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Deported and Ill:

the story no one wants to tell

Every day, in primary care and specialized clinics, we care for people with diabetes who carry much more than blood glucose numbers. They carry stories of rupture, fear, loss, and silence. Among them is a largely invisible reality: that of deported individuals living with a chronic disease such as diabetes.

Talking about diabetes means talking about continuous care, follow-up, education, and trust. When a person with diabetes faces the threat—or the reality—of deportation, the disease ceases to be merely a **clinical challenge** and becomes a **human experience** marked by fear, **uncertainty**, and the **rupture** of everything that was once familiar.

When we talk about deportation, what exactly do we mean? Deportation is the process through which a person is expelled from a country by an administrative or judicial decision related to their immigration status. Although it is often described in legal terms, in practice it represents a profound disruption of the individual's **life project**. It is not a voluntary return, but a forced departure that leaves little opportunity to prepare drugs, gather clinical reports, or ensure continuity of care.

In the United States, many individuals undergoing deportation proceedings are held in detention centers managed by Immigration and Customs Enforcement (ICE). These centers are not hospitals but custodial facilities where health care is provided in a limited manner and conditioned by the detention environment. During the deportation process, health care generally focuses on urgent issues and basic needs because it is shaped by the context of **deprivation of liberty**, security considerations, and the outsourcing of health services to contracted companies that are not part of the public health system.

People with diabetes in these centers may experience incomplete or delayed initial health evaluations, abrupt changes in treatment, delays in insulin administration, difficulties accessing blood glucose monitoring, and limitations in adapting their diet to their needs. As a result, time spent in these facilities often represents a period of diabetes decompensation, the consequences of which may persist even after deportation.

After deportation, continuity of care is rarely ensured. Many individuals arrive in the destination country without health coverage, without financial resources, and without clear information about how to access the local health system. All of this generates chronic stress, fear, and insecurity, which directly affect glycemic control. Interruption of treatment exposes individuals to a

higher risk of both acute and chronic complications.

Diabetes is not only controlled solely with drugs, but with stability, routines, and support.

Currently, **deportation should be understood as a social determinant of health**. It disrupts therapeutic relationships and exposes individuals to very different health systems, sometimes nonexistent or inaccessible. From the perspective of the social determinants of health, deportation affects:

- Real access to health care before, during, and after the process.
- Economic security and housing.
- Social and family support networks.
- The capacity for self-care, especially in people with chronic diseases such as diabetes.
- Mental health, increasing the risk of anxiety, depression, and posttraumatic stress.

Ignoring deportation as a social determinant of health means turning our backs on a reality that exists outside the consultation room but profoundly shapes what happens inside it. We tend to think of deportation as something we see in the news or on social media—something distant that happens to others. However, **deportation is much closer than we believe**.

It may be part of the history of an adult patient we care for, whose health or illness has been affected or even worsened by treatment interruption and lack of continuity of care. But it also affects children with diabetes who, from one day to the next, are separated from their parents and become administrative orphans in a system that does not always measure the human consequences of its decisions, for whom stability, routine, and family support are essential for disease control.

Recognizing deportation is an essential step toward **advancing more just, equitable, and truly human health care**—care that acknowledges how social and legal processes intersect with the lives of people with diabe- ➤

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» tes and does not leave behind those already in situations of extreme vulnerability.

From the health care sector, we have a key role. Not only as providers of care but also as professionals capable of **"looking beyond the diagnosis"** and understanding the life context of each individual.

"Deportation confronts us with a difficult reality": that an administrative order can break a life, a family, or a life project, but it does not interrupt a chronic disease. Diabetes remains there every day, even when home, treatment, or stability are

lost, and fear prevents people from asking for help. It is necessary to understand that behind every deportation there are bodies that continue to fall ill and people who continue to need care.

Therefore, not only as health professionals but also as human beings, it is essential in our interventions to **listen without judgment**, adapt therapeutic education in a **clear, brief, and understandable way**, and ask directly about real difficulties in accessing medication or necessary supplies. Creating spaces of trust and safety is as important as any pharmaco-

logical adjustment. Sometimes the most therapeutic gesture is simply saying: "I am here to help you". **D**

This article is also based, in addition to the available evidence, on the real testimony of a person with diabetes treated in primary care who experienced a deportation process from the United States and currently resides in the Canary Islands (Spain).

Their experience helps put a face to a largely invisible reality with a clear impact on health.

CONCLUSIONS

1. Deportation represents a serious disruption in diabetes management.
2. Interruption of treatment increases the risk of complications.
3. Stress and social vulnerability negatively affect metabolic control.
4. Health care must be comprehensive, humane, and culturally sensitive.
5. Ensuring access to health care is a matter of public health and human rights.

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