13,16,17].

HIV prevention and care are a particularly salient example of how RLS shapes health because it is both a lifelong chronic condition and an infectious disease. HIV outcomes depend on sustained access to care across the continuum: timely diagnosis, linkage to care, continuous retention, and adherence to antiretroviral therapy [18–20]. Across the US, Latines continue to represent one of the most vulnerable populations in terms of disproportionate HIV burden and HIV-related inequities [18,19,21–23]. Despite representing only about one-fifth of the US population (19%), Latine individuals accounted for nearly one-third (32%) of the 39,182 new HIV diagnoses reported in 2023 [24]. In the same year, 74% of Latines living with HIV received care, and 66% achieved viral suppression, defined as having fewer than 200 copies of HIV per milliliter of blood [24,25]. Persistent prevention inequities are also evident, with Latines representing only 18% of Pre-Exposure Prophylaxis for HIV prevention (PrEP) users in 2023, and a PrEP-to-Need Ratio of 7.4 [24].

These national inequalities are reflected in Maryland (MD). In 2024, Latine residents represented 11.9% of Maryland's population aged 13 years and older but accounted for 18.5% of new HIV diagnoses, while non-Hispanic White residents represented 48.1% of the population but 9.2% of new HIV diagnoses [26]. Maryland contains three of the federally designated jurisdictions in the Ending the HIV Epidemic in the US (EHE) initiative, a ten-year federal initiative to reduce new HIV infections by 90% by 2030. In Prince George's County, HIV diagnosis among Latine residents nearly doubled between 2018 and 2020

(7.5% vs. 14.9%), and Latines represent the highest proportion of late diagnoses [27]. Latines living with HIV report delays in diagnosis and ART initiation, and challenges with adherence and viral suppression [22,23]. These delays have consequences beyond individual health, as delayed diagnosis and viral suppression increase the risk of onward transmission and erode public health progress.

A growing body of literature has examined immigration status and health outcomes among Latine communities in the US, particularly among undocumented individuals [28–30]. These studies document how immigration policy and hostile enforcement climates shape engagement across the HIV care continuum [31–33]. For example, Latine immigrants living with HIV experience sociocultural barriers to engagement and retention in care, such as stigma, fear of deportation, language barriers, and work restrictions [10,31,32]. However, despite these efforts, fewer studies have examined these sociostructural barriers jointly while explicitly applying RLS as a political determinant of health to examine how immigration law, racialization, stigma, and institutional responses jointly shape the lived experiences of Latines with HIV across the HIV care continuum [5,6].

To understand the multi-level implications of RLS for Latines with HIV (LWH), we interviewed LWH, healthcare providers, and local stakeholders in Prince George's County, MD. This paper explores how RLS impacts the lived experiences of LWH across the HIV care continuum. By centering the lived experiences of LWH navigating a politically contested environment, this analysis advances understanding of RLS as a political determinant of health, with direct implications for the implementation of national public health strategies, including the federal EHE initiative.

2. Methods

2.1. Study Design

The current study was embedded within an NIH Center for AIDS Research at Emory University Adelante Award titled "Identifying Opportunities for a Multi-Level HIV Navigation Program for Latinos/as/xs Living in Prince George's County, Maryland." The parent study is an observational, qualitative study that aims to conduct a systems analysis of current HIV program infrastructure in Prince George's County, Maryland, to identify opportunities to develop and integrate a culturally and linguistically appropriate, multi-level HIV navigation and support program for Latines. The study included value stream mapping of a cohort of LWH engaged in HIV care (n = 15), semi-structured in-depth interviews (IDIs) with LWH accessing services and/or residing in Prince George's County (n = 21), healthcare providers with experience in HIV service provision in Prince George's County and the Latine community (n = 15), and key informants with knowledge, experience, and involvement with state and county leadership (n = 10). All in-depth interview data were collected between July 2024 and June 2025, with some interviews occurring before the 2024 US general elections, after the elections, and after the inauguration of the new presidential administration. The current study draws on semi-structured, in-depth interviews with LWH, healthcare providers, and key informants, yielding data from emergent discussions on immigration, politics, and the legal status of LWH.

2.2. Study Recruitment and Sample

LWH (n = 21) were recruited through informational flyers (in English and Spanish), study information shared by staff at a healthcare facility in Prince George's County, and participant-driven dissemination of study information to their networks. Eligibility criteria included: being 18 years or older, having a positive HIV diagnosis, and receiving HIV care and/or residing in Prince George's County. As shown in Table 1, LWH had a median age of 32 years (range: 21–46), mainly identified as cisgender men (16/21), and described their sexual

orientation as gay (14/21). All participants except one were Latin American immigrants, and among them, the median time living in the US was 3 years (range: 0.5–28 years). The median time since HIV diagnosis was 5 years (range: 0.33–21 years), and all participants reported being on antiretroviral therapy (ART), with a median time since ART initiation of 4 years (range: 0.33–21 years). We asked LWH about self-reported race, and most identified as *mestizo* (mixed race/heritage classification often referring to ancestry combining European and Indigenous descent) (11/21) or Latino (6/21). We did not directly inquire about legal status, as it was not among the parent study's aims. However, all foreign-born participants described their immigration experiences while discussing their HIV care engagement journeys, with some disclosing their legal status spontaneously during the semi-structured interviews.

Table 1. Overview of sociodemographic and HIV characteristics by sampling group: Latines with HIV engaged in care, healthcare providers, and local and state key informants.

Latines with HIV (*n* = 21)		**Health Care Providers (*n* = 15)**		**Key Informants (*n* = 10)**	
Characteristics	***n***	**Characteristics**	***n***	**Characteristics**	***n***
Age in years		*Age in years*		*Age in years*	
Median (range)	32 (21–46)	Median (range)	37 (24–76)	Median (range)	48 (34–71)
Gender		*Gender*		*Gender*	
Cisgender women	2	Cisgender women	11	Cisgender women	7
Transgender women	1	Transgender women	2	Cisgender men	3
Cisgender men	16	Cisgender men	2		
Gender non-binary	2				
Sexual orientation		*Identifies as Latine*		*Identifies as Latine*	
Gay	14	Yes	10	Yes	3
Straight	6	No	5	No	7
Pansexual	1	*Role*		*Affiliation*	
Self-identified race		Non-clinical		Health department official	
Mestizo	11	Peer navigators, community health workers, and educators	3	State (Maryland)	3
White	2			County (Prince George's County)	2
Indigenous	2				
Some other race					
Latine/Hispanic [1]	6	Case managers and counselors	7	Neighboring county	2
Years living in the US [2]					
Median (range)	3 (0.5–28)	Clinical		Non-governmental organization (NGO) leadership	3
Country of origin		Nurses and physicians	5		
United States of America	1				
México	2				
Guatemala	3				
Honduras	3				
El Salvador	4				
Nicaragua	4				
Venezuela	3				
Perú	1				
HIV characteristics					
Years living with HIV [3]					
Median (range)	5 (0.33–21)				
Currently on ART [4]					
Yes	21				

Table 1. *Cont.*

Latines with HIV (n = 21)		Health Care Providers (n = 15)		Key Informants (n = 10)	
Characteristics	***n***	**Characteristics**	***n***	**Characteristics**	***n***
No	0				
Years since ART initiation					
Median (range)	4 (0.33–21)				

[1] All LWH identified their ethnicity as Latine. When asked about their race, some participants also identified their race as Latine and did not report a different racial category. [2] Excluding one participant who was born in the United States. [3] Time since HIV diagnosis. [4] ART: Antiretroviral therapy.

Healthcare providers and staff (n = 15) were recruited via phone, email, or in-person interactions facilitated by a recruitment script; through participant-driven dissemination of study information to their networks; and through multidisciplinary HIV network meetings. Eligibility criteria included: being 18 years or older, providing HIV services in Prince George's County, and having experience engaging with LWH. Providers had a median age of 37 years (range: 24–76 years), most identified as cisgender women (11/15) and Latine (10/15) (See Table 1). Their roles ranged from non-clinical (peer navigators, community health workers, educators, case managers, and counselors) to clinical (nurses and physicians).

Key informants in Prince George's County and neighboring counties (n = 10) were invited to participate in the study using the same strategies as those used for healthcare providers and staff. Key informants' eligibility included: being 18 years or older and holding a leadership role in HIV programming in Prince George's County or a neighboring county. Key informants had a median age of 48 years (range 34–71 years), most identified as cisgender women (7/10), and non-Latine (7/10) (See Table 1). Regarding their roles, seven of the key informants were health department officials at the state or county level, including those in neighboring counties, while three held high-ranking leadership positions at non-governmental organizations in Prince George's County.

2.3. Data Collection, Management, and Analysis

All IDIs were conducted in the participant's language of choice, in Spanish or English, by five trained bilingual interviewers. Interviews were conducted in person at a private location within a healthcare center, over the phone, or via videoconference. Each IDI lasted approximately 60 min, and participants received 50 USD compensation per interview. For eight healthcare providers and staff, compensation was limited to 25 USD because their institutional policies restricted the amount they could accept for research participation.

All interviews were transcribed and analyzed in their original language, and for Spanish interviews, select quotes were translated into English for manuscript development. Following each interview, interviewers developed analytic summaries detailing the overall experience with the participants and highlighting major insights that emerged from the conversation. Transcribed interviews and their corresponding analytic summaries were thoroughly reviewed to allow for deeper immersion into the contextual realities of each participant and to develop the initial codebook for thematic analysis.

Data were analyzed by three trained bilingual (Spanish-English) researchers with qualitative research experience, under the ongoing guidance of the principal investigator, using thematic analysis with both inductive and deductive coding [34]. The codebook was collaboratively developed by all team members to ensure a shared understanding of code definitions and their application. Next, a subset of transcripts was double-coded by coders at the outset of analysis to establish consistency and shared interpretive standards across the team before coding independently. As coding progressed, any emergent codes proposed by individual coders were brought to the team for discussion before being integrated into

the codebook. Throughout coding, the team held regular debriefing sessions to discuss in detail how specific codes had been applied to transcript segments, allowing discrepancies in interpretation to be identified and resolved. Analytic memos were also used to further synthesize the data and inform the conceptualization of findings. Taken together, these steps allowed our team to assess the dependability and confirmability of the results.

For this study, data analysis focused on emergent discourse around immigration, politics, and legal status as they pertain to the Latine community living with HIV. In particular, data analysis was informed by the RLS conceptual framework and its implications for health and well-being, thereby enabling further synthesis of participants' perspectives, views, and opinions related to the emergent discourse described above. Due to the study occurring during a period of significant sociopolitical change, interview timing was considered during analysis and interpretation through triangulation with contemporary data sources and policy changes. The timing of the interviews varied by participant groups, with key informant and healthcare provider interviews conducted mostly before the 2024 US general elections, and LWH interviews taking place mostly after elections. ATLAS.ti version 25.0.1 [35] was used to manage qualitative data.

2.4. Ethical Considerations

This study received human subjects research approval from the Institutional Review Board of the Johns Hopkins University Bloomberg School of Public Health (Baltimore, MD, USA).

3. Results

Participants described their perspectives and experiences on issues affecting LWH, including immigration status, the current shifting political landscape and its effect on HIV care, and the institutional response to barriers affecting LWH care experiences. Emblematic quotes supporting the themes described in the following results are presented in Table 2.

Table 2. Thematic quotations by result section.

Result Section Theme	Emblematic Quotes
Racialized Legal Status among LWH: Perspectives and Lived Experiences	"*Trust is one of the biggest barriers, especially now, with fear of ICE and deportation, [making] clients and patients leery of interacting with the government and getting services from the government. Right after the election, we saw our numbers go down. We saw fewer people for the next few weeks coming in for services, coming in for testing, coming in for treatment because of that fear of, "If I come there, um, am I putting myself at risk of being deported? Am I putting my family at risk of being deported?*" (Neighboring county key informant, non-Latine, cisgender man)
	"*During one of my husband's clinic appointments, which I accompanied him to, I began to see that they had information available [for HIV], and I approached to request more information about it. . . that same day they told us: 'Look, if you want, we can start the entire process today, we can do it today.' But my husband and I talked at that moment, and he said to me: 'No, not yet.' Because the lawyer once told us something about the 90 days after arriving in the United States from El Salvador, . . . and it could harm any immigration proceedings. So at that moment, I told the person: 'No, we are going to wait until the date we complete the 90 days because we are afraid based on what our lawyer has told us about the process, so we don't want that to show up in the system and cause problems.'" (Cisgender man, 41 years old, 17 years living with HIV, half year living in the US)*
Discrimination in Healthcare and Intersectional Stigma	"*Because of the new administration, the rules changed, so now I don't have access to speak with the social workers at the institute where I was, because they were prohibited from speaking with undocumented Hispanics. . . and they were also being prohibited from speaking Spanish to patients. I see it as racism, something that wasn't seen here in this country before. . . . I was in danger going [to the clinic], because they told me they were starting to ask for [identification] at the entrance. That's why they were afraid they'd detain me there, that they'd ask me about my [legal] status.*" (Cisgender man, 46 years old, 21 years living with HIV, 20.5 years living in the US)

Table 2. *Cont.*

Result Section Theme	Emblematic Quotes
Discrimination in Healthcare and Intersectional Stigma	"*And I've lived it because I was a trans woman who came walking from El Salvador, I went through every stage of poverty you could imagine, I was homeless, I lived on the street, in shelters, and you feel it. I mean, the treatment you get is very different. Not all doctors, but I would even dare say that there are many doctors who don't even want to talk to you. If conversations with doctors already last a little, like 30 min, they make them even faster. So the medical care they're giving you is trash. Imagine it, a trans Latina woman, undocumented, homeless, living with HIV—what motivation is she going to have to take care of herself?*" (Peer navigator, Latine, transgender woman)
Economic Instability and Social Services	"*When work is slow, because I'm a waiter and sometimes people don't come in. For example, a month ago, there was a bad week because when immigration shows up people didn't come, since it's a Hispanic restaurant, they're afraid to go out. There are still a lot of people who aren't coming yet. They're afraid to go out. It goes badly for us, because you know a waiter makes USD 3, USD 4 an hour, what you earn is from tips.*" (Cisgender man, 42 years old, Guatemala, 4 years living with HIV, 3 years living in the US)
	"*If somebody says that they have housing needs, I'm like, "Shoot, a lot of people do." So it's really hard to be in the position where somebody has a lot of assistance needs and there are no resources to help them. It would be great if patients qualified for SNAP benefits or other things. But, without a legal status, most patients don't qualify.*" (Case manger, non-Latine, cisgender woman)
Fear of Deportation and the HIV care continuum	"*Right now the president has a policy that is going to deport a lot of people, right? . . . I'm worried because I don't have a formal immigration status. I'm very worried because Donald Trump is threatening to carry out mass deportations of those who are undocumented. [And that would affect my treatment in the US] because I still have to take medications.*" (Cisgender man, 33 years old, 1.6 years years living with HIV, 2 years living in the US).
	"*It doesn't happen often in 2024 that people die of HIV complications, but my hypothesis over the next few years is that more undocumented people are gonna die. And undocumented LGBTQ people are gonna die from HIV . . . The people who die from HIV nowadays are people who are homeless and have a lot going on, and people who are avoiding care for other reasons. And what's the most compelling reason to avoid care? To me, fear of deportation is pretty compelling and it scares the crap out of me.*" (Neighboring county key informant, non-Latine, cisgender woman)
Healthcare Coverage and Institutional Mistrust	"*A lot of [the Latines with HIV] need help. But from my understanding and my experience, they don't trust the system. And sadly, because of their lack of trust in the system, they're not open to sharing much. I know a lot of them who live as safely as they know how to live and may use another name, use another address. They may not share certain information because they don't wanna get caught surviving.*" (Case manager, non-Latine, cisgender woman)
Clinic and Institutional Response to Political Climate	"*I think that our clinic has done a really good job of going out to these emergency rooms, saying, hey, if you're noticing these people coming in for X, Y, Z, refer them to us. So not only do we see people for the infectious disease services, we're able to connect them to primary care, and there's the sliding fee scale, even if they're not insured. And these patients feel safe knowing that they don't have to be paranoid thinking, "Oh my goodness, if I go to be seen, somebody's going to know I'm here, or know my loved ones here, and deport us. And then all of it went to waste.*" (Nurse, non-Latine, cisgender woman)
	"*But unfortunately the resources we have at our disposal are fewer and fewer. These are patients who are very vulnerable . . . and one would always like to help more. The fundamental challenges are the economic resources that are not sufficient and the lack of government support for these patients, where many programs that were already implemented are being cut.*" (Nurse, Latine, cisgender woman)
	"*Everything starts with policy, but you have to have a voice. In order to have a voice, you've got to be in the community to find out what the needs are. And that's where I think a lot of the problem is. People who make the decisions, they're on a higher level, in an office, and they see nothing from where they sit . . . So for me, nothing lines up. And we're not going to end the epidemic because nothing's in alignment.*" (NGO key informant, non-Latine, cisgender woman)

3.1. Racialized Legal Status Among LWH: Perspectives and Lived Experiences

Anti-immigration, xenophobic, and racist narratives are pervasive across the US political landscape and media, as perceived by key informants and healthcare providers. Common tropes include seeing immigrants as "*coming [to the US] to take advantage of the system*" and abusing government services; scapegoating ethnic minorities; and creating harmful stereotypes of Latine people. At the decision-making level, key informants indicated that these stereotypes lead to one-size-fits-all interventions to address HIV among the Latine population, instead of creating tailored, client-centered strategies that adapt to the heterogeneity of LWH and their needs.

Across all groups, participants report a perception of increased implementation of immigration policies that facilitate and promote the deportation of non-citizens by ICE. Such federal policies result in heightened fear among LWH, restricted mobility, and distrust of authorities. Key informants and healthcare providers indicated that LWH were already hesitant to seek care before the 2024 presidential elections, commonly resorting to visiting the emergency room instead of consulting primary care, causing lost opportunities for HIV prevention, delays in diagnosis, and barriers to linkage to care. Furthermore, some key informants and healthcare providers also reported witnessing fewer Latine individuals seeking HIV services after the election due to the exacerbated fear of deportation of LWH.

LWH also reported experiencing the effects of racialized legal status as an ongoing condition of uncertainty that shaped their daily lives alongside HIV. These participants framed uncertainty itself, particularly surrounding immigration enforcement and shifting administrative policies, as one of the primary barriers and obstacles they faced. This uncertainty persisted despite efforts to comply with legal and social expectations such as "*do everything right*" and "*behave well*," reflecting how racialized legal status was experienced as unpredictable and beyond their individual control.

3.2. Discrimination in Healthcare and Intersectional Stigma

LWH fear that the change in administration could further restrict access to healthcare for an already stigmatized condition and population. Language and cultural barriers already create considerable barriers in healthcare settings for HIV care, and providers reported that some patients experience poor treatment because of their race/ethnicity or are denied care because of limited Spanish-language services, financial constraints, or immigration status. As a case manager stated, "*I have heard from patients having that type of discrimination because they're not legal in the US*." In the most severe case reported by a participant, a LWH described being denied HIV care at a government clinic following the inauguration of the new 2025 administration. Furthermore, this participant indicated that healthcare providers and staff, fearing racial profiling of LWH when accessing services and the weaponization of health data, contacted him through personal lines and referred him to a community-based clinic to continue his HIV treatment elsewhere.

In addition, across all groups, participants also discussed how immigration status-based discrimination interacts with other social vulnerabilities, including socioeconomic conditions, sexual orientation, and gender identity. One key informant and healthcare provider described this interaction by focusing on the experiences of transgender LWH. These participants described how transgender LWH have been targeted by legislation limiting their rights. They reported that while transgender LWH often escape traumatic environments in their countries of origin and arrive in the US with minimal resources, they continue to face differential treatment due to their intersecting identities, increasing their heightened risk for social exclusion and poor HIV outcomes.

3.3. Economic Instability and Social Services

LWH's lived experiences reveal economic instability as a central and compounding theme that shapes their ability to sustain HIV care. Legal status caused economic constraints through lack of work authorization and social security numbers, and barriers in establishing bank accounts. Fear of immigration enforcement, closely tied to the ongoing political climate, also disrupted employment and income stability, generating anxiety and low self-esteem. As an example, this is reflected in the experiences of one LWH participant, who shared how fear of deportation reduces customer flow in his workplace (restaurant), which immediately translates into financial strain and difficulty meeting basic needs such as rent, food, and daily living expenses.

Furthermore, LWH and healthcare providers described how economic insecurity was intensified by barriers to access and loss of supportive social services. In particular, healthcare providers and staff described the unique challenges of supporting non-US citizens LWH. These participants described how they lack eligibility to programs like SNAP (Supplemental Nutrition Assistance Program) and often face difficulties meeting paperwork requirements to receive assistance from other social support programs due to impediments related to obtaining "*legal documents*," including identity documents, driver's licenses, or social security numbers.

LWH also reported reduced or prohibited access to social workers, transportation assistance, food support, and housing-related resources, particularly following administrative or policy changes that disproportionately affected non-citizen Latines. They described how these changes restricted access to essential services, created barriers to engaging with programming like emotional support services, and increased stress and anxiety. Furthermore, among participants who still had access to some social support services, these changes heightened uncertainty about how long those resources would remain available.

3.4. Fear of Deportation and the HIV Care Continuum

Among LWH, fear of deportation was linked to concerns about losing access to affordable, continuous HIV treatment and the ability to manage their health. LWH described how deportation would disrupt access to HIV medications and clinical care. Some participants described the hardships they faced in their countries of origin, including high medication costs, difficulty obtaining medication regimens, limited HIV care clinics, high transportation costs, and long-distance travel to reach HIV care clinics. Participants often contrasted those experiences with their current access to HIV care in the US, describing their ability to access HIV care positively and reflecting on how deportation would likely result in treatment interruption or complete abandonment of HIV treatment and care.

Some key informants and healthcare providers expressed concern about what fear of deportation could lead to among LWH, particularly with disruptions in HIV care and treatment adherence. One key informant went further, describing concern about HIV related deaths among the most vulnerable LWH due to their avoidance of care because of fear of deportation.

3.5. Healthcare Coverage and Institutional Mistrust

Healthcare providers and key informants indicated that migratory legal status is a central barrier to accessing health insurance, limiting access to primary and specialty care services needed by LWH. Programs that grant access to HIV treatment for LWH vary by state and often exclude other medical services. Furthermore, LWH must navigate an already complex enrollment process filled with documentation requirements, which, due to institutional mistrust, healthcare providers report difficulty in obtaining this information.

Lack of institutional trust was reported by healthcare providers and key informants as a barrier to providing effective and quality care to LWH. Across both groups, participants reported receiving false identifying information or that LWH withheld relevant contact details, often hindering their ability to conduct follow-up consultations or engage in activities like contact-tracing. In particular, one healthcare provider further described being placed in a difficult position when a lack of institutional trust creates reluctance to share accurate personal contact information, which is perceived as a breach of trust with the Latine patients, who already "*feel targeted or hunted*" due to their legal status in the US.

3.6. Institutional Response to Political Climate

Key informants and healthcare providers have "*seen the struggles that the [Latine] community experience, especially those that are undocumented and immigrants*" and highlighted their commitment to ameliorate racialized legal status as a barrier for HIV care. Participants in these groups discussed the importance of establishing confidentiality, safety, and privacy in communications with LWH at clinics, providing telehealth for those with restricted mobility due to fear of deportation, proactively transferring patients to safer clinics, and connecting LWH to affordable and pro bono legal services.

Across groups, participants also indicated the need for establishing linkages to alternative social services and protection programs, including connecting LWH to churches, community-based organizations, and safety-net clinics that will not require proof of their legal status. However, most healthcare providers worry about clinics and organizations that provide HIV services being stretched thin and lacking resources, space, and staff to provide care to all uninsured and low-income LWH.

Healthcare providers also reported constantly encountering "*glass ceilings*" while striving to address upstream policies that affect LWH care, highlighting the need for developing accountable and transparent mechanisms for leadership. In their day-to-day practice, these participants reported feeling increasingly powerless serving LWH, leading to burnout from the augmented needs in the population. Key informants also reported funding-related challenges, such as bureaucracy and grant structure, that follow political interests and encourage siloing as a barrier to delivering services for LWH.

We synthesize our findings using a multilevel perspective (See Table 3) to describe how racialized legal status operates across macro, mesa, and micro-level structures that shape the health and well-being of LWH. Findings indicate that macro-level political conditions impact subsequent mesa and micro-levels, thus establishing racialized legal status as a political determinant of health.

Table 3. Multilevel Analysis of Racialized Legal Status Among LWH.

Level of Analysis	Theme	Key Mechanisms of Racialized Legal Status	Manifestations in Lived Experience	Implications for HIV Care	Emblematic Quotes
Macro (Structural/Political)	Political Climate and Anti-Immigrant Narratives	Common tropes in anti-immigrant political rhetoric include abusing access to government services, scapegoating ethnic minorities; and harmful stereotypes.	Victimization and discrimination in daily life and while accessing healthcare services due to legal status, race/ethnicity, and countries of origin.	Financial insecurity, hesitancy in seeking care, lack of linguistically and culturally congruent care, lack of trust.	"*In our current State of America everyone is blaming everything on brown and other people. Even those who are at the top don't like other people who came here unless they're cooking for them or they're cleaning for them or watching their kids. . . . Latino people understand the same thing that brown people in America have been going through. It's just flipped back and forth, towards [Black people] or both [Latino and Black people] at the same time.*" (Case manager, Latine, transgender woman)
	Immigration Policies and Enforcement	Perception of increased enforcement of deportation, racial profiling.	Fear of deportation and law enforcement (ICE), restricted mobility, distrust of authorities.	Visiting emergency rooms instead of consulting HIV prevention services, delaying HIV diagnosis and linkage to care.	"*It doesn't happen often in 2024 that people die of HIV complications, but my hypothesis over the next few years is that more undocumented people are gonna die. And undocumented LGBTQ people are gonna die from HIV. . . . The people who die from HIV nowadays are people who are homeless and have a lot going on, and people who are avoiding care for other reasons. And what's the most compelling reason to avoid care? To me, fear of deportation is pretty compelling and it scares the crap out of me.*" (Neighboring county key informant, non-Latine, cisgender woman)

Table 3. *Cont.*

Level of Analysis	Theme	Key Mechanisms of Racialized Legal Status	Manifestations in Lived Experience	Implications for HIV Care	Emblematic Quotes
Macro (Structural/Political)	Federal and state funding	Cuts to HIV services and resources accessible to LWH, defunded health centers and safety-net clinics, siloed funding creating barriers for collaboration.	Burnout and hopelessness of healthcare providers who serve LWH and are unable to meet their needs; disconnect between policymakers and the community, excessive bureaucracy.	Understaffing and lack of resources and infrastructure at HIV services for vulnerable populations, long wait times for appointments, delayed engagement in HIV care, exacerbation of barriers to care like transportation and housing insecurity.	"*The funding landscape is really uncertain. There's a threat in the house in the Senate of reducing or removing parts of HIV funding. And any reduction in funding then cuts down of what we're able to do. So fingers crossed. . . . It may feel more real now in this political environment, but that's always a threat.*" (Neighboring county key informant, non-Latine, cisgender man) "*Before I had a social worker, but with this new administration after January 20th, they prohibited us from communicating with all the social workers, especially us undocumented people.*" (Cisgender man, 46 years old, Guatemala, 15 years in the USA/since immigration)
	Social Services and Support Systems	Restricted and volatile access to social services to meet basic needs due to paperwork requirements and political climate.	Housing and food insecurity, financial instability, lack of transportation.	Barriers in access to HIV care, causing issues in retention in care and adherence to treatment.	"*With transportation, before they had a program where they would send you an Uber when you came to the clinics, you would come and they would send you, but nowadays it's not like that. Because they're short on federal [funds] with this president.*" (Transgender woman, 27 years old, 4 years living with HIV, 6 months living in the US)

Table 3. *Cont.*

Level of Analysis	Theme	Key Mechanisms of Racialized Legal Status	Manifestations in Lived Experience	Implications for HIV Care	Emblematic Quotes
Macro (Structural/Political)	Health insurance and the US health system	Racialized legal status limits eligibility for insurance, restricting access to HIV, primary, and specialty care.	State-dependent safety-net programs provide partial coverage for non-citizen LWH, often excluding mental, oral, and other comorbidity care and remaining vulnerable to defunding.	Restricted or unaffordable ART and HIV services, unmanaged comorbidities, undermining sustained engagement and viral suppression; poor physical and mental health.	"*We have the Maryland AIDS Drug Assistance Program, . . . which pays the premiums for health insurance plans for Latinos to have access to HIV care and just overall medical care and medication, whether they were documented or undocumented in this country. But that was for people living with HIV. Now, people that are not living with HIV, that is the challenge right there. How do they get health insurance? So there's really a lot of work to be done there because they're not eligible for Medicaid.*" (State key informant, Latine, cisgender man)
Meso (Institutional/ Community/Local)	Institutional mistrust	Lack of trust in healthcare facilities, clinics, and healthcare providers.	Reservation in interactions with the health system and sharing identifying information; Hesitancy in disclosing legal status to healthcare providers.	Care avoidance and low-quality care; broken patient-provider relationship; barriers to contact tracing for HIV.	"*I think a lot of that has to do with trust, trusting the system. I think a lot of Latinos that are coming here and a lot of them that I've worked with, they're not documented in this country. Now we're facing a possibility of that previous administration coming back and so there has been a lot of the hesitancy for Latinos to come in for medical care because . . . they're afraid and they don't trust that where they go, they're going to be safe. That's why we need to have a lot more community activists, meaning a priest, the church, a pharmacist because I know a lot of Latinos, they'll go to a pharmacist before they'll go to a doctor and ask for advice.*" (State key informant, Latine, cisgender man)

Table 3. *Cont.*

Level of Analysis	Theme	Key Mechanisms of Racialized Legal Status	Manifestations in Lived Experience	Implications for HIV Care	Emblematic Quotes
Meso (Institutional/ Community/Local)	Institutional response	Collaborating with community and faith-based organizations; reinforcing confidentiality and privacy; providing telehealth and legal services.	Create alternatives for LWH with barriers to access to governmental resources due to lack of insurance, financial means, and paperwork requirements.	Interventions rooted in the community foster trust and improve communication with LWH; straining of safety-net and community resources; provider burnout.	"*As I said, we are now living in atypical times. Many patients are afraid to go to the clinic. They are afraid because they are patients who don't have legal backing, so they are afraid right now of getting caught in one of the ICE raids. We always try to accommodate them, do the interviews, as I was saying, either by phone or by Zoom. And we also try to accommodate them with the schedule.*" (Nurse, Latine, cisgender woman)
Micro (Individual and psychosocial)	Identity and Stigma	Intersection of racialized legal status, HIV stigma, and sexual minority status.	Intersectional stigma (immigrant, HIV-positive, gay) leads to social exclusion.	Delayed disclosure, limited social support, challenges sustaining long-term engagement in care.	"*In the DMV, these are young trans women, mostly from Central America, El Salvador, Guatemala, who left their home countries and had a lot of traumatic experiences there and on the way here, and they have very little resources when they arrive and a lot of trauma. They're treated poorly in every way because of their multiple intersecting identities that are marginalized: they're undocumented, they're trans, they're Latina, and they don't speak English. They don't have a road to immigration status that will keep them safe. So, they're all over the place, right? They're in DC one night, they're in Prince George's for a few days. It's impossible in any of the ways that we normally get in touch with people to find out where they are today.*" (Neighboring county key informant, non-Latine, cisgender woman)

Table 3. *Cont.*

Level of Analysis	Theme	Key Mechanisms of Racialized Legal Status	Manifestations in Lived Experience	Implications for HIV Care	Emblematic Quotes
Micro (Individual and psychosocial)	Psychological and Emotional	Internalized fear of deportation which creates anticipatory stress, chronic uncertainty related to new immigration enforcements.	Traumatic experiences before and during migration cause distress and mental health burden, persistent anxiety, emotional distress, and fear of treatment interruption if deported; reactivation of trauma from homophobia and violence experienced in countries of origin.	Reduced mental well-being, difficulty in trusting providers, avoidance of institutional healthcare systems, fear of losing access to lifesaving ART.	"*. . .there are many other reasons too why sometimes I'm always worried and with anxiety, with everything that's happening right now here in the country. Everything becomes very uncertain, it's scary. With health services, sometimes you also start to think: 'Are these always going to be here, or are they not going to be here? What's going to happen?' Because you know you have a diagnosis that requires treatment that is ongoing.*" (Cisgender man, 41 years old, 17 years living with HIV, 6 months living in the US)
	Coping and Survival Strategies	Individualized response to racialized legal status.	Cultural and traditional beliefs, prioritization of survival needs over preventive care, fatalism and resignation.	Coping without structural relief or without knowing what the end goal/solution is.	"*The only obstacle I think I'm facing is the uncertainty of not knowing what will happen with these new [political] changes. And I think the obstacle becomes uncertainty because we don't know what's going to happen. However, I believe that with everything I try to do, and by behaving well and being a good citizen, that also relaxes me a little, and I say, "Well, if I'm not doing anything wrong, I have no reason to be affected, and whatever God wants will happen.'*" (Cisgender man, 33 years old, 7 years living with HIV, 2 years living in the US)

4. Discussion

RLS shapes the experience of all Latines living in the US, with consequences that intensify as one's position on the legal spectrum -citizen, permanent, temporary, discretionary, or undocumented- increases exposure to political, labor, and social exclusion [5]. Thus, it acts as a fundamental cause of health inequity [3]. RLS has long disproportionately impacted Latine immigrants, reflecting decades of exclusionary immigrant policies that produce structural vulnerability across employment, housing, healthcare, and daily life [3,13]. Our study, set during the transition between two presidential administrations, exemplifies how the political climate intensifies these dynamics. Ongoing policy debate and immigration enforcement strategies will continue to impact physical and mental health outcomes among immigrants through heightened fear, discrimination, restricted healthcare access, and erosion of social support structures [36–38].

Our findings illustrate a multi-level pathway through which social and legal exclusion embedded in racialized legal status (RLS) shapes HIV outcomes. At the macro (structural and political) level, immigration and health policies link insurance eligibility and affordable coverage to legal status, leaving many non-US citizens reliant on Emergency Medicaid and under-resourced safety-net delivery systems, with downstream consequences for delayed diagnosis and suboptimal disease control [39–41]. Systematic exclusion from social services creates compounding barriers as economic instability from restricted work authorization converges with inaccessible safety-net programs [42]. At the micro (psychosocial and individual) level, enforcement-oriented policy environments generate deportation fear, institutional mistrust, and anticipated stigma that discourage routine care and contribute to healthcare avoidance and disengagement from HIV services [18,19,39]. Together, these mechanisms show how systematic political exclusion becomes embodied through institutional barriers and psychosocial pathways that disrupt continuity across the HIV care continuum.

RLS has implications for HIV and other chronic conditions because it influences access to stable coverage and consistent healthcare engagement, shaping prevention, diagnosis, and long-term disease management [7,28]. Our findings demonstrated these dynamics across the legal spectrum: participants with undocumented status, temporary protections, and mixed-status family configurations described shared vulnerabilities (legal insecurity, anticipatory avoidance, care discontinuities) alongside status-specific contours, where partial protections buffered access yet remained undermined by policy volatility and spillover fear [8,9,39]. These mechanisms are not HIV-specific; they shape outcomes for other conditions, including diabetes, hypertension, and other chronic conditions requiring consistent monitoring and medication adherence [13,41]. Future research should move beyond an exclusive focus on undocumented status to examine how a broader spectrum of legal statuses and family configurations shapes HIV outcomes and chronic disease inequities through RLS [5–8].

Beyond these structural barriers, our findings also underscore the importance of addressing persistent HIV-related intersectional stigma as a critical determinant of healthcare engagement and chronic disease management. For LWH, this intersectional stigma may compound the effects of RLS by intensifying fears of judgment, disclosure, and discrimination in healthcare settings and institutional surveillance when seeking care [43]. Our findings further suggest that healthcare institutions play a critical role in either reducing or amplifying the effects of restrictive policies, highlighting the importance of institutional commitment, community engagement, and sustained resources to support equitable HIV care. Together, these results underscore the need for structural responses that account for the compounding effects of intersectional stigma and RLS on equitable access to care. The impact of RLS on HIV exposes a structural impediment to the federal EHE initiative. Each

EHE pillar (i.e., diagnose, treat, prevent, and respond) is compromised when fear, exclusion, and fragmented coverage disrupt HIV care and prevention among key populations, including immigrant populations [44]. The EHE initiative emphasizes a whole-person approach to HIV prevention and care that includes status-neutral approaches for improving engagement across the HIV care continuum. However, recent federal budget proposals and policy changes that reduce funding for HIV prevention and safety-net programs, including proposed reductions to the Ryan White HIV/AIDS Program (RWHAP), and broader restrictions affecting Medicaid and community-based services, threaten the infrastructure needed to implement this whole-person model [44–50]. In EHE jurisdictions with significant Latine communities, federal targets may remain unattainable without explicit attention to legal exclusion and racialization. Policy volatility further endangers the safety-net infrastructure on which LWH depend. RWHAP is critical because it covers populations who are excluded from Affordable Care Act provisions, yet is vulnerable to budget cuts and shifting political priorities [51]. This program becomes increasingly important among policy changes that, if enacted, could revoke Medicaid eligibility for refugees and asylees and eliminate coverage options for Deferred Action for Childhood Arrivals (DACA) recipients [36]. Defunding culturally and linguistically concordant care strategies under the argument of cutting services for "illegal aliens" creates a spillover effect that affects care for all Latines regardless of status [38]. Therefore, achieving EHE goals in jurisdictions like Prince George's County requires protecting Ryan White funding, ensuring safety-net eligibility is not contingent on immigration status, and investing in culturally and linguistically congruent care as core rather than supplementary infrastructure.

Most interventions aimed at addressing the negative effects of RLS on the health of LWH operate at the individual, institutional, and community levels [52]. For example, in our study, providers described telehealth as a strategy to mitigate mobility limitations due to fear of deportation. However, although telehealth increased access to Ryan White services during the COVID-19 pandemic, issues related to digital equity persist [53], and it cannot sustainably address the broader impact of decreased mobility on the well-being of LWH. At the local level, healthcare institutions that serve LWH collaborate with community and faith-based organizations to create alternative safety nets for Latines excluded from governmental resources as a result of their RLS [52]. Non-governmental organizations have fewer constraints in the use of resources and provide an alternative to ineligible individuals [40], and interventions rooted in the community foster trust and improve communication with LWH [20,52]. However, these approaches also place an additional economic burden on already-strained services for underserved communities. Furthermore, only focusing on peer-based, downstream solutions for upstream, structural barriers such as RLS may alleviate immediate needs but does not resolve the root causes of inequity and may create feelings of hopelessness and burnout among providers and healthcare institutions.

Addressing RLS as a political determinant of health among LWH requires multi-level solutions as it operates simultaneously across micro, mesa and macro-levels, often with each level reinforcing the others. Coordinated action across levels is needed to ensure that HIV access to LWH can effectively remain in place and prevent it from becoming destabilized by shifting political and policy priorities and environments. HIV scholars and practitioners must document the effects of RLS on LWH. Explicitly acknowledging RLS as a political determinant of health is essential to strengthening advocacy efforts and mobilizing the political and institutional change necessary to reduce health inequities among LWH and other communities at the intersection of immigration status and chronic disease management.

5. Limitations

This study is not without limitations. LWH who participated in this study were already engaged in HIV care, which may reflect a group with experience navigating complex healthcare systems in the US. Furthermore, the exploration of racialized legal status was an emergent theme, and we did not go into the study specifically intending to examine this political determinant of health. As a result, the data captured are limited. For example, although participants organically discussed immigration, politics, legal status, and identified their race, we did not record participants' legal status, particularly that of LWH, which limits our ability to compare experiences across legal categories. However, this does not negate the value of the findings. The study captures how social exclusion, translated into barriers to HIV care, operates through racialization via victimization, discrimination, restricted mobility, and distrust of authority, compounding formal legal status. In this way, the findings expand our understanding of how being perceived and profiled as Latine may shape chronic disease care management, engagement in services, and overall well-being in the current political context. Additionally, the richness of the data lies in the fact that it emerged as a theme from the changing political landscape between the 2024 US general elections and the 2025 transition of presidential administration.

6. Conclusions

Our study contributes to the growing evidence cementing racialized legal status as a political determinant of health. Health inequities among the Latine community in the US are not naturally occurring; rather, they stem from politically produced exclusionary policy environments that link access to care to an individual's race/ethnicity and legal status. Multilevel approaches are needed to begin reversing the impact of these policies and create an environment of inclusion, centering the voices and lived experiences of the communities most impacted, and addressing the structural conditions that produced and reproduced these inequities. Crucial structural responses include investing in culturally and linguistically congruent care, expanding safety net eligibility and resources, and protecting Ryan White HIV/AIDS Program funding. Future research should continue to extend fundamental cause theory to explicitly incorporate racialized legal status, providing the foundational grounding needed to strengthen advocacy efforts for policy changes that address its consequences on health equity and chronic disease management for Latines across the legal status spectrum, from undocumented to citizen status. Ending the HIV epidemic, and more broadly improving chronic disease management, requires a commitment to whole-person strategies that fully account for how racialized legal status shapes access to equitable care.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of the Johns Hopkins Bloomberg School of Public Health Institutional Review Board Office (Approval Code: IRB00026882; Approval Date: 2024-04-10).

Informed Consent Statement: Oral informed consent was obtained from all participants involved in the study prior to their participation.

Data Availability Statement: Participants did not provide explicit consent for their interview transcripts to be publicly shared. De-identified data are available upon reasonable request from the Johns Hopkins Bloomberg School of Public Health Institutional Review Board, which governed this study, at BSPH.irboffice@jhu.edu.

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