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THE UNITED STATES POLICY ON HIV INFECTED ALIENS: IS EXCLUSION AN EFFECTIVE SOLUTION?

INTRODUCTION

As of June, 1991, although only 366,455 Acquired Immune Deficiency Syndrome (AIDS) cases had been reported to the World Health Organization (WHO), WHO officials estimated that as many as 1.25 million people worldwide had actually contracted AIDS.¹ While there is no known cure for the disease, the percentage of the population that is afflicted with AIDS or infected with the human immunodeficiency virus (HIV), which causes the disease, is growing. The WHO predicts that there will be twenty-five to thirty million cases of HIV worldwide by the year 2000.² Due to the complexity of AIDS/HIV as a social phenomenon, the United States and other governments have found it necessary to enact legislation relating to AIDS/HIV, including immigration laws. The changing stance of United States policy regarding immigration is an example of impulsive government reaction to escalating public pressure in the face of the worldwide epidemic.

In 1987, Congress passed the Helms Amendment to the Supplemental Appropriations Act, which added HIV to the list of diseases for which an alien could be excluded from the United States.³ Three years later Congress passed the Immigration Act of 1990 which required the Department of Health and Human Services to analyze, in light of cur-

1. *In Brief* . . . , 6 AIDS Pol'y & L. (BNA) No.12 at 9 (June 26, 1991). AIDS is a disease characterized by the existence of a variety of infections or malignancies which occur due to defects in the body's otherwise healthy immune system. The disease AIDS is caused by the human immunodeficiency virus (HIV). HIV attacks those cells in the body which are responsible for alerting the immune system about potential infection. It is this defect in the immune system which leads to opportunistic infections, several of which are characterized as AIDS. Allan Gibofsky & Jeffrey C. Laurence, *AIDS: Current Medical and Scientific Aspects*, 9 JOURNAL OF LEGAL MEDICINE 497, 497-98(1988).

2. Adria-Ann McMurray, *Immigration Consequences of HIV Infection*, in AIDS PRACTICE MANUAL - A LEGAL AND EDUCATIONAL GUIDE (Paul Albert, Ruth Eisenberg, David A. Hansell, Jody Kathleen Marcus eds., 1991), 17-1, 17-19 (1991).

3. Supplemental Appropriations Act of 1987, Pub. L. No. 100-71, §§ 518, 101 Stat. 391, 475 (1987)[hereinafter Helms Amendment]. The Department of Health and Human Services subsequently amended 42 C.F.R. § 34.2(b)(4) to reflect the addition of HIV to the list of excludable diseases.

rent medical knowledge, the list of diseases which served as a basis for exclusion.⁴ In January, 1991, acting upon this directive, the Secretary of Health and Human Services, Dr. Louis Sullivan, recommended that HIV, along with all diseases except for infectious tuberculosis, be removed from the list of diseases which warrant exclusion.⁵ In May, 1991, in the face of strong opposition, the administration backed away from Secretary Sullivan's recommendation by reinstating the exclusion and calling for a sixty-day period of "debate and discussion" on the topic.⁶

This comment will critique the United States policy on HIV immigration exclusion. The first section of the comment will detail the various changes the government's immigration policy has undergone in arriving at its current position. The second section will argue that the United States policy is unjustified in light of the current medical knowledge about AIDS/HIV and the presently available means of testing. Finally, the comment will argue that an exclusionary policy ignores humanitarian concerns and results in discriminatory treatment of HIV-infected aliens. The comment concludes that the result of an exclusionary policy is a governmental scheme that is counter-productive to the nation's ultimate goal of identifying a solution to the AIDS pandemic. Because it tends to delay a solution to the AIDS crisis, the United States should permanently remove HIV from the list of excludable diseases.

I. EVOLUTION OF THE UNITED STATES HIV IMMIGRATION POLICY

Since its origin, the United States policy regarding HIV-infected aliens has gone through many modifications and currently stands unresolved because a major initiative was stalled just short of promulgation. In 1987, Congress passed an amendment to the Supplemental Appropriations Act⁷ requiring the addition of HIV to that section of the Immigration and Nationality Act of 1952 which excludes aliens who have a "dangerous contagious disease."⁸ This amendment, sponsored by Senator Jesse Helms (R-NC), effectively denied entry to certain cate-

4. Immigration Act of 1990, Pub. L. No. 101-649, § 601, 104 Stat 4978, 5067 (1990)(codified at 8 U.S.C. § 1182(a)(1)(A)(c)(Supp. 1991)).

5. Susan Okie, *U.S. Will Stop Excluding Immigrants, Travelers With AIDS Virus*, WASHINGTON POST, January 5, 1991, at A5.

6. Karen DeWitt, *In Shift, U.S. Plans to Keep Out People Carrying the AIDS Virus*, NEW YORK TIMES, May 26, 1991, at A1.

7. Helms Amendment, *supra* note 3.

8. Immigration and Nationality Act of 1952, 8 U.S.C. § 1182(a)(6) (Supp. V 1958).

gories of aliens who tested positive for HIV. There are two justifications which proponents of this policy advance: the protection of public health and the increasing costs to the American health care system responsible for the care of HIV-infected aliens.⁹ Senator Helms argued that because the number of AIDS cases was growing worldwide, unrestricted immigration would encourage the spread of the disease within the United States.¹⁰ He further contended that it was the government's duty as protector of the American people to deny entry to foreigners carrying the virus.¹¹

The amendment was passed over criticism. Senator John Danforth (R-MO), stressed the need to better educate Congress about the major philosophical, political and economic issues surrounding AIDS prior to the passage of any legislation.¹² Questions concerning the implementation of the HIV exclusion were raised by Senator Robert Dole (R-KS), who stated, "[i]t is my understanding that there is a concern as to who verifies the results and where the testing will be done. Many of the Third World Countries do not have the resources or the technology to do this sophisticated testing."¹³ This opposition proved insufficient to defeat passage of the bill, as legislators continued the long standing United States policy of excluding aliens for medical reasons.¹⁴ On July 11, 1987, Republican President Ronald Reagan signed the 1987 Supplemental Appropriations Bill, making the Helms Amendment law.¹⁵ The Code of Federal Regulations was subsequently amended on Au-

9. E.P. HUTCHINSON, LEGISLATIVE HISTORY OF AMERICAN IMMIGRATION POLICY 1788-1965, at 416 (1981).

10. Court E. Golumbic, *Closing the Open Door: The Impact of Human Immunodeficiency Virus Exclusion on the Legalization Program of the Immigration Reform and Control Act of 1986*, 15 YALE J. INT'L L. 162, 174 (1990).

11. *Id.* Senator Helm's analysis of the problem was that, "[i]t is only elementary that as the epidemic continues to grow and spread abroad, immigrants coming to this country in greater numbers will be bringing the AIDS virus to the United States." 133 CONG. REC. S7410-11 (statement of Sen. Helms) reprinted in Golumbic, *supra* note 10, at 174.

12. 133 CONG. REC. S7412-13 (statement of Sen. Danforth), (daily ed. June 2, 1987).

13. 133 CONG. REC. S7415 (statement of Sen. Dole), reprinted in Nancy E. Allin, *The AIDS Pandemic: International Travel and Immigration Restrictions and the World Health Organizations Response*, 28 VA. J. INT'L L. 1043, 1060 (1988).

14. In 1917, aliens considered to be idiots, imbeciles, epileptics, persons of constitutional psychopathic inferiority, among other alleged infirmities were denied entry. An Act to Regulate the Immigration of Aliens to, and the Residence of Aliens in the United States. ch. 29 Stat. 1084, 1085 (1891). In 1952 the Immigration and Nationality Act excluded aliens for the following medical reasons: insanity, affliction with psychopathic personality, epilepsy, narcotic drug addiction or chronic alcoholism, tuberculosis or leprosy. Immigration and Nationality Act of 1952, 8 U.S.C. § 1182(a)(1)-(7).

15. McMurray, *supra* note 2, at 17-3.

gust 28, 1987, by the Department of Health and Human Services (HHS) to add HIV to the list of excludable diseases.¹⁶

The Department of Justice, Department of State and HHS are each in part responsible for the administration and enforcement of immigration restrictions, and were therefore involved in implementing the Helms Amendment. First, the Department of Justice, which is responsible for the enforcement of immigration laws, vests authority in the executive office of the Attorney General,¹⁷ which delegates to the Immigration and Naturalization Service (INS) the authority to determine whether aliens should be admitted, deported or granted waivers.¹⁸ Second, the Department of State administers and enforces the visa granting provisions of the Immigration and Nationality Act.¹⁹ Under the 1987 law, the Secretary of State oversees all "powers, duties, and functions of diplomatic and consular officers . . . except those . . . relating to the granting or refusal of visas [and] the powers, duties, and functions of the Bureau of Consular Affairs."²⁰ The State Department's Bureau of Consular Affairs, which acts through its consular officers in various countries, requires the medical examination of aliens and is vested with authority to issue or deny visas.²¹ The decisions made by the consular officers to grant or deny a visa are not subject to judicial review.²² Third, HHS is responsible for promulgating the medical standards and procedures which govern immigration decisions.²³ The Public Health Service Physicians, agents of HHS, are authorized to conduct examinations of prospective aliens at the consulates prior to a visa determination.²⁴

16. Final Rule 52 Fed. Reg. 32540 (Aug. 28, 1987).

17. Nancy J. Eckhardt, *The Impact of AIDS on Immigration Law: Unresolved Issues*, 14 BROOK. J. INT'L L. 223, 229 (1988).

18. *Id.* A waiver allows certain categories of aliens entry despite the fact that they have tested positive for HIV. The waivers are available only in legalization, refugee and asylee, and non immigrant cases. McMurray, *supra* note 2, at 17-9.

19. Denise M. Druhot, *Immigration Laws Excluding Aliens on the Basis of Health: A Reassessment After AIDS*, 7 J. LEGAL MED. 85, 93 (1986).

20. Immigration and Nationality Act of 1952, 8 U.S.C. § 1104 (1952).

21. Eckhardt, *supra* note 17, at 229. See generally Wolff, *The Nonreviewability of Consular Visa Decisions: An Unjustified Aberration from American Justice*, 5 N.Y.L. SCH. J. INT'L & COMP. L. 341 (1984).

22. Eckhardt, *supra* note 17, at 229.

23. Druhot, *supra* note 19, at 94.

24. *Id.* Prior to the 1987 legislation which added HIV to the list of excludable diseases, the medical examination included: a general physical exam (including a surface exam and notations of suspicious mental/physical conditions); serological testing for syphilis; and chest X-rays for tuberculosis. Eckhardt, *supra* note 17, at 230. After the 1987 legislation added HIV to the list of

The 1987 Helms Amendment requires that only certain types of aliens undergo testing for the HIV virus. Whether or not a test is required depends upon the status of the alien attempting to enter the United States. An alien's status is based upon the reasons for entry and the anticipated length of stay in the United States. Although there are many alien statuses under the Immigration and Nationality Act of 1952, this comment will only address the statuses of immigrant and non-immigrant.²⁵ An *immigrant* is the term given to an alien applying for permanent residence in the United States.²⁶ All immigrants have to submit to a medical examination, including a serological test for detecting HIV, prior to entering the country.²⁷ If the immigrant tests positive for the excludable disease, entry is denied.²⁸ This denial is almost always final because immigrants are generally ineligible for a waiver.²⁹ *Non-immigrant* is the term given to an alien seeking temporary admission into the United States, for example a student or visitor.³⁰ There is no mandatory medical testing for non-immigrants, but a serological test can be ordered at the discretion of the consular official if there is suspicion that an alien might be infected with HIV.³¹ Waivers are available for non-immigrants who test positive for HIV only if three conditions are met: the alien's admission will not endanger public health; the risk of the alien spreading the infection is minimal; and the alien will not become a public charge.³² According to at least one immigration expert, the waiver requirements place an "unsurmountable burden of proof on the alien."³³ The burden of proof becomes more onerous to aliens who are unable to understand English or obtain legal counsel.

excludable diseases, the medical exam included a serological HIV test. *Id.* at 232.

25. The status of an alien can take other forms such as an *entrant* or *legalization* applicant, but such an analysis is beyond the scope of this comment.

26. Daniel Levy, *An Outline of Immigration Law*, 23 CLEARINGHOUSE REV. 814, 814 (Nov. 1989).

27. 42 C.F.R. § 34.4(a)(1)(i) (1989).

28. Immigration and Nationality Act of 1952, 8 U.S.C. § 1182(a) (1952).

29. McMurray, *supra* note 2, at 17-6. There are four exceptions to the general rule that immigrants will not be granted waivers. Waivers can be granted to: applicants who obtained lawful temporary residence under the legalization program; applicants who obtained lawful temporary residence under the seasonal agricultural workers legal program; refugees; or asylees applying for adjustment to permanent residence after one year in asylee status. *Id.* at 17-6 to 17-7.

30. Levy, *supra* note 26, at 814.

31. 42 C.F.R. § 34.4(a)(iii).

32. *Critics Say AIDS Waiver Policy at INS Contributes to Spread of HIV*, 5 AIDS Pol'y & L. (BNA) No. 14, at 5 (July 25, 1990).

33. *Id.* (quoting Susan Fortino of Travelers and Immigrants Aid in Chicago).

On October 27, 1990, Congress passed the Immigration Act of 1990.³⁴ On November 19, 1990, Republican President George Bush signed the act, which represented the first comprehensive revision of United States immigration policy in twenty-five years.³⁵ The new immigration law dropped the automatic exclusion of HIV infected aliens by eliminating the "dangerous contagious disease" standard of the Immigration and Nationality Act and replacing it with a provision that grants to the Secretary of Health and Human Services the authority to remove HIV infection from the list of excludable diseases.³⁶ The 1990 House Judiciary Committee report on the Immigration Act stated that the previous specific medical grounds for exclusion represented "outmoded and inflexible notions of medical diagnoses, and . . . they should be replaced with more enlightened and flexible alternatives that focus on the dangers that may be posed by mental and physical disorders."³⁷ The Immigration and Nationality Act of 1952, which governed immigration prior to the Immigration Act of 1990, stated that aliens could be excluded from the United States if they were "afflicted with any dangerous contagious disease."³⁸ This language created an extensive list of excludable diseases.³⁹ The Immigration Act of 1990 changed this standard to "a communicable disease of public health significance" in order to allow the Secretary of Health and Human Services discretion to revise the old list.⁴⁰

The revision under the Immigration Act of 1990 was enacted after the United States government was confronted with opposition from

34. Immigration Act of 1990, Pub. L. No. 101-649, § 101 et seq., 104 Stat 4978 et. seq. (1990).

35. McMurray, *supra* note 2, at 17-1.

36. Prior to the passage of the 1990 Immigration Act, the Immigration and Nationality Act, 8 U.S.C. § 1101 et. seq., excluded, among others, the following classes of aliens: "(1) Aliens who are feeble-minded; (2) Aliens who are insane; (3) Aliens who have had one or more attacks of insanity; (4) Aliens afflicted with psychopathic personality, epilepsy, or a mental defect; (5) Aliens who are narcotic drug addicts or chronic alcoholics; (6) Aliens who are afflicted with tuberculosis in any form, or with leprosy, or any dangerous contagious disease. . . ." *Id.* at § 212(a)(1)-(6). The Immigration Act of 1990 amended this list and changed the standard to exclude "(1) any alien who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services) to have a communicable disease of Public Health significance." Immigration Act of 1990, § 1182(a)(1)(A)(i).

37. H.R. REP. NO. 723(1), 101st Cong., 2d Sess. 6732 (1990).

38. Immigration and Nationality Act of 1952, 8 U.S.C. § 1182(a)(6) (Supp. V 1958).

39. 42 C.F.R. § 34.2(b) (1989). The term "dangerous contagious disease" included: Chan-croid; gonorrhoea; granuloma inguinale; human immunodeficiency virus (HIV) infection; leprosy, infectious; lymphogranuloma venereum; syphilis, infectious stage; tuberculosis, active. *Id.*

40. Immigration Act of 1990, 8 U.S.C. § 1182(a)(1)(A)(i).

both within and outside of the government. Three organizations in particular — the National Commission on AIDS, a presidentially appointed panel of experts to advise the government; the WHO, a branch of the United Nations that works to attain a minimum level of health throughout the world; and the Centers for Disease Control (CDC), a branch of the National Institutes of Health, the national government's chief medical research branch — put pressure on the government to change the 1987 HIV exclusion. As early as December, 1989, a group comprised of public health officials, lawyers, immigration experts and AIDS activists joined with the National Commission on AIDS in calling for a “comprehensive review” of United States visa and immigration laws relating to HIV and other communicable diseases.⁴¹ The comprehensive review was advocated because the Commission felt the 1987 exclusion was based upon “myth, prejudice, and social stigmatization” instead of public health realities.⁴² The WHO criticized the United States policy, stating that

screening efforts may be driven by unfounded concerns about casual transmission of HIV or a need to appear to be taking visible action against the HIV problem. The purposes of the screening programmes and the objectives to be achieved are not always clearly defined and the practical, economic and social costs of implementing such programmes may not have been carefully examined.⁴³

The government also faced internal criticism from the CDC which in March, 1990, recommended that the INS remove HIV, as well as most diseases, from the current list of exclusions.⁴⁴

As criticism of the current policy became prevalent, the United States began to ease restrictions in response to the pressure. In April, 1989, the INS denied a waiver to a Dutch of non-immigrant status who was attempting to enter the United States to attend the Eleventh National Lesbian and Gay Health Conference in San Francisco.⁴⁵ The INS detained the Dutch non-immigrant at a maximum security state

41. *AIDS Panel Asks DOJ to Review Policies; Groups Threaten Boycott of Meetings*, 4 AIDS Pol'y & L. (BNA) No. 23, at 1 (Dec. 13, 1989).

42. *Id.*

43. WORLD HEALTH ORGANIZATION, LEGISLATIVE RESPONSES TO AIDS 265 (1989).

44. *CDC Urges Major Revision to Excludable Disease List*, 5 AIDS Pol'y & L. (BNA) No. 4, at 2 (March 7, 1990).

45. *Congress Moving to Seek Modification of Rule Barring Seropositive Visitors*, 4 AIDS Pol'y & L. (BNA) No. 7, at 10 (April 19, 1989).

prison after finding azidothymidine (AZT), a drug used in HIV treatment, in his luggage.⁴⁶ On May 25, 1989, the INS reacted by altering its policy in order to allow HIV infected aliens into the United States for up to thirty days if the visit was for "public benefit."⁴⁷ Two months later, on July 20, 1989, the INS granted a further exception, extending the thirty-day limit for a Danish social worker who was traveling to the Fifth International AIDS Conference in Montreal.⁴⁸ While the INS was cautious in making the exception, they noted that the thirty-day limit for HIV-infected people would be "flexible."⁴⁹ Critics such as the Director of the National Gay Rights Advocates, charged that the thirty-day rule was not just flexible, but "arbitrary."⁵⁰

After the WHO, the Red Cross and the National Association for People with AIDS threatened to boycott two major international health conferences, the United States retreated once again from its restrictive policy. Individuals infected with HIV who wanted to attend the international health conferences would have to request a waiver of the immigration rules barring their entry, but the waiver would be granted without delay and no notation would be made upon their passports.⁵¹ In a last attempt to avoid the underlying issue of its exclusionary rule, the government on April 13, 1990, announced another limited exception, this one providing for the issuance of special ten-day visas for HIV-infected aliens to attend professional, scientific, or academic conferences in the United States.⁵² Although the Secretary of Health and Human Services said that the new policy would "support the free exchange of scientific information across international boundaries," AIDS activists saw the change as "an attempt by the federal government to make it look like it [was] taking action [while it was] really avoiding the substantive issue"⁵³ of whether HIV should be removed from the list of excludable diseases.

46. *U.S. Immigration Policy for AIDS Infected Aliens Criticized*, INTERPRETER RELEASES, Jan. 1, 1990, at 7.

47. *INS Eases Visa Restrictions For HIV-Infected Visitors*, 4 AIDS Pol'y & L. (BNA) No. 10, at 3 (May 31, 1989).

48. *INS Extends 30-Day Limit; NGRA Says Precedent Set*, 4 AIDS Pol'y & L. (BNA) No. 14, at 6 (July 26, 1989).

49. *Id.*

50. *INS Directive Cited in Request*, 4 AIDS Pol'y & L. (BNA) No. 14, at 6 (July 26, 1989).

51. *Limited Waivers to Be Issued for Health Conference Goers*, 5 AIDS Pol'y & L. (BNA) No. 1, at 2 (Jan. 24, 1990).

52. *New Visa Policy Not Likely to Avert Boycott of International Conferences*, 5 AIDS Pol'y & L. (BNA) No. 7, at 1 (April 18, 1990).

53. *Id.* at 8.

Under the Immigration Act of 1990, Secretary Sullivan was left with the task of defining "a dangerous contagious disease of public health significance."⁵⁴ The legislative history provided some guidelines upon which the Secretary could base this decision. In the 1990 Judiciary Committee Report on the Immigration Act, Congress made it clear that the purpose of modernizing the list of excludable diseases was to make it possible for those aliens not posing a significant danger of transmitting infectious diseases to enter the United States.⁵⁵ Congress no longer wanted the list of excludable diseases to be based upon irrational fears or prejudices, and instead indicated that the decision should be based upon current epidemiological principles and medical standards.⁵⁶

In accordance with these guidelines set out in the legislative history, Secretary Sullivan proposed the removal of HIV and all other contagious diseases except infectious tuberculosis (which can be transmitted through casual contact), from the list of excludable diseases.⁵⁷ The policy change was made public on December 28, 1990, after Secretary Sullivan notified the INS and the State Department.⁵⁸ The change was to be published in the Federal Register and to take effect, along with other changes made to the Immigration Act of 1990, on June 1, 1991.⁵⁹ As stated by one medical expert the HIV policy change "was a fine blow for science, and reverses what seemed a policy that was foolish and embarrassing to the United States."⁶⁰

On May 25, 1991, just one week prior to the effective date of the policy change, the United States government decided to postpone the publication date and mandated a sixty-day period of "debate and discussion" which would expire on August 2, 1991.⁶¹ The sixty-day waiting period came in response to the 40,000 letters received by the government expressing opposition to Secretary Sullivan's removal of HIV from the list of excludable diseases.⁶² The waiting period set Secretary

54. Immigration Act of 1990, 8 U.S.C. § 1182(a) (Supp. 1991).

55. H.R. REP. NO. 723(I), 101st Cong., 2d Sess. 6733 (1990).

56. H.R. CONF. REP. NO. 955, 101st. Cong., 2d Sess. 6793 (1990).

57. *Sullivan Implements 1990 Federal Law to Ban HIV-Related Exclusions of Aliens*, 5 AIDS POL'Y & L. (BNA) No. 24, at 1 (Jan. 9, 1991).

58. *HHS to Remove HIV From List of Contagious Diseases*, INTERPRETER RELEASES, Jan. 14, 1991, at 55.

59. *Id.*

60. *Id.* at 56 (quoting Dr. David Rogers, co-chair of the National Commission on AIDS).

61. *U.S. AIDS Immigration Policy Denounced*, UPI, June 20, 1991, available in LEXIS, Nexis Library, UPI File.

62. *Id.*

Sullivan's new policy back, as the administration instead issued an interim final rule "maintaining the status quo."⁶³ This interim rule will remain effective for an indefinite period until a permanent rule is issued by the HHS.⁶⁴ Once again this created tension between the government and those advocacy organizations which view the HIV restriction of aliens as a discriminatory policy unwarranted by medical facts.

This retreat by the United States government occurred while the Seventh International AIDS Conference was being held in Florence, Italy. Many conference participants made it clear that the Eighth International AIDS Conference, scheduled to be held in Boston in 1992, would be boycotted if the government did not remove the HIV immigration restrictions by August 3, 1991.⁶⁵ With the immigration issue remaining unsettled, the atmosphere at the Florence conference became one of frustration. Such emotion was verbalized by Dr. Max Essex, chairman of the Eighth International AIDS Conference:

The threat to our international fight against AIDS from intransigence, belligerence, and the denial of human rights may well leave us without the Boston conference. [But] it is not the loss of Boston that matters ultimately. It is the loss of solidarity, the lack of respect for human rights, and the loss of our rights to the free exchange of ideas that pose such a serious catastrophe for a successful effort against this AIDS pandemic.⁶⁶

The administration failed to decide upon a final rule by the proposed August 3, 1991, deadline. Boston did not host the 1992 International AIDS Conference.⁶⁷

II. MEDICAL ISSUES SURROUNDING THE HIV IMMIGRATION EXCLUSION

The most common rationale offered by the government for the HIV exclusion is that keeping out infected immigrants is necessary to

63. Interim Rule 56 Fed. Reg. 25000 (May 31, 1991).

64. *HIV Immigration Law Won't Change Because of Dispute, Officials Say*, 5 AIDS POL'Y & L. (BNA) No. 10, at 10 (May 29, 1991).

65. *U.S. AIDS Immigration Policy Denounced*, UPI, June 20, 1991, available in LEXIS, Nexis Library, UPI File.

66. *Settlement Over HIV-Infected Alien Issue Under Negotiation; Decision Expected Soon*, 6 AIDS POL'Y & L. (BNA) No. 13, at 2 (July 10, 1991).

67. Phillip J. Hiltz, *United States Policy on Infected Visitors Keeps AIDS Meeting Out of Country*, N.Y. TIMES, Aug. 17, 1991, at 6.

protect the public health of American citizens. This section will show that the government's position is misguided for two reasons: first, the conclusion that testing and barring HIV infected people will protect the public health is not supported by medical and scientific data; second, the method of testing which serves as the basis of exclusion is not reliable. This section will conclude that although testing may be successful in denying entry to some individuals who are infected, the benefits of such exclusion are minimal and cannot outweigh the humanitarian costs of implementing the HIV exclusion. This conclusion is supported by the analysis undertaken at the WHO Consultation on International Travel and HIV which concluded, "[n]o screening programme of international travelers can prevent the introduction and spread of HIV infection. Therefore, . . . HIV screening programmes for international travelers would, at best and at *great cost* retard *only briefly* the dissemination of HIV both globally and with respect to any particular country."⁶⁸

Despite the real need for some laws to protect against genuine threats to public health from aliens, current medical knowledge shows that such a principle does not apply to AIDS/HIV. HIV is the virus which causes the disease AIDS.⁶⁹ The HIV virus is called a retrovirus because of its ability to insert its genetic code into the human host, which begins to replicate the virus.⁷⁰ The virus is unique because it attacks only the white blood cells and in particular a subpopulation known as *helper cells*.⁷¹ These helper cells are responsible for initiating a body's immune response to typical viral attacks.⁷² Once the virus successfully attacks the helper cells, the body's immune system weakens, thereby increasing the probability of acquiring infections typically asso-

68. WORLD HEALTH ORGANIZATION, *SUPRA* note 43, at 261 (*emphasis in original*). The three issues examined by the Consultation were: the question of HIV screening of international travelers; the use of public conveyances by HIV-infected persons; and the need for information for international travellers on the prevention of HIV infection. *Id.* at 254.

69. Gerald H. Friedland & Robert S. Klein, *Transmission of the Human Immunodeficiency Virus*, 18 *NEW ENG. J. MED.* 1125, 1125 (1982). Viruses are microorganisms which consist of a nucleic acid at the core of a protective shell and are only capable of reproducing within other living cells by using elements of the host cell for synthesis of the virus. Scott H. Isaacman & Michael L. Closen, *Medical Principles, in AIDS CASES AND MATERIALS* 111 (1989) [hereinafter Isaacman & Closen]. A virus has been analogized to a hijacker on a microscopic level in which the virus enters the cells unexpectedly, and without permission use the native materials and cellular machinery of the host to replicate themselves. *Id.*

70. Gibofsky & Laurence, *supra* note 1, at 498.

71. *Id.* at 500.

72. *Id.*

ciated with AIDS.⁷³ Therefore, while HIV causes the problems in the immune system, AIDS, though an outward manifestation of HIV infection, is actually due to opportunistic infections or malignancies which take advantage of the immunological defects.⁷⁴

Despite the rapid spread of HIV among certain populations, such as homosexuals and intravenous (I.V.) drug users, the means of transmitting the virus are limited. Before HIV can be transmitted, there must be exposure to the living virus, entry of the virus into the host, and successful replication within the host.⁷⁵ At the present time the only three mediums which have been scientifically proven to be capable of transmitting HIV are blood, semen, and breast milk.⁷⁶ Transmission of the HIV virus through blood can occur by transfusion of infected blood or blood products, needle sharing among intravenous drug users, inoculation through injection with unsterilized needles and by open wound exposure.⁷⁷ Infection with the HIV virus through semen can occur by engaging in certain high-risk sexual activities.⁷⁸ Finally, perinatal transmission — the transmission of infection from women to their offspring — can occur in three ways: from the woman to the fetus through maternal circulation; from the woman to the infant during labor by ingestion of blood fluids; or from the woman to the infant shortly after birth through breast milk.⁷⁹ Therefore, “[a]lthough we are confronted by a public health problem of potentially catastrophic dimensions, it is essential to appreciate that unwarranted fears of HIV transmission have compounded the suffering of young men, women and children infected with HIV and have blunted an appropriate societal

73. *Id.*

74. *Id.* at 497.

75. Isaacman & Closen, *supra* note 69, at 113.

76. Luis Perreira, Address to Legal Responses to AIDS Seminar, University of Connecticut School of Law (August 28, 1990) [hereinafter Perreira]; Notes From the XI International Conference on AIDS, 4 HIV Update 5 (June 1990) (published by Hartford Hospital Dept. of Med.). HIV has been identified in other body fluids such as tears, saliva, urine, and cerebrospinal, cervical and amniotic fluids, but the mere isolation of HIV in these fluids has not led to a finding that they are a mode for the transmission of the virus. Gibofsky & Laurence, *supra* note 1, at 498-99.

77. Friedland & Klein, *supra* note 69, at 1126.

78. Isaacman & Closen, *supra* note 69, at 114-18. The probability of sexual transmission of HIV depends upon the type of sexual activity. Oral-genital contact poses less of a risk of transmission than genital-anal contact which has a very high incidence of transmission. The reason that there is a lower risk of transmission from oral-genital contact is that the semen which is harboring the infection would have to enter the blood stream through a cut in the mouth, whereas with genital-anal contact the virus can directly enter the blood stream. *Id.*

79. Freidland & Klein, *supra* note 69, at 1130.

response aimed at reduction of transmission.”⁸⁰

Once the virus is transmitted, infection progresses in three stages. First is the entry of the virus into the new human host cells where replication occurs. Although the virus is present at this time and capable of being transmitted, there will be a three-month to six-month window period before the body begins to produce antibodies.⁸¹ The second stage is the incubation period, which can last three years to fifteen years.⁸² During this period an individual can take on one of two roles: either that of the silent carrier with no outward symptoms, or that of the symptomatic HIV-infected individual.⁸³ The third and final stage is referred to as full-blown AIDS. A person identified as having reached this stage is characterized as having one or more opportunistic diseases.⁸⁴

Given the fact that transmission of the virus can only occur in three ways, denying entry to infected aliens is not the most effective way to protect the public health of American citizens. The medical realities indicate that energy and resources would be more beneficially used to educate individuals about HIV and the means of transmission.⁸⁵ Once infected individuals are aware of what behaviors present a risk of HIV transmission, they can modify their behavior in order to reduce the probability of infection.

For example, with blood transmission, sterilization of needles with commercial bleach will kill the virus instantly.⁸⁶ In the case of sexual transmission, a reduction of sexual partners and high risk practices, along with the use of a condom, can decrease the risk of transmitting HIV.⁸⁷ Also, since perinatal transmission can occur through breast feeding, some instances of transmission can be prevented by teaching

80. *Id.* at 1133.

81. *Perreira, supra* note 76.

82. *Id.*

83. *Id.* A person with symptomatic HIV may have a variety of symptoms such as diarrhea, nightsweats, fever, fatigue, and skin changes resulting in severe seriosis. The stage at which an individual manifested these symptomatic problems used to be referred to as AIDS-related complex or ARC. The Public Health Service no longer uses the term ARC to classify the second stage of the disease and instead uses a more complex system which classifies all individuals infected with the virus. See *Classification System for Human T-Lymphotropic Virus Type III Lymphadenopathy-Associated Virus Infections*, 35 MORBIDITY AND MORTALITY WEEKLY REPORT 334, 335-37 (1986).

84. *Perreira, supra* note 76.

85. WORLD HEALTH ORGANIZATION, *supra* note 43, at 261.

86. *Friedland & Klein, supra* note 69, at 1128.

87. *Id.* at 1130.

the mother to use formula instead of breast milk. Contrary to popular myth, close personal contact or non-sexual household contact such as sharing beds, toilets, bathing and kitchen facilities, or hugging will not result in a spread of the virus.⁸⁸ In general, available data indicate that transmission through any means is not as likely to be successful with only a few exposures as it would be with multiple repeated exposure.⁸⁹ Therefore, an educated individual can stop engaging in high-risk behavior and decrease the probability of becoming infected with the HIV virus. Not only is education rather than exclusion the most effective way to stop further spread of the virus, but a policy which bars infected aliens may actually contribute to the spread of the virus. An alien who knows that a positive HIV test will result in exclusion, and little or no chance of obtaining a waiver,⁹⁰ will be more likely to enter the United States illegally.⁹¹ Unable to find legal employment, these aliens will be forced underground where they will not receive proper counseling and medical treatment. Aliens in this situation are more likely to engage in high-risk behavior, thus contributing to the spread of HIV.⁹² In effect, the United States policy encourages people to avoid testing or to falsify their results rather than be tested and acknowledge the need for behavior modification.⁹³ As one author noted,

[t]he rationale for adding the HIV exclusion, controlling the spread of HIV and AIDS, will backfire since uncounseled aliens will not know how to contain the spread of the virus or have the resources to control the disease. They may even be forced into occupations that virtually guarantee spread of the disease.⁹⁴

Even accepting the United States government's postulate that excluding HIV-infected aliens will protect the public health, there is evidence that no testing scheme can effectively keep out all infected legal aliens. The United States exclusionary policy is carried out through two

88. *Id.* at 1132.

89. *Id.* at 1133.

90. See *supra* notes 25-32 and accompanying text.

91. Lynn A. Starr, *The Ineffectiveness and Impact of the Human Immunodeficiency Virus (HIV) Exclusion in United States Immigration Law*, 3 GEO. IMMIGR. L. J. 87, 98-99 (1989).

92. *Id.* at 89.

93. Larry Gostin & Paul Cleary, *An Exclusion That Makes No Sense: Why is The Sixth International AIDS Conference Being Hobbled?*, WASH. POST, June 15, 1990, at A25.

94. Starr, *supra* note 91, at 99. For example, individuals may turn to prostitution as a way to gain income.

serological tests, the Western Blot test and the ELISA test.⁹⁵ As with any other screening or diagnostic test, there are questions of validity and reliability. A test's *validity* depends upon the extent to which the test will be able to detect what it is searching for, in this case HIV antibodies.⁹⁶ A test's *reliability* depends upon the consistency in results if the test is performed a number of times under like situations.⁹⁷ Both the effectiveness of these tests and the procedures of the INS in administering the tests raise doubts as to their validity and reliability and thereby undermine the government's public health argument.

The validity of both the Western Blot test and ELISA test is uncertain for two reasons. First, because there is a window period of three to six months from infection, during which the body has not yet produced antibodies, some individuals who are infected will not test positive for the virus.⁹⁸ Second, a test which is aimed at detecting the level of antibodies, instead of the presence of the virus itself, can only indicate the probability of a particular person having the virus.⁹⁹

The INS testing procedures also highlight inherent questions as to the reliability of any test result. Both the individual administering the test and the laboratory location of the test may have effects upon the results. The actual serological testing of aliens, which began in December, 1987, is performed by the physicians who do all routine medical examinations for the INS.¹⁰⁰ Most INS physicians designated to test aliens have little or no experience with HIV antibody testing or the virus itself and are not properly trained to interpret HIV lab tests or to provide counseling before and after the tests.¹⁰¹ Because these physicians are inexperienced and untrained in administering the test, they may reduce the reliability of the results.

Since most aliens applying for a visa will be tested in their own countries at a United States consular office, geography plays an impor-

95. Rupert E.D. Whitaker & Richard K. Edwards, *An Ethical Analysis of the U.S. Immigration Policy of Screening Foreigners for the Human Immunodeficiency Virus*, 5 AIDS & PUB. POL'Y J. 145, 148 (1990).

96. Michael J. Barry et al., *Screening for HIV Infection: Risks, Benefits, and Burden of Proof*, 14 LAW, MED. & HEALTH CARE 259, 261 (1986).

97. *Id.* at 261.

98. *See supra* note 81 and accompanying text.

99. Michael J. Barry et al., *supra* note 96, at 260. The tests are designed to detect whether the body's immune system has begun to produce antibodies to fight HIV. Because the body needs time to produce antibodies the test cannot definitively answer whether or not an individual has HIV. Instead the test can only determine the probability of infection. *Id.*

100. McMurray, *supra* note 2, at 4.

101. *Id.*

tant role in the test results. The test results will vary because of the different laboratories administering the test. "[T]he INS screening program was implemented without the establishment of a reference laboratory, without guidelines for the standardization of reagents, procedures, interpretation criteria, or training; and without centralizing supplemental testing."¹⁰² It is probable that less-developed countries will have inadequate testing facilities, improper storage and transportation of materials, improper handling of blood samples and different climates, all of which yield a higher number of incorrect test results.¹⁰³ Therefore, the economic status of the nation where the applicant is tested may affect the results of the serological test.

The consequence of these testing problems is a high number of false negative and false positive test results.¹⁰⁴ Since its implementation the screening program conducted by the INS has tested more than three million foreigners and under optimistic assumptions there has been one false positive result for every fifteen persons detected.¹⁰⁵ This means that all of those immigrants who test false positive are being unjustly denied entry into the country. As for those who test false negative the problem is compounded by the sense of false security the individual now has which may lead to the unknowing spread of the virus.¹⁰⁶ All the resources that are necessary to provide for the testing and administration of the policy will not stop the spread of the disease, and may actually contribute to its spread. As stated by Dr. Jonathan Mann, director of WHO's Special Programme on AIDS,

[t]o the extent that we exclude the HIV-infected people from our midst we endanger the rest of society. To the extent to which we include those HIV-infected people in our midst we protect our society. . . . Excluding HIV-infected people from our midst endanger us all because it sends a clear signal to those who are HIV-infected or whose behaviours put them at risk of HIV infection, to hide or otherwise avoid being identified. Otherwise they could be uprooted from their jobs or their lives and sent away, so to speak. It would also encourage peo-

102. Whitaker & Edwards, *supra* note 95, at 151.

103. Starr, *supra* note 91, at 94.

104. A positive test result for an individual who is not actually infected is called a *false positive*, whereas a negative test result for an individual who is actually infected is called a *false negative*. Isaacman & Closen, *supra* note 69, at 149.

105. Gostin & Cleary, *supra* note 93, at A25.

106. WORLD HEALTH ORGANIZATION, *supra* note 43, at 261.

ple who are concerned that their behaviour might expose them to the virus, to think that those people who are infected have been sent away and therefore the people who remain in society are not infected, which, of course, would not be true. Second, if they might be exposed, under no circumstances would they have themselves tested because of the dangers in the event that they are infected. So the signal that's been sent becomes counterproductive to the protection of public health.¹⁰⁷

The effectiveness of the HIV exclusion is also diminished because of the limited population that is tested. As noted previously, under the Helms Amendment all persons of immigrant status attempting to enter the country are tested, while persons of non-immigrant status are only tested on a discretionary basis.¹⁰⁸ If the policy justification of the HIV exclusion is to protect United States citizens from the spread of the disease, then allowing one of two groups, both with the same capacity to spread HIV, to remain untested will frustrate the underlying purpose. While immigrants who are to remain in the United States for extended periods would seem the logical group to test if a choice had to be made, it is difficult to rationalize a distinction between the two groups based upon the length of stay when HIV can be transmitted in one day.

The government has responded to such criticism by asserting that the testing of non-immigrants would cause administrative and monetary problems.¹⁰⁹ Such problems could be obliterated if the exclusionary policy was removed entirely and the money saved from immigrant testing could be spent on more effective education and counselling programs. Another way to ease administrative and monetary burdens, which is currently used in France, is to test only those individuals that show clinical symptoms. This method will create administrative ease by clearly defining who must be tested. It will also lessen the monetary burden by decreasing the number of aliens who require a serological test.

Realizing that medical data does not support the exclusion of HIV-infected aliens, some opponents of the proposed unrestricted HIV immigration policy have argued that, even absent a serious threat to the public health, the American health care system could not sustain

107. Starr, *supra* note 91, at 100 (quoting Interview with Dr. Jonathan Mann, Director, Special Programme on AIDS, WHO Features No. 114 (Dec. 1987)).

108. See *supra* notes 26-31 and accompanying text.

109. Starr, *supra* note 91, at 96.

the monetary burden of HIV-infected aliens needing United States medical treatment.¹¹⁰ This argument fails to take into account the status of those aliens who would be entering the United States. Poor and infected aliens from developing countries will be in no position to move in large numbers to the United States.¹¹¹ Of the remaining immigrants from other developed nations, those who enter on a temporary basis will often be covered by their own country's socialized medical insurance, while those attempting to settle in the United States for long periods will not be granted an entry visa unless they prove the ability to support themselves.¹¹² Also, the underlying motives of such an argument are suspect because medical immigration policy has not previously been shaped by the resultant costs to the United States health care system. If policy decisions were made on this basis any alien with a costly ailment would also have been excluded. In support of this criticism, a Canadian report, released at the Seventh Annual International AIDS Conference, found that those aliens with HIV who entered Canada in 1988 would cost the health care system an estimated \$18.5 million over ten years, whereas aliens with heart disease would cost an estimated \$23.2 million over the same period.¹¹³

In conclusion, the current United States policy excluding HIV infected aliens is not the most effective way to combat the spread of the virus. With no currently known cure, risk-behavior modification is the most effective way to slow the transmission of the virus. Education and counseling provide the only successful means by which to implement a change in risk behavior. Excluding those infected aliens who manage to attain positive test results may arguably have an impact on the number of people infected with HIV in the United States, but this number is so slight that it cannot outweigh the costs. These costs not only include the direct expenses of testing, but also the humanitarian costs. As stated by the WHO Consultation on International Travel and HIV Infection,

[t]he diversion of resources towards HIV screening of international travellers and away from education programmes, protection of blood supply and other measures to prevent paren-

110. See HUTCHINSON, *supra* note 9, at 416.

111. Jerome E. Groopman, *Insult to Injury: A Doctor Protests; Bush Reneges, Bars HIV Patients from Emigration*, THE NEW REPUBLIC, June 24, 1991, at 13.

112. *Id.*

113. Dolores Kong, *HIV Positive Immigrants Find Their Lives Are Caught In Limbo*, BOSTON GLOBE, June 17, 1991, at A1.

teral and perinatal transmission, will be difficult to justify in view of the epidemiologica[1], legal, economic, political, cultural and ethical factors mitigating against adoption of such a policy.¹¹⁴

IV. HUMANITARIAN ISSUES SURROUNDING THE HIV IMMIGRATION EXCLUSION

This section will examine the humanitarian costs that arise from the HIV immigration restriction. The protection of public health against AIDS is a legitimate governmental aim, since the disease is one of the most serious medical threats of the day. United States immigration policy has long used the exclusion of infected aliens as a mechanism to combat further proliferation of various diseases,¹¹⁵ but the right of the government to exercise this type of police power must be balanced against the individual's rights.¹¹⁶ The HIV immigration restriction highlights this tension between fundamental civil liberties and the government's role in assuring public welfare. This section will first address the possible discriminatory impact of the HIV immigration exclusion. It will then analyze the specific effects of such a policy both globally and on individuals who have been excluded. This section, ignoring the fact that an exclusionary policy is ineffective in stopping the spread of HIV in the United States, will conclude that although there is a legitimate interest in protecting the public from the spread of AIDS, such interest is outweighed by the humanitarian concerns that are necessarily implicated by the HIV exclusion.

It has been globally recognized that "respect for [the] human rights and dignity of HIV-infected people and people with AIDS is vital to the success of national [and global] AIDS prevention and control programmes."¹¹⁷ Although the administration's decision to exclude HIV infected individuals may seem justifiable as a means to protect the public health, the human rights of the individuals who are being tested cannot be ignored. "AIDS is the first truly global strategy for health

114. WORLD HEALTH ORGANIZATION, *supra* note 43, at 261.

115. Druhot, *supra* note 19, at 87-89; Jorge L. Carro, *From Constitutional Psychopathic Inferiority to AIDS: What is in the Future for Homosexual Aliens?*, 7 YALE L. & POL'Y REV. 201, 222-23 (1989); Golumbic, *supra* note 10, at 177.

116. Wendy Parmet, *Legal Rights and Communicable Disease: AIDS, the Police Power, and Individual Liberty*, 14 J. HEALTH POL., POL'Y & L. 741 (1989).

117. 4 Progress Report of the Global Programme on AIDS WHO/GPA/GEN 88.3, 2 (Oct. 1988). The statement is a resolution which was adopted by the Forty-first World Health Assembly in May of 1988.

care which embraces not just health but people's human rights. . . In following an anti-AIDS/HIV strategy, governments should consider whether or not they are violating the basic human rights laid down in the U.N. Charter in their fight against the disease."¹¹⁸

The United Nations Charter was drafted in 1945,¹¹⁹ and provided an outline for the recognition of human rights.¹²⁰ The general concept was expressed in Article 55, which calls for the promotion and respect of the human rights and fundamental freedoms of all people.¹²¹ Three years later, in 1948, the Universal Declaration of Human Rights (the Declaration) was enacted.¹²² Article II, which states "no person is to be discriminated against by reason of their race, color, sex, language, religion, political opinion, national or social origin, property, birth or *other status*,"¹²³ articulates a concept which parallels Article 55 of the United Nations Charter. By including the operative words "other status," the Declaration goes beyond the Charter and establishes rights for HIV-infected individuals.

Debate on the juridical status of the Declaration still remains partially unsettled. Commentators have taken a wide range of positions as to the obligations of member nations under the Declaration. At one extreme, some argue that because the United Nations General Assembly did not intend to create binding legal obligations when it adopted the Declaration, the Declaration cannot denote binding obligations under international law, no matter how great its moral or political authority.¹²⁴ At the opposite extreme, some commentators have found that over the thirty years since its adoption, the Declaration has acquired the status of *jus cogens* because of the consistent practice by states and international institutions in invoking its provisions as evidence of international law.¹²⁵ The intermediate approach argues that the Declaration creates binding obligations for member states of the United Nations, not because they have become part of customary international law, but because they have presently accepted these obliga-

118. U.N., *WHO Officials Agree International Control Needed*, 4 AIDS Pol'y & L. (BNA) No. 15, at 9 (Aug. 9, 1989).

119. U.N. CHARTER (adopted in San Francisco, June 26, 1945).

120. Note, *Advocacy for AIDS Victims*, 20 INTER-AM. L. REV. 1, 8 (1988).

121. U.N. CHARTER art. 55.

122. G.A. Res. 217 A(III), U.N. Doc. A/810 at 71 (1945) [hereinafter Declaration].

123. *Id.* at art. II (emphasis added).

124. PAUL SIEGHART, *THE INTERNATIONAL LAW OF HUMAN RIGHTS* 53 (1984).

125. *Id.*

tions.¹²⁶ Although the status of the Declaration is not conclusive, there is ample support to show that it constitutes binding legal obligations for member states of the United Nations and as such can be applied to the United States in cases of the exclusion of HIV-infected individuals.¹²⁷

The question becomes how the HIV immigration exclusion might violate the Declaration. The principle of non-discrimination as embodied in Article II of the Declaration provides an appropriate standard by which to measure the validity of the HIV immigration exclusion. When analyzing the United States policy, a potential contradiction to Article II, which prohibits distinctions based on "other status," arises. Just as public health restrictions may infringe impermissibly on various other freedoms, such restrictions, used in a discriminatory manner, could unjustifiably bar admission of certain classes of aliens.¹²⁸

The United States policy facially discriminates against HIV-infected aliens by denying entry based on a seropositive HIV test. The government restricts entry on the alleged basis that such exclusion is necessary to protect the public health of American citizens and to protect the American health care system from increasing costs. As shown in the previous section, these two justifications can be discounted as valid reasons for the exclusionary policy. Denying entry to HIV-infected immigrants is not the most effective way to combat the disease and will do little to prevent further spread.¹²⁹ The cost to the health care system has not previously been a justification for denying entry to aliens, and if this was the standard other diseases would have to be

126. *Id.* In support of the intermediate position three independent arguments have been proposed. The first argument states that Articles 55 and 56 of the U.N. Charter create legal obligations for all member states to take action to observe human rights and fundamental freedoms. Although the U.N. Charter does not list these rights and freedoms, the Declaration supplies these missing parts. Since the wording of the Declaration mirrors that of the U.N. Charter, the members have retrospectively incorporated the list of rights and freedoms into the U.N. Charter by which they are bound. *Id.* at 54. The second argument states that the Declaration is a legitimate aid for interpreting the expression "human rights and fundamental freedoms" in the U.N. Charter. The general rule of interpretation of a treaty, that subsequent practice establishes the agreement of parties as to its content, is then applied. Since it has been consistent practice of states and the U.N. itself to cite the Declaration as an enumeration of the rights and freedoms in the U.N. Charter, it must now be so interpreted. *Id.* The final argument states that if the Declaration did not previously constitute an obligation for member states of the U.N., the proclamation signed at the U.N. International Conference on Human Rights in 1968, which stated that the Declaration did create a binding obligation on U.N. member states, now constitutes such an obligation. *Id.*

127. *Id.* at 54-55; Louis B. Shon, *The Human Rights Law of the Charter*, 12 TEX. INT'L L. J. 129, 133 (1977); Richard Bilder, *The Status of International Human Rights Law: An Overview*, in INTERNATIONAL HUMAN RIGHTS LAW AND PRACTICE 8 (James C. Tuttle ed., 1978).

128. Allin, *supra* note 13, at 1061.

129. See *supra* notes 68-94 and accompanying text.

added to the list of exclusions.¹³⁰ In light of the fact that no compelling rationale has been successfully offered in support of the exclusions, the resulting discrimination against HIV-infected aliens is not justifiable.

The existence of such discrimination against HIV-infected aliens is further supported by the history of the United States immigration policy on disease control and medical exclusions. The first Congressional restrictions on immigration were passed in 1875 under An Act Supplementary to the Acts in Relation to Immigration.¹³¹ It was four years later that Congress began to regulate the entrance of aliens on the basis of medical reasons.¹³² From the original restrictions of 1879 up to 1952, when the Immigration and Nationality Act was recodified, exclusion of aliens for medical reasons went through a series of additions and subtractions. In 1879, when the first such act was passed, the National Board of Health was allowed to inspect the conditions of ships and their passengers arriving at United States ports and to bar entry for medical reasons.¹³³ During 1891, medical inspection of aliens at United States ports began and aliens who were physically or mentally disabled, insane, had a dangerous contagious disease, or were likely to become public charges were excluded.¹³⁴ As xenophobia began to grow so did the list of types of excludable aliens, which in 1917 included but was not limited to: idiots; imbeciles; epileptics; persons of constitutional psychopathic inferiority; and persons with chronic alcoholism.¹³⁵

In 1952, with the passage of the newly written Immigration and Nationality Act¹³⁶ the list of aliens who could be excluded for medical reasons included: the feeble-minded; the insane; those who had one or more attacks of insanity; those afflicted with psychopathic personality, epilepsy, or a mental defect; narcotic drug addicts or chronic alcoholics; those afflicted with tuberculosis in any form, those with leprosy or any dangerous contagious disease; and those not within the first six classes

130. See *supra* notes 110-113 and accompanying text.

131. An Act Supplementary to the Acts in Relation to Immigration, 18 Stat. 477 (1875), (codified at U.S. Rev. Stat. ch. 141 (1878)).

132. An Act to Prevent the Introduction of Infectious or Contagious Diseases into the United States, and to Establish a National Board of Health, ch. 202, 20 Stat. 484, 85 (1879).

133. Druhot, *supra* note 19, at 88 (citing An Act to Prevent the Introduction of Contagious or Infectious Disease into the United States, ch. 11, 21 Stat. 5-7 (1879)).

134. *Id.* (citing An Act in Amendment to the Various Acts Relative to Immigration and the Importation of Aliens Under Contract or Agreement to Perform Labor, ch. 551, § 8, 26 Stat. 1084, 1085 (1891)).

135. *Id.* at 89 (citing An Act to Regulate the Immigration of Aliens to, and the Residence of Aliens in the United States, ch. 29, 39 Stat. 874, 875 (1917)).

136. Immigration and Nationality Act of 1952, 8 U.S.C. § 1101 et. seq. (1952).

who had a physical defect that may have affected their ability to earn a living.¹³⁷ The disabilities listed were not exclusive as, “[s]everal exclusionary categories - especially those relating to immoral, subversive, criminal and mentally ill aliens - [had] ‘penumbras’ that bar[red the] entry of aliens on the basis of the unacceptability of their beliefs or lifestyles.”¹³⁸

The current United States HIV immigration restriction seems to be reflective of past public health policies that are now accepted as having been based on irrational fears and prejudices. History has shown that “[t]he way a society responds to problems of disease reveals its deepest cultural, social, and moral values. These core values . . . shape and guide human perception and [responsive action]”¹³⁹ to new public health issues. Unfortunately, such responses have led to the use of disease control policies to oppress those who do not have acceptable beliefs or lifestyles.

One early example of this kind of oppression occurred in the first decade of the twentieth century when hysteria about venereal infections began to grow. Without the benefit of modern medical understanding, the government’s public health solution was to identify and single out prostitutes as a major threat to American health, thereby requiring those “reasonably suspected” as having the disease to undergo compulsory testing and subject themselves to quarantine.¹⁴⁰ As time progressed, there was growing recognition that such a policy was used to oppress this undesirable subpopulation, and was an ineffective method of disease control.¹⁴¹ This acknowledgement led to challenges against and the ultimate reversal of these public health restrictions on prostitutes.¹⁴² This exemplifies the potential of disease control policies to exclude groups of people who are viewed as leading unacceptable lifestyles.

The previous treatment of homosexuals, one of the groups disproportionately affected by the HIV exclusion, provides another example of this oppression. In 1967, the Supreme Court in *Boutilier v. INS*¹⁴³

137. *Id.* at § 1182(a)(1)-(7).

138. Note, *Immigration Policy and the Rights of Aliens*, 96 HARV. L. REV. 1286, 1340 (1983).

139. Allan M. Brandt, *AIDS: From Social History to Social Policy*, 14 LAW, MED. & HEALTH CARE 231 (1986).

140. *Id.* at 233.

141. Parmet, *supra* note 116 at 749.

142. *Id.*

143. 387 U.S. 118 (1967).

held that Boutilier, a homosexual, could be excluded under Section 212(a)(4) of the Immigration and Nationality Act of 1952, which excluded "[a]liens afflicted with psychopathic personality, or epilepsy, or a mental defect."¹⁴⁴ The issue arose again as recently as September, 1983, when two United States Courts of Appeals addressed the question of whether an alien can be excluded from entry into the United States because of the individual's sexual preference. The two courts handed down opposing decisions.

The Ninth Circuit, in *Hill v. INS*,¹⁴⁵ held that given the current legislative and administrative framework, aliens could not be excluded on the basis of homosexuality *per se*.¹⁴⁶ This analysis was supported by the fact that in 1979, the Public Health Service (PHS) revised its policy regarding the certification of mental defects under the Immigration and Nationality Act.¹⁴⁷ The Public Health Service found that homosexuality *per se* could no longer be considered a mental disease or defect because such a view was not consistent with current medical knowledge, and also found that homosexuality was not susceptible of determination through a medical diagnostic procedure.¹⁴⁸

Despite the intervening medical acknowledgement by the Public Health Service that homosexuality *per se* was not a mental defect, the Fifth Circuit in *In re Longstaff*¹⁴⁹ held that because Longstaff was a homosexual at the time of his entry into the United States in 1965, he was excludable as a sexual deviant.¹⁵⁰ Giving great deference to the INS's administrative scheme the court found an admission of homosexuality dispositive of the issue of excludability, even in the absence of any medical certification.¹⁵¹ The court reasoned that if "the alien admits the facts determining his excludability, the Board, other immigra-

144. Immigration and Nationality Act of 1952, 8 U.S.C. § 1182(a)(4)(1952). Subsequent to the lower court decision Congress enacted P.L. 89-236 which substituted the phrase "or sexual deviation" for "epilepsy". The *Boutilier* court, construing the earlier language, held that "as used in [the Act of 1952] psychopathic personality was a term of art intended to exclude homosexuals from entry into the United States". 387 U.S. at 121-23.

145. 714 F.2d 1470 (9th Cir. 1983).

146. *Id.* at 1480.

147. *Id.* at 1472 (citing 56 Interpreter Releases 387, 398 (1979)).

148. *Hill*, 714 F.2d at 1472-73. The court noted that, "according to the comprehensive listing of currently recognized psychiatric diagnoses in the 1974 revised edition and the 1978 edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, homosexuality is not considered to be a psychiatric disorder" *Id.* at 1472 n.3.

149. 716 F.2d 1439 (5th Cir. 1983), *cert. denied*, 467 U.S. 1219 (1984).

150. *Id.* at 1440.

151. *Id.* at 1450.

tion officials, and the courts may assuredly act on the basis of that admission."¹⁵² The decision of the Fifth Circuit to ignore current medical knowledge and defer to administrative ease evidences the persistent discriminatory nature of the exclusion.

This holding, which ignored the medical precedents set by the PHS, can be analogized to the exclusion of HIV-infected aliens. HIV has created feelings of hysteria among the general public in the face of a spreading AIDS pandemic. This mood reinforces the hasty enactment of policies as legislators want to appear to be taking steps toward controlling the virus. But the persistent refusal to accept current medical evidence as a basis for the removal of the HIV immigration exclusion raises questions about the underlying purpose of the policy. It is this discrimination against HIV-infected aliens in the absence of a legitimate justification which violates the non-discrimination provision of Article II of the Declaration.

The policy of excluding HIV-infected aliens, which reinforces society's misguided perceptions about HIV and its means of transmission, has not been limited to the United States¹⁵³ and poses global problems. Countries currently without restrictions on HIV-infected aliens may be inclined to enact restrictive procedures in response or retaliation to the United States. The probability of possible retaliatory measures is increased because of the impression that the United States is actually to blame for the spread of the disease throughout the world. These impressions are derived from the fact that as of April 1, 1987 86 percent

152. *Id.* at 1449. "The court in *Longstaff* cited several cases in support of its position that an alien's admission of homosexuality could serve as the basis of exclusion. *Id.* at 1449 n.52. "None of these cases cited, however, [was] persuasive authority for the court's conclusion because in each case, the decision to deport was based on medical evidence or authority." Samuel M. Silvers, *The Exclusion and Expulsion of Homosexual Aliens*, 15 COLUM. HUM. RTS. L. REV. 295, 313 n.135 (1984).

153. The following is a list and brief explanation of current or recent restrictive policies in other countries. The former U.S.S.R. required all foreign visitors staying for a period of greater than three months, who were from countries where AIDS was prevalent, and all persons belonging to risk groups, to be screened for the virus. WORLD HEALTH ORGANIZATION, *supra* note 43, at 194. Iraq requires that all foreign travelers staying in Iraq for more than five days be tested prior to entry. Erik Eckholm, *A Travelers Guide to AIDS*, N.Y. Times, Sept. 27, 1987, § 10, at 21, 27. China requires that any alien entering China with the intent to stay one year or more, or any alien attempting to gain permanent entry, test for the virus. If the test results are positive the alien will be denied entry. WORLD HEALTH ORGANIZATION, *supra* note 43, at 38-39. The law of Thailand mandates that any alien with AIDS cannot enter the Kingdom. *Id.* at 192. France has a unique policy in that they test only those individuals who have clinical symptoms. An individual who is infected with HIV cannot be denied a residence card if they do not show any clinical symptoms. *Id.* at 78-79. Other countries that have restrictive entry policies for people infected with HIV include Bulgaria, Argentina, South Africa, India, Sri-Lanka and Bangladesh. Eckholm, *supra*.

of all cases reported to the WHO were from the Americas and 91 percent of these cases were from the United States.¹⁵⁴ The dangers of such retaliation include the hampering of all international travel, restrictions on open business, restricted access to United States military bases,¹⁵⁵ and, most importantly, restrictions on the free exchange of information both medical and non-medical.¹⁵⁶ Since the disease will not limit itself to the borders of any one country, the exchange of medical information and technology will be necessary to attack the disease at a global level. Some critics have noted that

[t]he global implication of AIDS has already become apparent for continued freedom of travel, for the unrestricted conduct of business, for the maintenance of security, for unrestricted international health cooperation and assistance, and for human rights. Nevertheless, U.S. government agencies thus far have focused on implications of the disease primarily in terms of specific agency interests. There appears to be no coordinated overview of the foreign policy implications and no framework for how or whether or when to discuss such policy issues with other friendly countries.¹⁵⁷

Any successful attempts to stop the spread of the virus will have to include all countries, since no area of the world is free from infection.

Apart from the global implications, the denial of entry to HIV infected aliens raises humanitarian concerns for the specific individual. If an individual is excluded will he/she receive proper medical treatment? Because all those who test positive must return to their own countries, those who live in less developed countries may receive inappropriate or no medical care.¹⁵⁸ For example, an HIV-infected alien from Haiti will be forced to leave the United States, where counseling and experimental drugs are available, and return to Haiti where, in 1987, there were only five beds for people infected with AIDS¹⁵⁹ and total resources that were equivalent to only two percent of the United

154. Jonathan Mann, *Worldwide Strategies for HIV Control: WHO's Special Programme on AIDS*, 14 *LAW, MED. & HEALTH CARE* 290, 291 (1986).

155. Lois McHugh, *AIDS: International Problems and Issues*, in *AIDS LEGAL, LEGISLATIVE AND POLICY ISSUES* 389 (Norman Quist ed., 1989); Allin, *supra* note 13, at 1056.

156. Starr, *supra* note 91, at 109-10.

157. Paul Kreisberg & Harry Blaney, *AIDS A Foreign Policy Issue Too: It affects travel, business, national security*, *WASH. POST*, Oct. 12, 1987, at A19.

158. Golumbic, *supra* note 10, at 181.

159. Lee Hockstader, *For an AIDS "cure," Folk doctor charges \$1 a Shot*, *Wash. Post*, Sept. 29, 1987, at Health 12, 16.

States resources for combatting the disease.¹⁶⁰

The lack of proper medical treatment may be a minor problem, however, in comparison with the dilemma posed by those aliens who are forced out of the United States and then denied reentry into their own country once they have tested positive. Senator Alan Simpson (R-WY), recognized the potential problem:

[D]o you exclude them and deport them to a country that will not take them? Then what are we talking about? Leaving them here illegally in a status with a communicable disease? That is a possibility. Or, are you talking about detention or areas where they will be quarantined? That is really where we are headed here.¹⁶¹

Also, some countries which allow infected aliens to reenter may nevertheless bar them from employment and persecute them as outcasts.¹⁶²

In balancing the police power of the government to protect public health against the individual's rights, the issues of discrimination and potential damaging effects both globally and upon the individual excluded must be considered. The public health argument fails in the case of HIV because of the limited nature of transmission and the fact that education, along with counseling, provides the only current available means of containing the spread of the virus. Thus while the police power or public health justification lacks weight, the humanitarian concerns created by the HIV exclusion are compelling. The policy poses conflicts with the non-discrimination provision of Article II of the Declaration because of its discriminatory impact upon HIV-infected aliens, and also results in harmful consequences at both a global and individual level. The result is a United States immigration policy which flies "in the face of strong international opinion and practice, [leads] to unconscionable infringement of human rights and dignity, and . . . reinforce[s] a false impression that AIDS and HIV infection are a general threat when in fact they are sharply restricted in their mode of transmission."¹⁶³

160. PANOS INSTITUTE, *AIDS AND THE THIRD WORLD* 83 (1989). Another example provided by the Panos Institute Report cites that, "[w]hile the U.S. allocated \$2,000 million to AIDS research and control, a hospital dealing with AIDS in Kampala cannot obtain bleach to disinfect its test tubes." *Id.* at 48.

161. 133 CONG. REC. S7415 (June 2, 1987)(statement of Sen. Simpson).

162. Rona Morrow, Comment, *AIDS and Immigration: the United States Attempts to Deport a Disease*, 20 INTER-AM. L. REV. 131, 157-58 (1988).

163. *AIDS Panel Asks DOJ to Review Policies: Groups Threaten Boycott of Meetings*, 4

CONCLUSION

The AIDS pandemic is a current health care crisis of potentially catastrophic dimensions. As the number of people infected with the virus grows, the specific population groups that it affects are also expanding. If the United States government is to enact a disease control immigration policy that is both efficient and just, the government must permanently remove HIV from the list of excludable diseases.

The current United States immigration restriction on HIV-infected aliens proves to be both counter-productive and unjust. It is counter-productive since a policy which excludes infected aliens will do little in terms of education and counseling, which remains the most effective way to slow down the virus's spread. In addition the restrictive policy is unjust, and creates serious humanitarian problems. The exclusion is potentially violative of the non-discrimination provision of the Universal Declaration of Human Rights because of its discriminatory impact on HIV-infected aliens. The policy also ignores the potential civil rights ramifications upon the global community as well as the excluded individual. In comparing this policy to past disease control policies, it can be seen that the United States government's decisions in the area continue to be based on unsubstantiated fears of contagion and irrational prejudices rather than sound public health policies.

With no cure currently available, the virus will inevitably be present in society for an indefinite period. If the United States and other countries are to be successful in their fight against this pandemic they must open their doors along with their minds and attack the virus with an immigration policy that both acknowledges current medical principles and respects the human rights of those with HIV or AIDS.

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