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## THE IMMIGRATION HIV EXCLUSION: AN INEFFECTIVE MEANS FOR PROMOTING PUBLIC HEALTH IN A GLOBAL AGE

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### INTRODUCTION

In recent years, the popular media have bombarded the American public with information about relatively new disease threats. Many of these diseases originated outside the United States. For example, the West Nile Virus, which scientists believe has been in the United States since at least 1999, is thought to be closely related to strains of a virus found in Africa, West Asia, and the Middle East.<sup>1</sup> Since the discovery of West Nile virus in New York City in early 2000,<sup>2</sup> the virus is now recognized as an established seasonal epidemic in the United States.<sup>3</sup> In early 2003, Severe Acute Respiratory Syndrome (“SARS”), which originated in Asia, gained international attention when the illness spread over a few months to more than twenty-four countries, including the United States.<sup>4</sup> Of the eight persons known to be infected with SARS in the United States, all had contracted the highly contagious disease while traveling in other parts of the world.<sup>5</sup> Later that same year, the United States Department of Agriculture (“USDA”) confirmed that bovine spongiform encephalopathy (“BSE”), popularly known as “mad cow” dis-

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<sup>1</sup> Centers for Disease Control & Prevention, Overview of West Nile Virus, at <http://www.cdc.gov/ncidod/dvbid/westnile/qa/overview.htm> (last visited Nov. 13, 2004).

<sup>2</sup> *Id.*

<sup>3</sup> Centers for Disease Control & Prevention, West Nile Virus: What You Need to Know, at [http://www.cdc.gov/ncidod/dvbid/westnile/wnv\\_factSheet.htm](http://www.cdc.gov/ncidod/dvbid/westnile/wnv_factSheet.htm) (last visited Nov. 13, 2004) [hereinafter CDC, West Nile Virus].

<sup>4</sup> Centers for Disease Control & Prevention, Fact Sheet: Basic Information About SARS, at <http://www.cdc.gov/ncidod/sars/factsheet.htm> (last visited Nov. 15, 2004) [hereinafter CDC, SARS Fact Sheet].

<sup>5</sup> *Id.*

ease, had been detected in a cow in Washington State.<sup>6</sup> The infected cow was traced to a herd in Canada.<sup>7</sup> These epidemics seem to have awakened a fear in the United States of foreign public health threats. Yet this is not the first time a foreign disease has raised fears in the United States. More than twenty years ago, Acquired Immune Deficiency Syndrome (“AIDS”), which is thought to have originated in Africa,<sup>8</sup> created a similar media buzz. Today, AIDS, which is caused by the human immunodeficiency virus (“HIV”) has developed into a global epidemic.<sup>9</sup>

Public health law and public health agencies have been charged with combating the threat of disease within the United States.<sup>10</sup> In order to effectively meet this challenge, legislation should be tailored to our knowledge of each disease. To effectively prevent or contain communicable disease, law and policy should treat diseases differently according to various factors such as their method and rate of transmission. For example, while travel restrictions and quarantine may be appropriate measures for a disease such as SARS, which is spread through close person-to-person contact,<sup>11</sup> it would be rash to adopt these measures in an attempt to contain West Nile Virus, which is transmitted primarily by an infected mosquito’s bite.<sup>12</sup> But fear combined with improper conceptions of diseases and the nature and manner of transmission may lead to laws ineffective in achieving public health goals.

Such a law is found in the Immigration and Nationality Act,<sup>13</sup> which defines specific grounds upon which an immigrant or a non-immigrant visitor may be denied entry to the United States.<sup>14</sup> Under

<sup>6</sup> Centers for Disease Control & Prevention, Questions and Answers Regarding Bovine Spongiform Encephalopathy (BSE) and Creutzfeldt-Jakob Disease (CJD), at [http://www.cdc.gov/ncidod/diseases/cjd/bse\\_cjd\\_qa.htm](http://www.cdc.gov/ncidod/diseases/cjd/bse_cjd_qa.htm) (last visited Nov. 13, 2004).

<sup>7</sup> *Id.*

<sup>8</sup> Centers for Disease Control & Prevention, Where Did HIV Come From?, at <http://www.cdc.gov/hiv/pubs/faq/faq3.htm> (last visited Nov. 13, 2004) [hereinafter CDC, Where Did HIV Come From].

<sup>9</sup> UNAIDS & WORLD HEALTH ORGANIZATION, AIDS EPIDEMIC UPDATE 4 (2003) at <http://www.unaids.org/EN/Resources/Publications/Corporate+publications/AIDS+epidemic+update+-+December+2003.asp> (last visited Mar. 23, 2005) [hereinafter UNAIDS, AIDS EPIDEMIC UPDATE] (noting that HIV/AIDS “killed more than three million people in 2003, and an estimated five million acquired the human immunodeficiency virus (HIV)—bringing to forty million the number of people living with the virus” worldwide).

<sup>10</sup> *Id.*

<sup>11</sup> CDC, SARS Fact Sheet, *supra* note 4.

<sup>12</sup> CDC, West Nile Virus, *supra* note 3.

<sup>13</sup> Immigration and Nationality Act, 8 U.S.C.S. § 1182(a) (Law. Co-op. 2004).

<sup>14</sup> *Id.*

this section of the Act, any immigrant or prospective immigrant who is found to have a “communicable disease of public health significance,” including infection with HIV, will be deemed inadmissible to the United States.<sup>15</sup> The power to define the term “communicable disease of public health significance” is delegated to the Secretary of Health and Human Services.<sup>16</sup> Accordingly, the Centers for Disease Control’s National Center for Infectious Disease publishes a list of diseases that meet this definition.<sup>17</sup> This list currently includes eight diseases: tuberculosis, HIV infection, syphilis, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venerum, and Hansen’s disease (leprosy).<sup>18</sup> Of the eight named diseases, HIV infection has been the most controversial.<sup>19</sup>

From a public health law and policy perspective, a provision banning immigrants who test positive for a communicable disease is an ineffective means to promote public health goals both in the United States and abroad. This provision contradicts everything we know about the transmission of HIV/AIDS. Furthermore, the ban goes beyond being just ineffective: It may actually be harmful. The ban may exacerbate the spread of the illness by seriously undermining proven efforts of prevention and control.

This comment seeks to analyze the compatibility of the theory of public health law and policy with public health immigration restrictions. First, it will give a brief history and description of the HIV/AIDS global pandemic and immigration restrictions pertaining to the virus. This comment will next address the practical consequences of the immigration restriction. A discussion of the general policies and goals of public health law and a discussion of models of communicable disease will follow. Finally, this comment will analyze the immigration ban under each of the models, and will conclude with suggestions for the future.

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<sup>15</sup> § 1182(a)(1)(A)(i).

<sup>16</sup> § 1182(a)(1)(A)(iii).

<sup>17</sup> Centers for Disease Control & Prevention, Communicable Diseases of Public Health Significance, at <http://www.cdc.gov/ncidod/dg/diseases.htm> (last visited Nov. 13, 2004).

<sup>18</sup> *Id.*

<sup>19</sup> See Juan P. Osuna, *The Exclusion from the United States of Aliens Infected with the AIDS Virus: Recent Developments and Prospects for the Future*, 16 HOUS. J. INT’L L. 1, 2 (1993) (noting that HIV exclusion has been one of the most controversial and volatile issues in immigration law).

**I. BACKGROUND: THE GLOBAL PANDEMIC OF HIV/AIDS, IMMIGRATION RESTRICTIONS, AND PUBLIC HEALTH**

**A. HIV: Emergence in the U.S. and Abroad and the Response of Public Health Officials and Agencies**

In an age of increasing globalization, the borders drawn by individual nation-states are less and less effective in protecting those residing within them from contagious disease.<sup>20</sup> The United States' public health and prevention measures may be inadequate, in and of themselves, to combat an epidemic exacerbated by globalization.<sup>21</sup> In fact, many public health experts concur that national and international public health are indistinguishable as a result of globalization trends.<sup>22</sup> One of the causes of the spread of disease that can be attributed to globalization is the movement of people and goods across borders.<sup>23</sup> Thus, in analyzing the effects of any legislation that attempts to promote public health goals, it is important to consider both domestic and global public health efforts.

In the case of AIDS, analyzing the history and pattern of transmission, along with the differing attempts to contain transmission, may be helpful in understanding how public health law and agencies can better contain the disease. AIDS is caused by HIV.<sup>24</sup> AIDS infection results in the weakening of the body's immune system, causing the person infected with HIV to be highly susceptible to

<sup>20</sup> See Holly Rogers, *Protecting Americans from Disease in a Global Society*, 22 SUFFOLK TRANS-NAT'L L. REV. 205, 205 (1998) (noting that "globalization has exposed the world to increased transportation and commerce, diminished significance of international borders, and strengthened influence of international authority," thereby increasing Americans' vulnerability to disease).

<sup>21</sup> See *id.* at 207-08 (noting that although the United States has effectively utilized public health and technology to fight disease within its borders, this success is threatened by the significantly lower standards of health care in many developing countries as well as complacency in the United States).

<sup>22</sup> David P. Fidler, *The Globalization of Public Health: Emerging Infectious Diseases and International Relations*, 5 IND. J. GLOBAL LEG. STUD. 11, 11 (1997).

<sup>23</sup> See Rogers, *supra* note 20, at 208-09 (citing human travel across borders as well as the adoption of free trade agreements that increase international traffic through "reduced barriers to trade"). See also Scott Burris, *Law as a Structural Factor in the Spread of Communicable Disease*, 36 HOUS. L. REV. 1755, 1762-63 (1999) ("Travel, trade, and the migration of human populations have historically spread disease. The impact of European diseases like smallpox upon the original inhabitants of the Americas was catastrophic. . . . [E]very day more than one million people cross a border from one nation to another.") [hereinafter Burris, *Law as a Structural Factor*].

<sup>24</sup> Centers for Disease Control & Prevention, What Is HIV?, at <http://www.cdc.gov/hiv/pubs/faq/faq1.htm> (last visited Nov. 13, 2004) [hereinafter CDC, What Is HIV].

infectious diseases and cancers.<sup>25</sup> HIV is transmitted from person to person by contact of an infected person's blood, semen, or vaginal secretion with another individual's mucous membranes or blood.<sup>26</sup> Commonly known means of transmission include unprotected sexual behaviors; contact with infected blood by needle sharing; and transmission from a mother to a child during breastfeeding or childbirth.<sup>27</sup> Shortly after transmission, the body begins to produce antibodies to the HIV virus.<sup>28</sup> Tests for HIV detect the presence of these antibodies in the bloodstream.<sup>29</sup> But tests are generally unable to immediately detect the virus, and it may take up to six months for an HIV-infected person to test positive for the virus.<sup>30</sup> During this period, the HIV-infected person is capable of transmitting the virus to others.<sup>31</sup>

The earliest cases of HIV/AIDS are thought to have occurred in Africa in the late 1950s.<sup>32</sup> In the United States, the first cases were detected in the late 1970s and early 1980s, primarily among homosexual men.<sup>33</sup> From what scientists believe to have been a single virus,<sup>34</sup> the AIDS epidemic has grown both globally and in the United States at alarming rates. Five million people acquired HIV in 2003, and 3 million people are estimated to have died as a result of AIDS that same year.<sup>35</sup> The total number of people living with HIV worldwide rose to 40 million in 2003.<sup>36</sup> In the United States, from 1981 through 2001, 1.3 to 1.4 million people were infected with HIV.<sup>37</sup> In

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<sup>25</sup> Faith G. Pendleton, *The United States Exclusion of HIV-Positive Aliens: Realities and Illusions*, 18 SUFFOLK TRANSNAT'L L. REV. 269, 270 (1995) [hereinafter Pendleton, *U.S. Exclusion of HIV-Positive Aliens*].

<sup>26</sup> CDC, *What Is HIV*, *supra* note 24.

<sup>27</sup> Centers for Disease Control & Prevention, *HIV and AIDS: Are You at Risk?*, at <http://www.cdc.gov/hiv/pubs/brochure/atrisk.htm> (last visited Nov. 13, 2004).

<sup>28</sup> Pendleton, *U.S. Exclusion of HIV-Positive Aliens*, *supra* note 25, at 270.

<sup>29</sup> *Id.* at 270–71.

<sup>30</sup> *Id.* at 271.

<sup>31</sup> *Id.*

<sup>32</sup> See CDC, *Where Did HIV Come From*, *supra* note 8 (noting that a blood sample collected from a man in 1959 from the Democratic Republic of Congo provided the earliest identification of the modern HIV-1 virus, which may have been around as early as the 1940s or 1950s).

<sup>33</sup> *Id.*

<sup>34</sup> See *id.* (noting a genetic analysis of the blood sample collected from the earliest known individual with AIDS indicates that HIV-1 may have originated from a single virus).

<sup>35</sup> UNAIDS, *AIDS EPIDEMIC UPDATE*, *supra* note 9, at 4.

<sup>36</sup> *Id.*

<sup>37</sup> Centers for Disease Control & Prevention, *Advancing HIV Prevention: New Strategies for a Changing Epidemic—United States 2003*, in *MORBIDITY & MORTALITY WEEKLY REP.*, Apr. 18,

the history of the epidemic in the United States, the Centers for Disease Control (“CDC”) received reports of 816,149 cases of AIDS and 467,910 deaths from AIDS.<sup>38</sup> Of those living with HIV in the United States, it is estimated that one third are unaware that they are HIV-positive.<sup>39</sup> In the United States, public and private health organizations have attempted to stymie the epidemic, primarily through HIV testing and counseling.<sup>40</sup> Additionally, agencies continue to use various measures generally proven to be effective in combating other sexually transmitted diseases, such as education, appropriate routine screening, identification of new cases, partner notification, and access to treatment and prevention services for those infected.<sup>41</sup>

Globally, HIV prevention efforts face different challenges than those in the United States and other developed countries.<sup>42</sup> The principal difference between prevention efforts in developed countries (including the United States) and the developing world is perhaps our relative wealth.<sup>43</sup> Current movements in the international community point to a human rights-oriented approach to the AIDS/HIV epidemic in the global arena.<sup>44</sup> Poverty and disease feed off each other in the developing world.<sup>45</sup> Disease itself can lead to the

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2003, at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5215a1.htm> (last visited Nov. 13, 2004) [hereinafter CDC, *Advancing HIV Prevention*].

<sup>38</sup> *Id.*

<sup>39</sup> The White House, *The HIV/AIDS Epidemic: 20 Years in the U.S.*, at <http://www.whitehouse.gov/onap/facts.html> (last visited Nov. 13, 2004) (estimating that 900,000 people in the United States are living with HIV, and that 300,000 are unaware they are carrying the virus).

<sup>40</sup> Scott Burris, *Law and the Social Risk of Health Care: Lessons from HIV Testing*, 61 ALB. L. REV. 831, 833 (1997) [hereinafter Burris, *Social Risk of Health Care*].

<sup>41</sup> CDC, *Advancing HIV Prevention*, *supra* note 37.

<sup>42</sup> See UNAIDS, AIDS EPIDEMIC UPDATE, *supra* note 9, at 4 (naming poverty, marginalization, lack of education, and lack of access to antiviral drug therapy as unique challenges faced in the developing world).

<sup>43</sup> See J.M. Spectar, *The Hybrid Horseman of the Apocalypse: The Global AIDS Pandemic and the North-South Fracas*, 29 GA. J. INT'L & COMP. L. 253, 259 (explaining the cycle between poverty and disease in the developing world where widespread disease cripples the economic, social, and political structures of governments, in turn creating more poverty). See also Burris, *Law as a Structural Factor*, *supra* note 23, at 1785 (asserting that, “Within our own borders, our best protection against infectious disease is relative wealth, which gives us the information, the motivation, and the capacity to lead maximally safe lives.”).

<sup>44</sup> UNAIDS, HIV/AIDS, Human Rights & Law, at [http://www.unaids.org/en/in+focus/hiv\\_aids\\_human\\_rights.asp](http://www.unaids.org/en/in+focus/hiv_aids_human_rights.asp) (last visited Nov. 13, 2004) (reporting that “[s]everal years of experience in addressing the HIV/AIDS epidemic have confirmed that the promotion and protection of human rights constitute an essential component in preventing transmission of HIV, reducing vulnerability to infection and the impact of HIV/AIDS.”) [hereinafter UNAIDS, HIV/AIDS, Human Rights & Law].

<sup>45</sup> Spectar, *supra* note 43, at 258–59.

destabilization of developing countries.<sup>46</sup> Under this theory, it is believed that prevention can be attained through protecting human rights and confronting the structural factors that create vulnerability to disease in a given population.<sup>47</sup>

### **B. Restricting Travel and Migration of HIV-Positive Individuals: History and Modern Developments of the Public Health Exclusion Under Immigration Law**

Since becoming aware of HIV/AIDS as an emerging infectious disease, nations have attempted, against the urging of the World Health Organization (“WHO”), to restrict the movement of persons who are infected with HIV/AIDS.<sup>48</sup> Legislation varies from country to country: “[S]ome have imposed restrictions on all aliens that have tested positive for HIV, while other nations have imposed testing requirements as conditions for entry, denying entry to those who test positive for the virus.”<sup>49</sup> Sixty countries around the world require HIV tests for specific noncitizen individuals who wish to enter the country.<sup>50</sup>

The first intersection of contagious disease law and immigration law in the United States appeared in the 1891 Act.<sup>51</sup> Under this act, “persons suffering from a loathsome or dangerous contagious disease” could be excluded from the United States on those grounds.<sup>52</sup> Under this law, loathsome diseases were defined subjectively as “those whose presence excites abhorrence in others and

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<sup>46</sup> See *id.* (noting that the spread of AIDS in the developing nations of Africa drives poverty, which in turn drives the spread of AIDS). “At the onset of the epidemic, HIV/AIDS was mainly seen as a serious health threat. However . . . the pandemic is now considered a ‘development crisis.’” *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> Sarah N. Qureshi, *Global Ostracism of HIV-Positive Aliens: International Restrictions Barring HIV-Positive Aliens*, 19 MD. J. INT’L L. & TRADE 81, 82 (1995). “[D]uring the past decade, countries all over the world have set up barriers against those with AIDS to ‘protect’ their citizens from the spread of the disease, despite the constant admonitions of the World Health Organization.” *Id.*

<sup>49</sup> *Id.* at 81.

<sup>50</sup> AIDS Education Global Information System, *Traveling with HIV*, at <http://www.aegis.com/topics/travel.html> (last visited Nov. 13, 2004). Each country listed indicates the specific group required to be tested. Groups range from mine workers in South Africa, to anyone suspected of being HIV positive in Colombia. It is unclear in many of the listings what the effect of a positive test would be on entry. *Id.*

<sup>51</sup> Osuna, *supra* note 19, at 6.

<sup>52</sup> *Id.*

which are essentially chronic.”<sup>53</sup> Dangerous contagious diseases were defined by example.<sup>54</sup> Due to this new legislation, public health officials began providing medical inspections of immigrants at major United States ports of entry.<sup>55</sup> These first examinations were conducted on only a small percentage of arriving immigrants and resulted in few exclusions.<sup>56</sup> In 1952, Congress implemented the Immigration and Nationality Act (“INA”).<sup>57</sup> In its original 1952 form, the INA contained thirty-one grounds of exclusion, including health grounds such as aliens infected with a “dangerous contagious disease,” as delineated by the United States Public Health Service (“PHS”) of the CDC under the Department of Health and Human Services.<sup>58</sup> Until 1990, the procedure for determination of contagious diseases that were excludable remained essentially the same, leaving the PHS in control of the designation.<sup>59</sup>

In the late 1980s, when the AIDS/HIV epidemic was thrust into the public eye, the PHS began to debate adding AIDS to the list of dangerous contagious diseases, which then included chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, infectious syphilis, infectious leprosy, and infectious tuberculosis.<sup>60</sup> In June of 1987, the PHS added AIDS to the list of excludable contagious diseases.<sup>61</sup> In considering whether to add AIDS, the PHS also proposed adding HIV to the list in place of AIDS.<sup>62</sup> The rationale behind this proposal stemmed from the fact that HIV-infected aliens were capable of transmitting the HIV virus that would ultimately develop into AIDS.<sup>63</sup> The Senate subsequently passed an amendment to compel the President to add HIV to the list in place of

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<sup>53</sup> Amy L. Fairchild & Eileen Tynan, *Policies of Containment: Immigration in the Era of AIDS*, 84 AM. J. OF PUB. HEALTH 2011, 2019 n.5 (1994) (citing A.C. Reed, *The Medical Side of Immigration*, 80 POPULAR SCI. MONTHLY 384, 388 (1912)).

<sup>54</sup> See *id.* (giving examples of dangerous contagious diseases, including trachoma, filariasis, hookworm infection, amoebic dysentery, and endemic hematuria).

<sup>55</sup> *Id.* at 2011.

<sup>56</sup> *Id.* “At Ellis Island, only a few seconds were devoted to the examination of each arrival, and . . . only 1% to 3% of immigrants were ‘marked’ for more careful inspection [and] exclusion on the basis of medical examination was rare.”

<sup>57</sup> Osuna, *supra* note 19, at 7.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.* at 8.

<sup>61</sup> *Id.*

<sup>62</sup> Osuna, *supra* note 19, at 8.

<sup>63</sup> *Id.*

AIDS.<sup>64</sup> In August 1987, the PHS replaced AIDS with HIV on the list of contagious diseases.<sup>65</sup> To an extent, the addition of HIV to the list of dangerous contagious diseases reflected a consistency in the law, because the former list of communicable diseases of public health significance had included several sexually transmitted diseases since the 1952 enactment.<sup>66</sup> But the amendment itself was inconsistent with the way the INA had traditionally allowed for designation of excludable diseases.<sup>67</sup> It gave the Senate the power to designate and add a disease to the existing list of excludable diseases.<sup>68</sup> Restricting HIV-infected individuals' travel and immigration to the United States spurred a domestic and international controversy.<sup>69</sup>

The enforcement of this regulation required testing of immigrants and others seeking admission to the United States.<sup>70</sup> Those required to be tested under the PHS guidelines fell into four categories: (1) those who were coming on immigrant or fiancé visas; (2) refugees; (3) applicants who were applying for legalization under the Immigration Reform and Control Act of 1986; and (4) applicants already present in the United States who were applying for an adjustment of status to permanent residency.<sup>71</sup> Significantly, the PHS guidelines did not require the testing of nonimmigrants, which includes aliens visiting the United States on visas for business or travel who are not seeking permanent residence or citizenship in the United States.<sup>72</sup> However, Immigration and Naturalization Services ("INS") was permitted to require a test if an alien in this class was suspected of being infected with HIV.<sup>73</sup>

In 1990, Congress reacted to the criticism on the statutory HIV exclusion and eliminated the congressional ban on HIV, allowing

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<sup>64</sup> See Peter A. Barta, *Lambskin Borders: An Argument for the Abolition of the United States' Exclusion of HIV-Positive Immigrants*, 12 GEO. IMMIGR. L.J. 323, 327 (1998) (the amendment was passed 96-0 with little discussion, debate, or study).

<sup>65</sup> Osuna, *supra* note 19, at 11-12.

<sup>66</sup> See Barta, *supra* note 64, at 326 (listing several sexually transmitted diseases as "dangerous contagious diseases" that triggered the immigration bar).

<sup>67</sup> *Id.* at 327.

<sup>68</sup> *Id.*

<sup>69</sup> See *id.* at 327-28 (noting that regulation "jeopardized international scientific cooperation, embarrassed the United States in the international health community, and invited retaliation against HIV-positive Americans traveling abroad").

<sup>70</sup> See Osuna, *supra* note 19, at 9 (stating that Immigration and Naturalization Services and the State Department began testing persons for the HIV virus in 1987).

<sup>71</sup> *Id.* at 9-10.

<sup>72</sup> *Id.* at 5, 11.

<sup>73</sup> *Id.*

the PHS to resume the power to define “communicable disease[s] of public health significance” under the INA.<sup>74</sup> The CDC recommended that all of the diseases on the exclusion list, except for contagious tuberculosis, be removed.<sup>75</sup> In January of 1991, the Secretary of Health and Human Services also recommended that HIV be dropped from the immigration exclusion list.<sup>76</sup> On the other side of the debate, many legislators were receiving pressure from their constituents, who feared a flood of HIV-positive immigrants would lead to an AIDS epidemic in the states.<sup>77</sup> Other arguments for the continuing exclusion of HIV-positive immigrants centered upon doubts as to the healthcare industry’s ability to shoulder a large influx of HIV and AIDS infected immigrants.<sup>78</sup> In the face of the heated controversy, the PHS did not follow the recommendations of the Secretary for the Department of Health and Human Services, nor did it delete any diseases from the list.<sup>79</sup> Thus, HIV and other sexually transmitted diseases continued to be a ground of exclusion for immigrants.<sup>80</sup>

In 1992, the debate surrounding the inclusion of HIV as an excludable disease resurfaced again in the National Institutes of Health Revitalization Bill (“Health Revitalization Bill”).<sup>81</sup> The Health Revitalization Bill contained an amendment which provided that “‘notwithstanding any other provisions of law, regulation or directive,’ HIV would constitute ‘a communicable disease of public health significance’ for purposes of the health-related exclusion grounds under the Immigration Act of 1990.”<sup>82</sup> Thus, the effect of the amendment contained in the Health Revitalization Bill was to once again take the power to define excludable diseases from Health and Human Services and delegate that power to Congress.<sup>83</sup>

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<sup>74</sup> Barta, *supra* note 64, at 328.

<sup>75</sup> *Id.*

<sup>76</sup> *See id.* at 328–29. (The Secretary argued that “[t]he risk of (or protection from) HIV infection comes not from the nationality of the infected person, but from the specific behaviors that are practiced . . . . Our best defense against further spread of HIV infection, whether from a U.S. citizen or alien, is an educated public.”).

<sup>77</sup> *See id.* at 329–30 (noting that fifty-seven Republican legislators sent a letter to the Secretary of Health and Human Services asking him to reconsider removing HIV from the list of excludable diseases).

<sup>78</sup> *Id.* at 330.

<sup>79</sup> Barta, *supra* note 64, at 330.

<sup>80</sup> *See id.*

<sup>81</sup> *Id.* at 336.

<sup>82</sup> *Id.* at 336.

<sup>83</sup> *Id.*

The amendment passed in 1993, and the provision took the effect of a statutory mandate.<sup>84</sup>

With the passage of the Health Revitalization Act, a provision was added that allowed HIV-positive immigrants and nonimmigrants to obtain discretionary waivers from INS.<sup>85</sup> Immigrants and nonimmigrants are subject to different requirements when applying for this waiver.<sup>86</sup> A nonimmigrant is subject to the provisions found at INA § 212(d)(3).<sup>87</sup> When deciding whether or not to grant a waiver to a nonimmigrant, the INS, now broken into separate agencies for enforcement and immigration services and located in the Department of Homeland Security,<sup>88</sup> requires the adjudicating officer to take into account several nonbinding factors, including “whether the person seeking admission (1) is currently afflicted with symptoms of the disease; (2) is coming to the United States for a short visit; (3) has insurance or assets that will enable the person to pay medical expenses should he or she become ill; (4) and whether there is a reason to believe that the person poses a danger to the public health. . . .”<sup>89</sup>

For aliens seeking to enter the United States as immigrants, the requirements for granting a waiver are more stringent. In this case, the applicant must meet the requirements set out in INA 212(g): the applicant must be “the spouse or unmarried son or daughter or the minor, unmarried adopted child of a U.S. citizen or Lawful Permanent Resident (“LPR”) or “have a son or daughter or lawfully adopted child who is a U.S. Citizen or LPR;” or the applicant must be “eligible for classification as a self-petitioning spouse or child (in-

<sup>84</sup> Barta, *supra* note 64, at 338-39.

<sup>85</sup> *Id.* at 341.

<sup>86</sup> Immigration and Nationality Act §§ 212(d)(3), 212(g), 1182(d)(3), 1182(g) (Law. Co-op. 2004).

<sup>87</sup> §§ 212(d)(3), 1182(d)(3).

<sup>88</sup> See Issue Paper, American Immigration Lawyers Association, Immigration and the Department of Homeland Security: Challenges and Changes (2004), available at <http://www.aila.org/fileViewer.aspx?docID=9844> (last visited Nov. 13, 2004) (noting that the President upon signing of the Homeland Security Act, transferred INS functions to the new Department of Homeland Security and designated the Directorate of Border and Transportation Security (“BTS”) to deal with enforcement functions through Immigration and Customs Enforcement (“ICE”) and the U.S. Customs and Border Protection (“CBP”) and service functions through United States Citizenship and Immigration Services (“USCIS”).

<sup>89</sup> Barta, *supra* note 64, at 341 (citing INS Cable HQ 235-C, Aug. 19, 1993, reprinted in 71 INTERP. REL. 653 (May 16, 1994)).

cluding your derivative children) because of abuse.”<sup>90</sup> Once the family relationship requirement is met, the alien seeking admission as an immigrant must also show that

the danger to the public health created by the alien’s admission to the United States is minimal; the possibility of spread of disease created by the person’s admission to the United States is minimal; and there will be no additional cost incurred by any level of government agency of the United States without prior consent of that agency.<sup>91</sup>

In 1995 the INS issued a memorandum explaining how an applicant can meet the above mentioned grounds.<sup>92</sup> To meet the first two prongs, an applicant may submit, in addition to a personal statement, a statement from a counselor or physician describing his or her knowledge of the disease and familiarity with its modes of transmission.<sup>93</sup> Proving that the applicant will not burden the healthcare system of the United States is much more difficult.<sup>94</sup> The best way to overcome this third prong is through proof of private insurance.<sup>95</sup> However, it can be difficult or impossible for an applicant to obtain private health insurance due to the fact that HIV infection may be seen as a pre-existing condition.<sup>96</sup>

### C. HIV Infected Immigrants and Visitors: Practical Operation of the Exclusion.

Each year millions of individuals enter the United States from abroad as immigrants, visitors (nonimmigrants), or returning United States citizens.<sup>97</sup> Additionally, millions of aliens who enter

<sup>90</sup> See U.S. Citizenship & Immigration Services, U.S. Dep’t of Homeland Sec., Medical Examinations, at [http://uscis.gov/graphics/medical\\_exam.htm](http://uscis.gov/graphics/medical_exam.htm) (last visited Nov. 13, 2004) (summarizing Immigration and Nationality Act § 212(g)). See also Immigration and Nationality Act §§ 209(c), 1159(c) (Law. Co-op 2004) (allowing waiver for refugees and asylees if the waiver is for public interest, family unity or humanitarian purposes); Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386 (Oct. 28, 2000) (showing Immigration and Nationality Act § 212(g) waiver amended to include provision for waiver for battered spouse or child of a U.S. citizen or LPR).

<sup>91</sup> Barta, *supra* note 64, at 341–42.

<sup>92</sup> GAIL PENDLETON, HIV AND IMMIGRANTS: A MANUAL FOR AIDS SERVICE PROVIDERS 11 (1997) [hereinafter PENDLETON, HIV AND IMMIGRANTS].

<sup>93</sup> *Id.* at 11–12.

<sup>94</sup> *Id.* at 12.

<sup>95</sup> *Id.*

<sup>96</sup> *Id.* at 13.

<sup>97</sup> See OFFICE OF IMMIGRATION STATS., DEP’T OF HOMELAND SEC., 2002 YEARBOOK OF IMMIGRATION STATISTICS 3 (2003), available at <http://uscis.gov/graphics/shared/aboutus/statistics/Yearbook2002.pdf> (last visited Nov. 13, 2004) (listing immigrant admissions for 2002 at 1,063,732 and nonimmigrant admissions at 27.9 million).

the United States as unauthorized immigrants, or visitors who entered legally under visas, may remain past their date of authorization.<sup>98</sup> Of these individuals, who is subject to exclusion on the grounds of HIV-positive status?

To examine how the HIV exclusion operates in practice, it is helpful to discuss individuals entering from abroad into the United States as falling into eight distinct categories: Immigrants entering as LPRs; applicants for adjustment of status; nonimmigrants; refugees; asylum seekers; unauthorized immigrants; returning LPRs; and returning United States citizens.<sup>99</sup> Some of the categories require the individual to submit to a medical examination to prove admissibility to the United States on medical grounds.<sup>100</sup> The medical examination includes a blood test for all individuals fifteen years of age or older.<sup>101</sup> Additionally, individuals under age fifteen may be tested for HIV if the physician suspects that the patient may be infected.<sup>102</sup>

Immigrants seeking admission into the United States as lawful permanent residents apply through a consulate abroad and become lawful permanent residents at the moment they gain admission through a port of entry to the United States.<sup>103</sup> LPR status is gained through a variety of ways.<sup>104</sup> A United States citizen's family member or a United States employer may petition for the immigrant.<sup>105</sup> Additionally, an individual may receive LPR status either by being chosen in a lottery or through a special law for battered spouses and children of LPRs or United States citizens.<sup>106</sup> In 2002, some 384,427 new immigrants entered the United States.<sup>107</sup> These immigrants were required to undergo a medical exam abroad which tested them for HIV infection.<sup>108</sup> Likewise, an immigrant already within the United States may apply for LPR status through an adjustment of

<sup>98</sup> See *id.* at 213 (estimating that 7 million unauthorized immigrants were living in the U.S. as of January 2000).

<sup>99</sup> See U.S. Citizenship & Immigration Services, *supra* note 90.

<sup>100</sup> See *id.* (listing adjustment of status applicants, K and V nonimmigrant (temporary) visa applicants, refugees, refugee adjustment applicants, asylees, and asylee adjustment applicants as required to have a medical exam).

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> OFFICE OF IMMIGRATION STATS., *supra* note 97, at 4.

<sup>104</sup> *Id.*

<sup>105</sup> PENDLETON, HIV AND IMMIGRANTS, *supra* note 92, at 10.

<sup>106</sup> *Id.*

<sup>107</sup> OFFICE OF IMMIGRATION STATS., *supra* note 97, at 6-7.

<sup>108</sup> See U.S. Citizenship & Immigration Services, *supra* note 90.

status application.<sup>109</sup> In 2002, 679,305 individuals were admitted to the United States under the adjustment of status application.<sup>110</sup> These individuals were similarly required to undergo a medical examination in the United States which tested for HIV.<sup>111</sup> Any immigrant or adjustment of status applicant who tests positive for HIV will not be granted LPR status unless they apply for and obtain a waiver.<sup>112</sup> Many applicants for adjustment, specifically those who do not have a qualifying family member under the INA section 212(g) waiver, will not be eligible for the waiver.<sup>113</sup>

A nonimmigrant is defined as “an alien admitted to the United States for a specified purpose and temporary period but not for permanent residence.”<sup>114</sup> In 2002, the United States admitted more than 27.9 million nonimmigrants.<sup>115</sup> With the exception of individuals holding K and V visas,<sup>116</sup> a medical exam is not required for nonimmigrants.<sup>117</sup> However, HIV-positive status remains a ground of exclusion for all noncitizens and non-LPRs, and these individuals must apply for a visa to enter the country legally.<sup>118</sup> In the process of visa application, United States Citizenship and Immigration Services (“USCIS”) relies on self disclosure to detect individuals infected with HIV who are attempting to enter the United States.<sup>119</sup> This presents a special problem for HIV-positive individuals seeking nonimmigrant visas. If the individual indicates that he or she is not HIV-positive in order to obtain a visa, the application may be denied for fraud.<sup>120</sup> However, if the individual indicates that he or she is HIV-positive, the application will be denied unless the indi-

<sup>109</sup> See OFFICE OF IMMIGRATION STATS., *supra* note 97, at 7.

<sup>110</sup> *Id.*

<sup>111</sup> U.S. Citizenship & Immigration Services, *supra* note 90.

<sup>112</sup> PENDLETON, HIV AND IMMIGRANTS, *supra* note 92, at 4.

<sup>113</sup> Immigration and Nationality Act § 212(g) (Law. Co-op. 2004).

<sup>114</sup> OFFICE OF IMMIGRATION STATS., *supra* note 97, at 82.

<sup>115</sup> *Id.*

<sup>116</sup> See U.S. Citizenship & Immigration Services, *supra* note 90 (explaining that medical examinations are required for K visas, which are nonimmigrant visas for fiancés or spouses of United States citizens and V visas, which are for the spouse or child of LPRs).

<sup>117</sup> *Id.*

<sup>118</sup> PENDLETON, HIV AND IMMIGRANTS, *supra* note 92, at 3–4.

<sup>119</sup> SAN FRANCISCO AIDS FOUNDATION, *Basic Information about HIV and Immigrants*, in HIV & IMMIGRANTS: A MANUAL FOR AIDS SERVICE PROVIDERS 19, available at [http://www.nationalimmigrationproject.org/HIV/2004HIVManual/HIVpdfno\\_brwn.pdf](http://www.nationalimmigrationproject.org/HIV/2004HIVManual/HIVpdfno_brwn.pdf) (last visited Jan. 28, 2005) (explaining that individuals coming to the United States as nonimmigrants to study, work, or visit must fill out a nonimmigrant visa application which asks if they have ever been afflicted with a communicable disease of public health significance).

<sup>120</sup> *Id.*

vidual can secure a waiver.<sup>121</sup> Additionally, if an Immigration and Customs Enforcement (“ICE”) officer suspects that the person is HIV-positive, the officer may deny entry unless the individual asks for a waiver.<sup>122</sup> An officer may, for example, suspect that a nonimmigrant is HIV-positive if he finds HIV medicine or literature in the individual’s luggage.<sup>123</sup>

A refugee is an individual outside of the United States “who is unable or unwilling to return to his or her country of nationality because of persecution or a well founded fear of persecution.”<sup>124</sup> In 2002, nearly 27,000 refugees arrived in the United States.<sup>125</sup> Refugees are required to undergo the medical examination while outside of the United States.<sup>126</sup> One year after arrival in the United States, refugees may apply for LPR status.<sup>127</sup> At the time of application, they will not be required to repeat the medical examination, unless a medical ground of inadmissibility is subsequently discovered.<sup>128</sup> An asylum seeker must meet the same definition as a refugee; however, an asylum seeker applies for refugee status from within the United States.<sup>129</sup> In 2002, 89,726 individuals filed asylum applications; of those applications, 18,652 individuals were granted asylum in the United States.<sup>130</sup> Asylum seekers within the United States are not required to undergo a medical exam.<sup>131</sup> However, individuals who are granted asylum are eligible to adjust to LPR status after one year, at which time they will be required to undergo the medical examination.<sup>132</sup> If HIV is detected during this exam, they will be required to obtain a waiver similar to that required for all adjustment of status applicants.<sup>133</sup>

Unauthorized immigrants are “foreign-born persons who entered the United States without inspection, or who violated the terms of a temporary admission and who have not acquired LPR

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<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.* at 19.

<sup>124</sup> OFFICE OF IMMIGRATION STATS., *supra* note 97, at 49.

<sup>125</sup> *Id.* at 52.

<sup>126</sup> U.S. Citizenship & Immigration Services, *supra* note 90.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> OFFICE OF IMMIGRATION STATS., *supra* note 97, at 54.

<sup>130</sup> *Id.* at 60.

<sup>131</sup> U.S. Citizenship & Immigration Services, *supra* note 90.

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

status or gained temporary protection against removal by applying for an immigration benefit.<sup>134</sup> It is estimated that there were 7 million unauthorized immigrants residing in the United States as of 2000.<sup>135</sup> Unauthorized immigrants who crossed the border without inspection have subverted the ordinary visa or immigrant application procedure. These individuals may likewise subvert the medical examination required of authorized immigrants and visitors. Immigrants and nonimmigrants who entered legally through immigrant or nonimmigrant visa procedures have either been tested or questioned regarding their HIV status.<sup>136</sup> Immigration and Customs Enforcement may remove unauthorized immigrants for HIV-positive status if they entered the United States without permission.<sup>137</sup> However, it is much easier for ICE to remove individuals on the grounds of an unauthorized entry into the United States than it is to remove them for being HIV-positive.<sup>138</sup> Accordingly, most individuals in this position are removed from the United States on immigration grounds as opposed to public health grounds.<sup>139</sup>

LPRs returning from visits abroad generally may not be denied re-entry to the United States because of HIV-positive status.<sup>140</sup> However, if an LPR has been absent from the United States for 180 days or more, or has committed certain crimes, he or she may be subject to the grounds of inadmissibility, including the HIV and other public health exclusions.<sup>141</sup> United States citizens returning from abroad are not subjected to HIV testing or exclusion upon re-entry to the United States.<sup>142</sup>

Thus, it is clear that there are large gaps in the process of admitting HIV-positive individuals from abroad to the United States. For example, of those who enter the United States legally from abroad, only a small percentage are actually required to be tested

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<sup>134</sup> OFFICE OF IMMIGRATION STATS., *supra* note 97, at 213.

<sup>135</sup> *Id.*

<sup>136</sup> See U.S. Citizenship and Immigration Services, *supra* note 90. See also SAN FRANCISCO AIDS FOUNDATION, *supra* note 119, at 19 (explaining that noncitizens seeking LPR status must undergo a medical exam including an HIV test or have been asked, "Have you ever been afflicted with a communicable disease of public health significance?").

<sup>137</sup> PENDLETON, HIV AND IMMIGRANTS, *supra* note 92, at 4.

<sup>138</sup> *Id.*

<sup>139</sup> *Id.*

<sup>140</sup> *Id.* at 5.

<sup>141</sup> *Id.*

<sup>142</sup> PENDLETON, HIV AND IMMIGRANTS, *supra* note 92, at 4-5.

for HIV.<sup>143</sup> The difference is hardly insignificant, as nonimmigrant admissions, who are not required to be tested for HIV, number in the millions.<sup>144</sup> By relying on these nonimmigrants to self-report, instead of requiring them to be tested, the human tendency to under-report to secure a benefit is ignored. Furthermore, returning United States citizens and LPRs who have been abroad in areas of high prevalence of HIV/AIDS are not tested upon re-entry into the United States.<sup>145</sup> Finally, because the HIV tests work by detecting the presence of antibodies in an infected person, and these antibodies may not develop for up to six to twelve months, individuals who undergo the medical examination and have been recently infected may circumvent the ban.<sup>146</sup>

#### D. Understanding Public Health Priorities and Law and Controlling Communicable Disease

Public health can be thought of as encompassing the general health and well-being of a population, as well as the standards and availability of medical care.<sup>147</sup> Though definitions of public health differ,<sup>148</sup> “[a]t a minimum, the goal of public health is to attain the highest level and widest distribution of physical and mental health that a society reasonably can achieve within the limits of the resources it chooses to devote to the task.”<sup>149</sup> But garnering support

<sup>143</sup> See OFFICE OF IMMIGRATION STATS., *supra* note 97, at 7, 82 (noting that in 2002, 384,427 new immigrants entered the U.S. and reporting that in 2002, there were more than 27.9 million nonimmigrant admissions). See also PENDLETON, *supra* note 92, at 10 (explaining that new immigrants must undergo a medical exam abroad which will test them for HIV infection); U.S. Citizenship & Immigration Services, *supra* note 90 (relating that with limited exceptions nonimmigrant visitors are not required to be tested for HIV).

<sup>144</sup> See OFFICE OF IMMIGRATION STATS., *supra* note 97, at 7, 82 (noting that in 2002, 384,427 new immigrants entered the U.S. and reporting that in 2002 there were more than 27.9 million nonimmigrant admissions).

<sup>145</sup> See PENDLETON, HIV AND IMMIGRANTS, *supra* note 92, at 5.

<sup>146</sup> National HIV Testing Resources, Centers for Disease Control and Prevention, Frequently Asked Questions About HIV and HIV Testing, at <http://www.hivtest.org/subindex.cfm?FuseAction=FAQ> (last visited Nov. 13, 2004) (noting that detectable antibodies develop within three months of infection; on average, after twenty days; and that in rare cases, it may take up to six to twelve months to produce detectable antibodies).

<sup>147</sup> Lawrence Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 67 (1999) (stating that the term “public health” tends to be broadly defined).

<sup>148</sup> See *id.* (citing the constitution of the World Health Organization (WHO) and Institute of Medicine (IOM) definitions of public health).

<sup>149</sup> *Id.*

for public health within the general population can be a formidable task.<sup>150</sup>

Implementing an effective body of public health legislation and policy presents an array of difficulties to public health authorities who seek to enhance public health through policy changes.<sup>151</sup> Many of the impediments that public health officials may encounter in their efforts to control and prevent communicable disease may stem from the general public's differing views on the spread and control of communicable disease.<sup>152</sup>

Understanding disease control law and public health requires an analysis of the views of the public pertaining to the causes of communicable disease and public health's role in preventing or containing communicable disease.<sup>153</sup> Three major models of public health and the control of communicable disease are described by Lawrence Gostin.<sup>154</sup>

The first, the microbial model, is the "germ theory," which characterizes disease as stemming from a germ or microbial infection.<sup>155</sup> The task of public health under this model is to eliminate the germ or prevent its communication to the general public.<sup>156</sup> This model is perhaps the most accepted view by the general public, because it is most consistent with the layperson's concept of communicable disease.<sup>157</sup> The types of measures consistent with the "germ theory" "have been in place so long that the burdens they impose are thought of as a normal part of life."<sup>158</sup> Measures taken by public health officials that reflect these concerns and methodologies may have the highest support from the general public.<sup>159</sup> However, ac-

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<sup>150</sup> See *id.* at 66 (noting that though "most people support a high level of public health, fewer are eager to pay for it, and most are positively opposed to changing their own activities to promote it").

<sup>151</sup> See *id.* (stating that although public health officials have tremendous legal power, they are often constrained in its use by political, cultural, or resource reasons).

<sup>152</sup> See Gostin et al., *supra* note 147, at 66-69.

<sup>153</sup> See *id.*

<sup>154</sup> *Id.* at 69.

<sup>155</sup> *Id.* at 70.

<sup>156</sup> *Id.*

<sup>157</sup> Gostin et al., *supra* note 147, at 70.

<sup>158</sup> *Id.* (providing the examples of school vaccination requirements and health department regulation of food preparation workers).

<sup>159</sup> See *id.* Activities supported by the public have included vaccination, water purification, mosquito abatement, and meat inspection as measures under this model to which the public accepts and encourages. *Id.* Additionally, germ identification, screening, and disease reporting requirements tend to have general support. *Id.*

ceptance of these types of measures, meant to control or identify individuals who are infected with or are carrying the disease, can become controversial when there is a stigma associated with the particular disease.<sup>160</sup>

A second model emerged in the second half of this century; this model focused on human behavior as a method for perpetuating—and, conversely, controlling—the spread of communicable disease.<sup>161</sup> Under this theory, the focus shifts from the germ to the human behavior that actually moves the germ from person to person.<sup>162</sup> This model has been criticized on three grounds.<sup>163</sup> First, this focus tends to give an overly individualistic view of public health.<sup>164</sup> This may lead to complacency in the public regarding disease, and discourage remedial measures that require “concerted social action.”<sup>165</sup> Second, the theory calls for measures that may interfere with personal choices about behavior.<sup>166</sup> This interference may be resisted by the public on the grounds of its perceived paternalistic object.<sup>167</sup> Thirdly, measures that purport to change individual behaviors often change the meaning of the behavior itself.<sup>168</sup> When the meaning of the measure is changed in the public eye, it may suddenly conflict with other social and moral norms, and thus become controversial.<sup>169</sup> For example, government action such as giving out condoms in sex education programs or needle exchange programs for drug users often becomes controversial because those in opposition believe these programs endorse drug use or teenage sexual activity.<sup>170</sup>

<sup>160</sup> See *id.* at 71 (citing HIV as an example of a disease in which HIV-positive individuals and advocates have been opposed to identification and control).

<sup>161</sup> *Id.* at 71.

<sup>162</sup> Gostin et al., *supra* note 147, at 71.

<sup>163</sup> *Id.* at 72.

<sup>164</sup> *Id.* The control of behavior can become “for cultural and political reasons, a warrant for treating health entirely as a matter of personal responsibility.” *Id.* Thus health will be seen as a reward for moral behavior and disease is easily stigmatized. *Id.*

<sup>165</sup> *Id.*

<sup>166</sup> See *id.* at 73 (giving the example of laws that require individuals to wear motorcycle helmets).

<sup>167</sup> See Gostin et al., *supra* note 147, at 73.

<sup>168</sup> See *id.* For example, attempts by public health campaigns to promote use of condoms to guard against sexually transmitted diseases may change the very meaning of using a condom to “I think I (or you) might have a disease,” as opposed to the intended message that “everybody uses condoms.”

<sup>169</sup> *Id.*

<sup>170</sup> *Id.* at 73–74.

A final model, the ecological model, turns its focus to the environment in which the public health exists as a whole.<sup>171</sup> “The ecological model conceives of illness not as an external threat such as a pathogen or toxin, nor as a function of personal choices, but rather as a product of society’s interaction with its environment.”<sup>172</sup> The ecological model encompasses social and physical structural aspects of society which include distribution of wealth, attitudes towards sexual behavior, and relationships and economic conditions.<sup>173</sup> Changing negative environmental factors or encouraging public health under this model is effected through changes in virtually every aspect of the society.<sup>174</sup> This model can be conceived of as a “mirror, reflecting how a society produces and distributes wealth, creates conditions for human health (or its antithesis), constructs social norms, and organizes its people[s] and communities.”<sup>175</sup> Additionally, the public may even fight this type of analysis because, in order to achieve the goal of systemic reform, it is inevitable that “public health regulations targeting the causes of injury and disease will challenge behavior that people enjoy, that constitutes their moral vision, or that makes them money.”<sup>176</sup>

These models can be helpful in the analysis of public health goals and effects of legislation outside of the traditional public health sphere. In considering the context in which the public health ground of exclusion arose in immigration law, it is important to consider which of these views lawmakers and their constituents believe.

## II. ANALYSIS

Where does the immigration exclusion fit? The following is an analysis of the public health exclusion under the three models of public health.

### A. Microbial Model

The grounds for inadmissibility for HIV-infected immigrants or visitors seems to fall most easily under the conceptual framework

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<sup>171</sup> See *id.* at 74.

<sup>172</sup> Gostin et al., *supra* note 147, at 74.

<sup>173</sup> *Id.* at 74–75.

<sup>174</sup> *Id.*

<sup>175</sup> *Id.* at 76.

<sup>176</sup> *Id.*

of the microbial model.<sup>177</sup> In attempting to deal with AIDS and HIV in the United States by restricting immigrants and visitors who are HIV-positive from entering our borders, legislators seem to apply the “germ theory.”<sup>178</sup> The attempt to seal off the United States from the threat of HIV/AIDS in immigration law is dependent upon effectively screening those who enter from abroad and bring with them the HIV/AIDS virus. This approach fails to adequately address the HIV/AIDS epidemic in several ways.

First, the immigration restriction does not effectively close off those within the United States from HIV or AIDS. This can be seen in the way the law is applied. In the United States, only a small group of individuals entering from abroad are actually tested.<sup>179</sup> Nonimmigrant visitors, asylum seekers, returning LPRs, and returning United States citizens are not required to be tested for HIV to gain entry into the United States.<sup>180</sup> The fact that nonimmigrants alone accounted for 27.9 million entries into the United States in 2002 illustrates the relatively large portion of total entries into the United States that are not required to be tested for HIV.<sup>181</sup> Additionally, in the age of increasing global migration and increasingly porous borders, it is unrealistic to think that the HIV/AIDS virus can be stopped effectively at the border.<sup>182</sup> Furthermore, due to the fact that antibodies may not be detectable in an infected individual for up to six months after infection, even the individuals who have been required to submit proof of HIV-negative status may be bringing the virus into the United States.<sup>183</sup>

Use of the germ theory as the conceptual framework of the immigration restriction on HIV-positive aliens ignores and undermines what we know about the HIV/AIDS virus and its

<sup>177</sup> Gostin et al., *supra* note 147, at 70.

<sup>178</sup> *See id.* (explaining, under the microbial model, the purpose of law and public health measures is to “identify the pathogen and to eliminate or contain it”). *See also* Barta, *supra* note 64, at 325–56 (noting that in 1987, a domestic quarantine was proposed to contain the AIDS epidemic, and that although the quarantine was ultimately rejected, it was incorporated into immigration law).

<sup>179</sup> *See* OFFICE OF IMMIGRATION STATS., *supra* note 97, at 7 (noting that in 2002 384,427 immigrants, and 115,832 refugees entered the U.S.). *See also* U.S. Citizenship & Immigration Services, *supra* note 90 (explaining that immigrants and refugees are the only entrants actually tested before entry to the United States).

<sup>180</sup> U.S. Citizenship & Immigration Services, *supra* note 90.

<sup>181</sup> OFFICE OF IMMIGRATION STATS., *supra* note 97, at 3.

<sup>182</sup> *See id.* at 213 (noting that an estimated 7 million unauthorized immigrants were living in the United States in the year 2000).

<sup>183</sup> Pendleton, *U.S. Exclusion of HIV-Positive Aliens*, *supra* note 25, at 297.

transmission. HIV/AIDS is not transmitted through casual contact.<sup>184</sup> HIV is not spread “through the air, or from food, water or other objects.”<sup>185</sup> Likewise, “nor will an infected person in a common public setting place another individual inadvertently or unwillingly at risk.”<sup>186</sup> Thus, the mere presence of an HIV-infected person in society will not pose a rampant threat of infection to other individuals, unless the HIV-infected person engages in specific non-casual behaviors that are known to result in transmission.<sup>187</sup> The rule of exclusion additionally ignores the fact that, prior to the ban on immigrants, AIDS and the HIV virus were already present in the United States.<sup>188</sup> Inconsistently, the list of communicable diseases that serve as a ban for immigration purposes fails to list some serious communicable diseases that are not widely present in the United States.<sup>189</sup>

Finally, the exclusion of HIV-positive immigrants may actually serve to hinder the efforts of national public health systems to educate the public and eradicate the disease. Within the United States, the government largely attempted to stay the spread of HIV/AIDS through education and voluntary testing.<sup>190</sup> The emphasis of educational efforts was on the modification of behaviors which might place an individual at risk.<sup>191</sup> Laws were created to prevent discrimination against HIV-positive people.<sup>192</sup>

These anti-discriminatory and educational approaches used within the United States differ markedly from the germ theory-driven policies designed to stop HIV-positive individuals at the

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<sup>184</sup> See Barta, *supra* note 64, at 343 (noting that “the CDC has categorically ruled out the possibility that HIV can be spread through casual contact . . . fears that other, thus far undiscovered methods of transmitting HIV may exist are not supported by scientific evidence”).

<sup>185</sup> *Id.*

<sup>186</sup> *Id.*

<sup>187</sup> See *id.* at 343 (stating that HIV can be transmitted prenatally or through semen, blood, vaginal fluids, and breast milk).

<sup>188</sup> See CDC, Where Did HIV Come From, *supra* note 8 (indicating that the first known case of AIDS in the United States appeared in the late 1970s or early 1980s).

<sup>189</sup> See Rogers, *supra* note 20, at 210 (citing Ebola hemorrhagic fever as a serious communicable disease that is not listed as a disease that will bar an immigrant or visitor from entering the United States).

<sup>190</sup> Pendleton, *U.S. Exclusion of HIV-Positive Aliens*, *supra* note 25, at 279.

<sup>191</sup> See *id.* at 279–82 (noting that the media has flooded the public with information regarding transmission, prevention and treatment of HIV, and that the government has implemented measures to ensure that people engage in safe sexual practices and that intravenous drug users use clean needles).

<sup>192</sup> See *id.* at 280 (listing laws against discrimination in housing, health care, education, and employment).

threshold. The ban creates the illusion that HIV necessarily comes from an outside source.<sup>193</sup> This foreign threat concept of HIV is erroneous.<sup>194</sup> Recent studies confirm that most foreign-born individuals within the United States testing positive for HIV contracted the virus while in the United States.<sup>195</sup>

The misconception further results in various serious hindrances to the HIV prevention efforts in this country; it falsely stigmatizes “outsiders” as carriers of disease, creating a false sense of security to United States citizens and residents.<sup>196</sup> Stigmatization and fear of deportation drives HIV-positive immigrants underground, where they will be unable to access the public health services and information designed to prevent transmission.<sup>197</sup> The ban on HIV-positive individuals under the immigration laws of the United States undermines education- and behavior-oriented preventative measures. The emphasis on banning individuals infected with HIV could better serve public health goals by emphasizing testing, education, and behavior modification of immigrants seeking to enter the United States.

## B. Behavioral Model

Perhaps a more realistic and effective way to target the HIV/AIDS epidemic in the United States is to focus on a behavioral concept of disease control. In fact, in recognizing that changes in behavior are an effective means to cut risk of transmission, the United States has implemented domestic measures that emphasize education and testing.<sup>198</sup> Thus, re-conceptualizing our immigration poli-

<sup>193</sup> Barta, *supra* note 64, at 348.

<sup>194</sup> See *id.* (noting that the HIV prevalence in the United States is relatively high compared with the rest of the world and that an immigrant is more likely to contract HIV from an American than to transmit HIV to an American).

<sup>195</sup> See Nina T. Harawa et al., *HIV Prevalence Among Foreign- and U.S.-Born Clients in Public HIV Clinics*, 92 AM. J. OF PUB. HEALTH 1958, 1961–62 (2002) (noting that the “largest proportion of documented AIDS cases are reported in persons aged 30 through 39 years, generally indicating HIV infection during the client’s 20s during which time the clients were living in the United States”).

<sup>196</sup> See Barta, *supra* note 64, at 353 (discussing the fear that may drive HIV-positive immigrants underground). See also Margaret A. Sommerville & Sarah Wilson, *Crossing Boundaries: Travel, Immigration, Human Rights and AIDS*, 43 MCGILL L.J. 781, 785 (1988) (noting that entry restrictions create fear of the threat of disease through migration and “provid[e] . . . an appearance of protection” against those who are restricted).

<sup>197</sup> See Barta, *supra* note 64, at 352–53 (explaining that HIV-positive aliens in fear of deportation are advised to go underground to avoid detection, which may result in loss of contact with agencies that may provide health and preventative educational services).

<sup>198</sup> *Id.* at 350.

cies under the behavioral model would be more consistent with domestic policies.

Some countries around the world have continued to test immigrants and visitors for HIV, but have not used positive test results as grounds for exclusion.<sup>199</sup> Information on HIV-positive individuals seeking to enter these countries is used proactively “to alert health-care organizations and other caregivers of the necessity of providing care for HIV-positive aliens.”<sup>200</sup> A similar policy in the United States would give agencies a chance to provide education and prevention services to this vulnerable population.

Although behavior-oriented immigration policies would seem to be most consistent with measures taken domestically to further prevent HIV infection, there are shortcomings to this approach as well. First, a focus on controlling the individual behaviors that transmit HIV can lead to measures that make disease control entirely a matter of personal responsibility, thus negating publicly shared aspects that are vital to disease control.<sup>201</sup> Through this model, the social meaning of disease is altered, and HIV infection may come to be seen as a punishment for socially aberrant behaviors.<sup>202</sup> When behavior is blamed for disease, the victim of the disease is also blamed, resulting in stigmatization of HIV-positive individuals.<sup>203</sup> Second, the behavioral model’s narrow conception of disease prevention tends to ignore the underlying motivations and causes of the behaviors it seeks to modify.<sup>204</sup>

### C. Ecological Model

The ecological model of disease seems to be the most effective means of conceiving possible strategies for HIV prevention. By focusing on the environmental and social conditions promoting HIV-spreading behavior, the ecological model may avoid the pitfalls of the microbial and behavioral models.<sup>205</sup> An ecological approach to disease control focuses on “social institutions and activities, human inequality, and economic activities as the major health risks in a

<sup>199</sup> Qureshi, *supra* note 48, at 85.

<sup>200</sup> *Id.*

<sup>201</sup> Gostin et al., *supra* note 147, at 72.

<sup>202</sup> *Id.*

<sup>203</sup> *Id.* “[T]he stigma of HIV . . . is based not just on the notion that the carrier is contaminated, but also, independently . . . that he is responsible for his own illness.” *Id.*

<sup>204</sup> *See id.* at 74–75 (explaining that exposure to disease and behavior has social roots).

<sup>205</sup> *Id.* at 75.

population.”<sup>206</sup> In evaluating basic analytical elements under the ecological model, it is important to note the role that society’s laws and legal institutions play in the realm of public health.<sup>207</sup> In fact, law can be seen as playing a direct role in infectious diseases.<sup>208</sup>

Consistent with the multi-factor approach of the ecological model, human rights are recognized as the key in creating a social environment that maximizes the public health.<sup>209</sup> A human-rights analysis is particularly appropriate when examining a population’s vulnerability to HIV.<sup>210</sup> International health organizations such as the United Nations Program on HIV/AIDS (“UNAIDS”) promote the ecological model and conceptualize the global HIV/AIDS epidemic in terms of broad human rights.<sup>211</sup> The UNAIDS plan notes that the “[l]ack of respect for human rights continues to increase vulnerability to HIV infection of individuals and the whole society.”<sup>212</sup> Discrimination against HIV/AIDS-infected visitors violates the recognized human right of nondiscrimination.<sup>213</sup> Degradation of this vital human right, through the immigration restriction on HIV/AIDS-infected aliens, hinders the efforts of global health organizations to cope with the AIDS epidemic.<sup>214</sup> Although the WHO advocates for the elimination of discriminatory entry restrictions for

<sup>206</sup> Gostin et al., *supra* note 147, at 75.

<sup>207</sup> See Burris, *Social Risk of Health Care*, *supra* note 40, at 1770. “[L]egal structures . . . have been identified as important and malleable factors in health.” *Id.*

<sup>208</sup> *Id.* at 1770–71. “[S]ome health risks (for example, poor access to sterile injection equipment) have been directly attributed to law, and law has been deployed to change unhealthy norms (smoking, for instance) or behaviors (such as driving while drunk).” *Id.*

<sup>209</sup> *Id.* at 1775.

<sup>210</sup> See *id.* (noting that vulnerability to HIV is dependent on a population’s ability to make and carry out “free and informed decisions about their health,” and that this capability implicates human rights such as “autonomy, equality, economic opportunity, education, free access to information, and freedom of assembly . . .”).

<sup>211</sup> See UNAIDS, *HIV/AIDS, Human Rights & Law*, *supra* note 14 (listing several fundamental human rights such as “the right to non-discrimination, equal protection and equality before the law, privacy, liberty of movement, work, equal access to education, housing, health care, social security, assistance and welfare . . .”).

<sup>212</sup> *Id.*

<sup>213</sup> See United Nations, Universal Declaration of Human Rights, U.N. G.A. Res. 217A, 3 U.N. GAOR, U.N. Doc. A/810, at 71 (1948), available at <http://www.un.org/Overview/rights.html> (last visited Nov. 19, 2004) (declaring “Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”).

<sup>214</sup> See UNAIDS, *HIV/AIDS, Human Rights & Law*, *supra* note 44 (“The goal of realizing human rights is fundamental to the global fight against AIDS.” (quoting Peter Piot, Address at 59th Session of the United Nations Commission on Human Rights (Mar. 19, 2003))).

HIV/AIDS-infected travelers and immigrants,<sup>215</sup> the United States persists in maintaining this law.<sup>216</sup>

It is important to analyze the continued imposition of this law as a structural factor in the spread of disease.<sup>217</sup> The discriminatory ban on HIV-infected immigrants and visitors can be thought of as a structural cause of the disease. To the extent that “[l]aw operates to create and preserve social relations of status and power” by ordering “social meaning,” law can drive societal perceptions about what is “right, appropriate, or natural to do.”<sup>218</sup> Therefore, the current law apparently informs society that it is permissible—and even right—to discriminate against, stigmatize, and marginalize HIV/AIDS-infected individuals in particular, and immigrants by inference.

### III. CONCLUSIONS AND PROPOSALS FOR A MODEL OF PREVENTION MORE CONSISTENT WITH THE CURRENT HIV/AIDS EPIDEMIC

The current immigration restriction on HIV/AIDS-infected travelers and immigrants makes no sense. The restriction is rooted in an ineffective concept of disease control.<sup>219</sup> The restriction fails to adequately exclude HIV/AIDS-infected individuals at our borders.<sup>220</sup> Furthermore, the restriction is inconsistent with HIV/AIDS control and prevention measures used both domestically<sup>221</sup> and

<sup>215</sup> See Qureshi, *supra* note 48, at 85 (noting that the WHO has a policy against AIDS-related discrimination).

<sup>216</sup> Immigration and Nationality Act, § 1182(a)(1) (Law. Co-op. 2004). See also National Center for Infectious Disease, Division of Global Migration and Quarantine, Communicable Diseases of Public Health Significance, at <http://www.cdc.gov/ncidod/dq/diseases.htm> (last visited Nov. 13, 2004) (listing HIV as a communicable disease of public health significance).

<sup>217</sup> See Burris, *Law as a Structural Factor*, *supra* note 23, at 1778 (explaining that a structural analysis of health entails viewing illness as a byproduct of the society in which we live, controllable by determining and altering the causes of the illness).

<sup>218</sup> *Id.* at 1778–79.

<sup>219</sup> See Gostin et al., *supra* note 147, at 70 (explaining that the microbial model focuses on identifying and containing the pathogen that causes disease).

<sup>220</sup> See OFFICE OF IMMIGRATION STATS., *supra* note 97, at 7 (noting that in 2002, 10,252 asylum seekers were granted entrance to the United States). See also U.S. Citizenship and Immigration Services, *supra* note 90 (explaining that certain groups of entrants, including asylees and some nonimmigrant visa applicants, are not required to undergo HIV testing).

<sup>221</sup> See Barta, *supra* note 64, at 350 (recognizing that prevention measures in the United States include educational programs focused on behaviors that make an individual vulnerable to HIV/AIDS infection).

abroad.<sup>222</sup> The continued employment of this policy will undoubtedly incur further criticism from both the international and domestic public health community.<sup>223</sup>

In the face of the undeniable reality of increasing globalization and migration, it is necessary that the United States develop a more effective means of handling HIV/AIDS-infected immigrants and travelers.<sup>224</sup>

The United States should cooperate with the global community in HIV prevention efforts. To effectively do this, the United States must acknowledge the reality of the threat that HIV/AIDS poses. For instance, to effectively confront the problem of disease at a structural level, we must acknowledge basic concepts in disease emergence:

Emergence of infectious diseases is complex.  
Infectious diseases are dynamic.  
Most new infections are not caused by genuinely new pathogens.  
Agents involved in new and reemergent infections cross taxonomic lines. . . .  
The concept of microbe as the cause of disease is inadequate and incomplete.  
Human activities are the most potent factors driving disease emergence.  
Social, economic, political, climatic, technologic, and environmental factors shape disease patterns and influence emergence.  
Understanding and responding to disease emergence requires a global perspective, conceptually and geographically.  
The current global situation favors disease emergence.<sup>225</sup>

The United States must recognize that a key to prevention domestically is prevention globally. Prevention includes acknowledging the structural and ecological factors that drive the spread of disease. Namely, it is important to address the connection between poverty in the developing world and disease in the developed

<sup>222</sup> See UNAIDS, AIDS EPIDEMIC UPDATE, *supra* note 9 (listing the violation of human rights as a contributing factor to the spread of HIV infection).

<sup>223</sup> See Barta, *supra* note 64, at 349. A report created by WHO criticized entry exclusions on immigrants and international travelers on the following grounds: no screening program can prevent HIV infection and spread; in any specific country, the screening may only temporarily slow the rate of infection; and the screening diverts resources from more effective disease control measures. *Id.* See also Sommerville & Wilson, *supra* note 196, at 800.

<sup>224</sup> See Barta, *supra* note 64, at 329 (noting that “the risk of . . . HIV comes not from the nationality of the infected person, but from the specific behaviors that are practiced . . . allowing HIV infected aliens into this country will not impose a significant additional risk of HIV infection to the U.S. population, where prevalence of HIV is already widespread”).

<sup>225</sup> Burris, *Law as a Structural Factor*, *supra* note 23, at 1760.

world,<sup>226</sup> as well as the role that strengthening human rights can play in addressing the structural causes of disease.<sup>227</sup>

The United States should change its current policy of exclusion to a policy of compassion and education. Pre-entry testing of immigrants and travelers should be used to reach out to HIV/AIDS-infected immigrants, incorporate them into our public health system, and provide education on behaviors that increase the possibility of transmission.<sup>228</sup>

The United States should make policies and decisions based on the totality of the ecological causes of the HIV/AIDS epidemic. In the case of immigrants, the prevention efforts in the United States should recognize that efforts aimed at the general public may not reach immigrants who are often marginalized. The prevention efforts should acknowledge factors specific to migrant populations, which might increase their vulnerability to infection. For example, migrating populations may be more susceptible to infection because of language barriers, differing cultural and health beliefs, and other factors, including “financial instability, relationship disruption, and unequal sex ratios resulting from sex-segregated migration patterns.”<sup>229</sup> A more effective means of combating HIV/AIDS in the United States is to acknowledge the special public health considerations that should be afforded and implemented in addressing immigrant public health. Protecting the health of immigrants in the United States protects the health of the global community. Thus, it becomes important to develop an adequate public health system that ensures that individuals have access to suitable treatment and are informed consumers of healthcare.

In conclusion, removal of the HIV restriction on immigrants and visitors to the United States is an important step in aligning law with public health goals and concepts. The current restriction is ineffectively designed. It is based more on fear and discrimination

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<sup>226</sup> Fidler, *supra* note 22, at 24 (stating that Third World poverty has been cited as negatively impacting the public health in the First World).

<sup>227</sup> UNAIDS, AIDS EPIDEMIC UPDATE, *supra* note 9, at 13.

<sup>228</sup> See Qureshi, *supra* note 48, at 85 (noting that some countries comply with international efforts by testing and then notifying service providers of the need for care).

<sup>229</sup> Harawa et al., *supra* note 195, at 1962. Some behaviors increase vulnerability of immigrant groups by leading to “increased partner changes, prostitution, and substance use, as well as inadequate access to health care.” *Id.* See also Susan T. Cookson et al., *Migrating Populations—A Closer View of Who, Why, and So What*, 7 EMERGING INFECTIOUS DISEASES 551 (June 2001), available at [http://www.cdc.gov/ncidod/eid/vol7no3\\_supp/pdf/cookson.pdf](http://www.cdc.gov/ncidod/eid/vol7no3_supp/pdf/cookson.pdf) (last visited Nov. 13, 2004) (naming language and cultural health beliefs as special concerns in the public health of immigrant populations).

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than on prevention and control. Until the United States amends its policy towards HIV positive immigrants, the law will continue to hinder global and domestic efforts to thwart the disease. In the future, public health agencies and lawmakers will struggle to enact legislation and create policies designed to contain disease threats. But at the same time, the current immigration restriction on HIV-positive individuals should be reviewed as a reminder that each disease threat must be handled according to its special characteristics.

