

Moving Beyond the U.S. Government Policy of Inadmissibility of HIV-Infected Noncitizens

A Report of the CSIS Task Force on HIV/AIDS

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The CSIS Task Force on HIV/AIDS

The CSIS Task Force on HIV/AIDS is cochaired by former senator and majority leader Bill Frist (R-Tenn.) and Senator Russell Feingold (D-Wis.) and is funded principally by the Bill and Melinda Gates Foundation, with project support and input from the Henry J. Kaiser Family Foundation, the David and Lucile Packard Foundation, and Merck and Co. The Task Force outlines strategic choices that lie ahead for the United States in fighting the global HIV/AIDS pandemic. It is composed of experts from Congress, the administration, public health groups, the corporate sector, activists, and others who help shape its direction and scope and disseminate its findings to a broader U.S. audience.

The Task Force seeks to build bipartisan consensus on critical U.S. policy initiatives and to emphasize to senior U.S. policymakers, opinion leaders, and the corporate sector the centrality of U.S. leadership in strengthening country-level capacities to enhance prevention, care, and treatment of HIV/AIDS. J. Stephen Morrison, director of the CSIS Africa Program, manages the overall project, in cooperation with the CSIS Freeman Chair in China Studies, the CSIS Russia and Eurasia Program, and the CSIS South Asian Program.

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Health-related grounds for inadmissibility: “Any alien...who is determined (in accordance with regulations prescribed by the Secretary of Health and Human Services)¹ to have a communicable disease of public health significance, which shall include infection with the etiologic agent for acquired immune deficiency syndrome.”—Immigration and Nationality Act, Sec. 212. [8 U.S.C. 1182]

Introduction

Under current U.S. law and policy, HIV infection is grounds for denying admission of noncitizens, including both nonimmigrants and immigrants, to the United States. Although waivers to this policy of HIV inadmissibility² are available for some, but not all, visa applicants, such waivers are generally granted on a discretionary, case-by-case basis. The U.S. inadmissibility policy was put into place 20 years ago, when knowledge about HIV transmission and prevention was far more limited and the national debate over HIV/AIDS was overheated, dominated by fear of infected foreigners, and, many argue, infused with stigma

¹ Since 1993, Congress has explicitly *required* the U.S. secretary of health and human services to include HIV on the list of “communicable disease of public health significance.”

² Beyond people with HIV and other disease categories, examples of others who fall into the U.S. Citizenship and Immigration Services (USCIS) “inadmissible” category include persons who: (1) are controlled substance traffickers; (2) have committed severe violations of religious freedom; (3) are involved in international child abduction; (4) are significant traffickers of other persons; (5) have engaged in terrorist activity; (6) were participants in Nazi persecution or genocide; (7) are practicing polygamists; (7) are engaged in prostitution; (8) are involved in child abduction; (9) are involved in money laundering; and/or (10) have renounced U.S. citizenship for tax purposes. See general classes of aliens ineligible to receive visas and ineligible for admission, Immigration and Nationality Act (INA), Sec. 212.

against persons living with HIV. The central policy imperatives at that time were to protect American citizens from what was perceived to be a grave external threat and to preempt the entry and potentially heavy cost burden of a large population of noncitizens living with HIV. Mobilizing the global community against the HIV/AIDS pandemic was not yet a major U.S. foreign policy priority. Prior to 1993, the U.S. Public Health Service had authority to determine which communicable diseases were considered to have public health significance for the purposes of inadmissibility. In 1993 Congress declared that HIV was an exceptional threat to the country and directed on a permanent statutory basis that persons living with HIV be considered inadmissible. This intervention singled out HIV in a way not done for any other disease.

Since that time, U.S. visa policy with regards to HIV has remained unchanged despite the evolving views and recommendations of U.S. public health authorities, dramatic shifts in national and international HIV awareness and control efforts, and a conspicuous escalation of U.S. global leadership on HIV/AIDS.

First, from a public health perspective, it is now understood that the external disease threat was exaggerated, as was the likely medical cost burden of nonimmigrants and visitors. The risk of a surge of HIV-infected foreigners arriving on U.S. shores is low: in the last 10 years, wealthy countries with comparatively more open admission policies have not experienced a flood of impoverished HIV-infected wards. Further, there is today broad recognition of how HIV-related stigma and discrimination can undermine HIV prevention and control efforts.

Second, there has been a radical shift in the global context of HIV efforts. U.S. government engagement and resource commitments in global efforts to control HIV/AIDS and mitigate its impact have risen dramatically in the last decade, and the global pandemic is acknowledged to be a major U.S. foreign policy priority. In this context, the current HIV inadmissibility policy is viewed increasingly as antiquated and incompatible with the goals and practices of the President's Emergency Plan for AIDS Relief (PEPFAR) and as a liability in ensuring effective U.S. global leadership on HIV/AIDS. With over \$8.3 billion in HIV prevention, care, and treatment assistance flowing to low- and middle-income countries from industrialized countries and international organizations, there are fewer incentives today for an HIV-infected person to travel to the United States when opportunities for care are increasingly available at home. Further, in a new global context, an inadmissibility policy that many consider obsolete and discriminatory detracts from the genuine and significant achievements of U.S. global leadership on HIV over the last decade. In fact, alongside only a small number of other countries, the United States has one of the more stringent policies of HIV inadmissibility in the world for short-term travelers. Many other countries have adopted more moderate approaches that may provide a better balance of

preserving civil liberties, protecting public health, and asserting global leadership in both their short-term travel and immigration policies.³

Increasing awareness of these realities and policy concerns prompted the White House to propose on World AIDS Day, December 1, 2006, a “categorical waiver” to allow HIV-infected visitors to enter the United States “through a streamlined process.”⁴ Although the categorical waiver is not intended to address admissions for other than short-term visitors, it is nonetheless a first step in alleviating discrimination against at least some noncitizens with HIV/AIDS. It has also invited a new, broadened debate on the merits of a U.S. policy of inadmissibility, after many years of virtually no discourse.

The United States now has an opportunity to move beyond the inadmissibility requirement, end a policy that many consider stigmatizing, and ensure that the U.S. approach is consistent with U.S. national interests and its global leadership role and is aligned with accumulated public health best practices. A new approach could in fact strengthen U.S. global and domestic leadership on HIV/AIDS.

This paper provides a brief overview of U.S. law and policy concerning inadmissibility of HIV-infected applicants for immigrant and nonimmigrant visas. It lays out a menu of concrete options that might be pursued, both in the short term by the administration in its proposed rulemaking for HIV-infected visitors, and in the longer term by the U.S. Congress as it weighs future legislative action to address HIV inadmissibility more broadly. A revised approach will need to differentiate between immigrants and nonimmigrants and to carefully balance complex public health and privacy interests. For example, the need to respect individual civil liberties and confidentiality must be weighed against the benefits of expanding the number of individuals who have been tested for HIV, know their status, and are thereby better able to protect themselves and reduce their transmission to others. Balancing these interests in a sensitive and responsible way is the emerging core challenge before policymakers working in this important area.

Background

Acquired Immunodeficiency Syndrome (AIDS) was first reported in 1981, more than 25 years ago, and its causative agent, the Human Immunodeficiency Virus (HIV), was definitively identified in 1985. In May 1987, about a year after blood testing for HIV/AIDS became commercially available, the U.S. Department of

³ U.S. Department of State, “Human Immunodeficiency Virus (HIV) Testing Requirements for Entry into Foreign Countries” (updated through December 2006), http://travel.state.gov/travel/tips/brochures/brochures_1230.html; AIDSmap UK, “Countries and their Entry Restrictions” (updated through April 2006), <http://www.aidsmap.com/en/docs/C92D5639-E779-44EC-B8F8-0CECCC23275A.asp>.

⁴ White House, “Fact Sheet: World AIDS Day 2006,” press release, December 1, 2006, <http://www.whitehouse.gov/news/releases/2006/12/20061201-2.html>, under the heading of “The President Is Dedicated to Ending Discrimination against People Living with HIV/AIDS” and noting that the “President considers the participation of people living with HIV/AIDS a critical element in the global HIV/AIDS response.”

Health and Human Services (DHHS) announced that AIDS was to be added to the list of “dangerous contagious diseases” for which prospective immigrants and other noncitizens were considered inadmissible and were therefore barred from entry into, and/or removed⁵ from, the United States. Later that year, after limited debate, Congress overwhelmingly passed a bill substituting “Human Immunodeficiency Virus infection” for “AIDS” on that list. That new law, implemented in December 1987,⁶ effectively mandated HIV screening for all persons over 14 years of age applying for immigrant or nonimmigrant visas.

In 1990, Congress changed the name of the list of inadmissible diseases from “dangerous contagious diseases” to “communicable diseases of public health significance” and provided the secretary of health and human services with authority to decide which diseases should be included on that list.⁷ The next year, on the basis of a Centers for Disease Control (CDC) recommendation, subsequently endorsed by both the assistant secretary and secretary of health and human services,⁸ DHHS issued a proposed rulemaking to eliminate HIV (and several other diseases) from the list. Powerfully positioned members of Congress raised strong objections in the public comment period by arguing that HIV/AIDS posed a grave external threat, and DHHS dropped its effort to eliminate HIV from the removal list.⁹

Two years later, after a similar attempt under a different administration to remove HIV from the list, Congress partially rescinded the listing authority earlier provided to DHHS by explicitly codifying the inclusion of HIV on the list, for purposes of removal of noncitizens, *regardless of any subsequent public health or other DHHS determination that might be made* [authors’ emphasis].¹⁰ Congressional debate on the HIV/AIDS aspects of this act was again contentious and polarizing, and again an alarmist perspective prevailed. The 1993 law eliminated DHHS decisionmaking authority for HIV, effectively singling HIV out as an exceptional infectious disease that warranted a policy of inadmissibility. The president subsequently signed the provision into law, and it remains in force to this day.

In 1989, soon after implementation of the inadmissibility policy, an HIV-infected Dutch visitor to the United States was incarcerated for several days on arrival in Minnesota when the antiretroviral drug AZT was found in his luggage

⁵ “Removal” is the *current* term for U.S. government denial of entry of noncitizens or, if they are already inside the United States, their deportation. The previously used term was “exclusion.”

⁶ USCIS, “Waiver of Excludability for Immigrants,” *Adjudicator’s Field Manual* (Washington, D.C.: USCIS, December 2006), chap. 41.

⁷ The other seven communicable diseases on this list, as of February 2007, include tuberculosis, leprosy [Hansen’s disease], syphilis, chancroid, gonorrhea, granuloma inguinale, and lymphogranuloma venereum. The latter five are also sexually transmitted infections. See <http://www.cdc.gov/ncidod/dq/diseases.htm>.

⁸ DHHS, “Communicable Diseases and Foreign Visitors” press release, January 15, 1991, <http://www.hhs.gov/news/press/pre1995pres/910125.txt>.

⁹ Joyce C. Violet, *Immigration: HIV-Positive Aliens—Questions and Answers*, Report No. 96-954 EPW (Washington, D.C.: Congressional Research Service, November 26, 1996).

¹⁰ This change was contained in a provision of the 1993 National Institutes of Health Revitalization Act.

during a U.S. customs inspection. That event triggered a threatened boycott, narrowly avoided, of the 1990 International AIDS Conference in San Francisco. Subsequently, the International AIDS Society (IAS), the primary sponsor of the biennial International AIDS Conferences that began in Atlanta in 1984, registered its opposition to the U.S. inadmissibility policy for nonimmigrants by relocating the 1992 conference from Boston to Amsterdam. Since 1992, IAS has adhered to the position that the United States (and any other country with a similar inadmissibility policy) is an unacceptable venue for the conference, and it has selected other countries for all seven subsequent international conferences, and for the upcoming 2008 conference, to be held in Mexico City. The net effect is that, by 2008, no International AIDS Conference will have been held on U.S. soil for 18 years. In addition to its symbolic effects, there are practical implications, as major opportunities have been lost to use these large, media-saturated gatherings to raise U.S. public awareness of the global HIV/AIDS pandemic, deepen public support for assertive U.S. engagement in global and domestic HIV/AIDS efforts, and bring thousands of leading scientific, community, and public policy experts on HIV/AIDS to the United States.

Two explicit policy interests undergirded the 1987 introduction of the HIV inadmissibility policy: (1) a public health rationale—the belief that preventing entry of HIV-infected noncitizens would help protect U.S. citizens from becoming infected with HIV; and (2) a public charge/cost rationale—the belief that preventing entry of HIV-infected noncitizens would check untoward resource burdens on the U.S. health and social service systems. Bigotry against the gay community also played an important part, many observers conclude, pointing to early congressional debates around the policy, in which AIDS activists were characterized by use of terms such as “homosexual rights fanatics.”¹¹

- *The public health rationale.* Relatively limited information about HIV transmission available in the late 1980s may have allowed for some continuing uncertainty *at that time* about the nature of HIV transmission risks, including transmission through casual contact. However, that earlier uncertainty has now evaporated. The current expert consensus, which squares with both the 1991 and 1993 DHHS proposals, is that the public health rationale for automatic exclusion of HIV-infected individuals, as originally framed, is no longer valid.¹² HIV is transmitted through certain bodily fluids, is not airborne, and is not transmitted through casual contact. In addition, two recent data reviews among HIV-infected immigrants to the United States

¹¹ Senator Helms of North Carolina, “Dangerous Moves at HHS,” 101st Congress, 2nd sess., *Congressional Record* (May 7, 1990): S5738, <http://thomas.loc.gov/cgi-bin/query/D?r101:47:/temp/~r1016Z2XC9::>; Representative McDermott of Washington, “Change Our AIDS/HIV Immigration Policy,” 102nd Congress, 2nd sess., *Congressional Record* (July 21, 1992): H6253, <http://thomas.loc.gov/cgi-bin/query/D?r102:8:/temp/~r102aaGz45::>.

¹² UNAIDS and International Organization on Migration (IOM), *UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions*, June 2004, http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/activities/health/UNAIDS_IOM_statement_travel_restrictions.pdf.

concluded that, based on age at arrival in the United States and length of U.S. residency, many, or even most, had probably become infected *after* arrival.¹³

There are now approximately 1.2 million HIV-infected U.S. residents, about one-fourth of whom are unaware of their HIV infection.¹⁴ However, the current inadmissibility policy may in fact provide a false sense of security to U.S. citizens by implying that their risk of contracting HIV through sex is associated primarily with sexual activity with noncitizens. Additionally, legal permanent residents and immigrants already living legally in the United States who suspect that they have been infected by HIV may be reluctant to seek necessary HIV testing or care because they *incorrectly* believe that they are subject to deportation or removal if immigration authorities become aware of their HIV infection. (Identification of HIV infection among noncitizens who are already legally in the United States is *not* grounds for removal or deportation.¹⁵ However, such HIV-infected residents who *voluntarily* leave the United States can be barred from reentry.)

- *The public charge/cost rationale.* The policy of inadmissibility also rests on a second argument relating to costs and focused on a concern about an undue HIV-related health, social service, and/or financial burden on the U.S. health care system. Though these concerns are valid, other provisions of U.S. immigration law already require that immigrants demonstrate in various ways, including provision of a formal and legally binding sponsor's affidavit of support, that they are unlikely to become a "public charge," thereby minimizing the possible economic burdens that HIV-infected immigrants might impose on the government and/or the health and social service systems. Although carrying out more formal cost studies could be a prudent step, these other provisions of immigration law lessen the need to address cost issues in a context specific to HIV disease. This aspect of HIV exceptionalism is also seen by some as inherently discriminatory, given that other costly chronic health problems, such as cardiovascular or kidney disease, are not singled out in visa procedures as individual disease issues, but are instead handled through the sponsor's affidavit of support and public charge assessment.

In sum, the original public health rationale for the HIV inadmissibility position, initially weak at best, has lost any remaining validity in the face of accumulated public health knowledge and evolving best practices. So too, cost

¹³ See Nina T. Harawa et al., "HIV Prevalence among Foreign- and U.S.-born Clients of Public STD Clinics," *American Journal of Public Health* 92 (2002):1958–1963; and Los Angeles County Department of Health Services, "HIV and AIDS among Recent Immigrants," in *An Epidemiologic Profile of HIV and AIDS in Los Angeles County through 1998*, January 1999, <http://www.lapublichealth.org/hiv/reports/epipro/1998/epipro39.htm>.

¹⁴ M. Glynn and P. Rhodes, "Estimated HIV Prevalence in the United States at the End of 2003" (Abstract 595, National HIV Prevention Conference, Atlanta, Ga., June 2005).

¹⁵ This paper does not address the issue of HIV infection in undocumented noncitizens. In fact, undocumented noncitizens who entered the United States illegally as immigrants or visitors and who are later identified as HIV infected are subject to the same exclusion processes as other illegal immigrants and/or visitors who are *not* infected by HIV. Their HIV status need not be a deciding factor in decisions about their ultimate immigration status.

and system burden considerations can largely be addressed by measures not specifically related to HIV that are contained within the overall visa application process.

Current Law: The Visa Application and HIV Waiver Processes

Three broad categories of people apply for visas to enter the United States: (1) those wishing to enter for a short term as nonimmigrants (e.g., tourists, business travelers, others visiting relatives); (2) those wishing to enter as nonimmigrants but for a longer term (e.g., students at academic institutions); and (3) those intending to immigrate and become citizens. A fourth and related visa category includes current U.S. legal residents who initially enter as refugees, asylum seekers, or other nonimmigrant categories and who later wish to adjust their status to become lawful permanent residents.

Current policy on HIV inadmissibility, including screening and removal requirements, applies to “any alien who is determined to have a communicable disease of public health significance” and therefore encompasses all categories of noncitizens.

U.S. law requires HIV screening of applicants for permanent immigration to the United States and exclusion or removal of those found to be infected. Nonimmigrant visitors to the United States, while not routinely required to be tested for HIV to obtain their visas, must answer a specific screening question about having a “communicable disease of public health significance.” Under both the 1987 and 1993 legislation, however, nonimmigrant visitors to the United States who do not disclose an HIV infection during the visa application or entry process but who U.S. immigration officials suspect to be HIV infected can be refused entry, required to have an HIV test, and removed (e.g., if anti-HIV or anti-AIDS medications are found during a customs inspection).

Although waivers of HIV-related inadmissibility are possible for some—but not all—categories of visa applicants, they are issued on a discretionary and case-by-case basis and are sometimes difficult or impossible to obtain. In practice, the HIV testing requirements have been focused more narrowly on immigrant visa applicants 15 years of age or older, including those applicants who are already legally residing in the United States and wish to adjust their residency status, rather than on short-term visitors such as tourists and business travelers.

Below are the specific visa application and waiver processes for each of the major categories of noncitizens, as they pertain to the HIV inadmissibility policy.

Short-term Nonimmigrant Visa Applicants

Short-term nonimmigrant visa applicants, including tourists, business travelers, persons visiting family members, etc., are required in the visa application form to answer the following question: “Do you have or have you ever had a communicable disease of public health significance?” HIV is not explicitly listed as one of the diseases. Those who answer “yes” face additional questions about

specific diseases and, for HIV, must apply for a waiver of inadmissibility to enter the United States.

Waivers may be granted for individuals with HIV seeking short-term (less than 30 days) nonimmigrant visas who have disclosed their HIV infection and who, in the view of USCIS staff, (1) do not have symptoms of AIDS; *and* (2) do not pose an obvious danger to the public health; *and* (3) can document that they have sufficient resources, including health insurance, to cover their medical expenses in the United States in case of illness.

In addition, blanket short-term “designated event” waivers to allow U.S. visa issuance for attendance for the duration of specific conferences or other designated events of public interest can be issued on occasion to HIV-infected travelers wishing to attend those events, provided that the travelers are not acutely ill. This procedure must be initiated by DHHS, although the process that leads to its initiation is not clearly defined in any public guidance.

Visa Waiver Program Applicants

The USCIS Visa Waiver Program (VWP) allows nationals of certain countries to travel to the United States for tourism or business for stays of 90 days or less without obtaining a visa. Established in 1986, the program seeks to eliminate unnecessary barriers to travel and promote tourism. In brief, nationals from participating VWP countries¹⁶ may use the program if they have a machine-readable passport, travel on an approved carrier, intend to stay in the United States for 90 days or less, are traveling for tourism or business, and are able to demonstrate that they have sufficient funds to support themselves while in the United States. The I-94W form that VWP applicants must obtain prior to departure and sign and present at U.S. arrival asks about issues of inadmissibility, including communicable diseases. Travelers answering “yes” to that question are ineligible for the VWP, and a standard nonimmigrant visa, with waiver of inadmissibility, is then required.

Students and Other Longer-term Nonimmigrant Visa Applicants

All nonimmigrant visa applicants, including applicants for student visas and other longer-term visas, are required to answer the same question about “communicable disease of public health significance.” Student visa applicants are *not* eligible for HIV waivers, nor are applicants for various temporary worker visa categories. However, applicants for several other nonimmigrant visa categories (e.g., some “K” and “V” visas, which are based on family unification principles) are waiver eligible.¹⁷

¹⁶ The 27 countries currently participating in the Visa Waiver Program include: Andorra, Australia, Austria, Belgium, Brunei, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Liechtenstein, Luxembourg, Monaco, the Netherlands, New Zealand, Norway, Portugal, San Marino, Singapore, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom. See http://travel.state.gov/visa/temp/without/without_1990.html#qualify.

¹⁷ USCIS, “Exception to Nonimmigrant HIV Waiver Policy for K and V Nonimmigrants,” interoffice memorandum from William R. Yates, associate director, operations, to regional

Immigrant Visa Applicants

Nonresident applicants for U.S. immigrant visas are required to undergo a full medical examination by State Department–appointed physicians (called “civil surgeons” in U.S. government parlance) that includes, among other things, serologic testing for HIV and syphilis.¹⁸ Results are sent directly to the respective U.S. consular offices, although post-test counseling of HIV-infected applicants is recommended in the documents originally describing this process.¹⁹ (Only limited information is available to document the occurrence of adequate counseling for applicants found to be HIV infected during visa-related civil surgeon examinations in the United States or in other countries.)

Not surprisingly, provisions for waivers of inadmissibility are more stringent for HIV-infected immigrant visa applicants than for persons in those nonimmigrant visa categories that permit waivers. (In addition, the availability of such immigrant visa waivers may not be widely known.²⁰) Waivers for HIV-infected applicants for permanent U.S. immigration can be granted at the discretion of the U.S. attorney general only for certain categories of immigrant visa applicants and only when the applicant is able to demonstrate that (1) the danger to public health created by admission is minimal; *and* (2) the possibility of HIV spread after admission is minimal; *and* (3) no government agency will incur any cost as a result of HIV/AIDS without its prior consent. Categories of visa applicants eligible for these specific waivers include (a) “first degree relatives” (spouses, parents, and unmarried children) of current U.S. citizens, (b) first degree relatives of aliens already admitted for lawful permanent residence (LPR), or (c) first degree relatives of resident aliens on immigrant visas. These first degree relatives already resident in the United States function as the sponsor of the waiver application. Other categories of immigrant applicants (e.g., immigration through permanent or long-term employment opportunity, diversity visa lottery winners, immigration through investment, etc.) are *not* currently eligible for HIV waivers.

Obtaining an immigrant waiver of HIV inadmissibility requires a number of steps, some of which are complex. (The following description is not intended to be exhaustive.) The waiver application, submitted with the appropriate fee, must include information identifying the waiver sponsor who meets the family eligibility requirements listed above. Information must also be provided documenting the several discretionary criteria listed earlier. Meeting the first two

directors, service center directors, district directors, and national benefit center director, November 2, 2004, http://www.uscis.gov/files/pressrelease/KandV_HIV110204.pdf.

¹⁸ Nonimmigrant aliens who are already in the United States legally may apply for “adjustment of status” to an immigrant visa category and must generally undergo the same examination, including HIV testing, by a U.S.-based civil surgeon.

¹⁹ See DHHS, “Medical Examination of Aliens,” *Federal Register*, vol. 52, no. 107, August 28, 1987, p. 32542; and Department of Justice, “Frequently Asked Questions for Form I-693, Medical Examination of Aliens Seeking Adjustment of Status,” n.d.

²⁰ Rupert E.D. Whitaker and Richard K. Edwards, “An Ethical Analysis of the U.S. Immigration Policy of Screening Foreigners for the Human Immunodeficiency Virus,” *AIDS Public Policy Journal* 5 (Winter 1990): 145–156.

criteria requires documentation by a health care worker of the applicant's awareness of their HIV status, including knowledge of HIV transmission routes and risks, attendance at counseling sessions, etc. As is true for all immigrant visa applicants, sponsors are required to file a formal affidavit of support, demonstrating that they are able to help maintain the applicant at 125 percent of the federal poverty level income. Applicants must also successfully demonstrate that they are unlikely to become a "public charge," defined by USCIS as receiving public cash benefits for income maintenance or having been institutionalized for long-term care.²¹ Factors such as the sponsors' own resources, additional letters of support from other relatives in the United States, eligibility for health insurance, and demonstrations of employment or employability are examples of other helpful documentation. The applicant and his or her sponsor must also identify a U.S. physician who agrees to provide care to the HIV-infected applicant after arrival. Finally, a supplement to the waiver application, eventually certified by the CDC, requires the signature of a state or local health officer where the applicant will reside, attesting that the identified physician is competent to provide HIV care.

Any nonimmigrants already living in the United States, who wish to adjust their status to lawful permanent resident, if eligible, must undergo the same full civil surgeon medical examination and HIV testing described above for other immigrant visa applicants. With the exception of those wishing to adjust to LPR from refugee or asylum seeker status, procedures for HIV waivers are identical to those for applicants outside the United States.

Refugee and Asylum-seeking Visa Applicants

Refugees and asylum seekers are admitted to the United States on humanitarian grounds. Applicants for refugee classification are required to have a medical examination, including an HIV test, and although HIV-infected refugee applicants are considered inadmissible, a waiver may be granted if other requirements for refugee status are met. To apply for the separate immigration category of asylee, asylum seekers must also meet the requirements of refugee classification, must already be physically present in United States, and must file applications for asylum within one year of arrival. No initial medical examination is required for asylum applicants.

As with all immigrant visa applicants, refugees and asylees who later apply for an adjustment of status to LPR must undergo a medical examination, including an HIV test.²² Applicants found to be inadmissible because of HIV infection have the option of applying for a waiver. However, unlike other classes of nonimmigrant and immigrant applicants, and consistent with the humanitarian grounds of their admission into the United States, asylees and refugees applying for an HIV waiver are *not* required to have a family sponsor, nor are they required

²¹ "Public Charge: INA Sections 212(a)(4) and 237(a)(5)," U.S. Department of Justice, Immigration and Naturalization Service memorandum, dated May 20, 1999, from Michael A. Pearson, executive associate commissioner, to all regional directors.

²² Refugees are exempted from this examination requirement if they previously had an examination as part of their original refugee application.

to demonstrate that they do not pose a “public charge” risk. This distinction in terms of their HIV waiver requirements was apparently made, with congressional notification, because refugees and asylees, once admitted, are able to access some existing federal programs that are not currently available to other permanent immigrant applicants.

Policy Options before Congress and the Executive Branch

There is an emerging consensus that the current policy of excluding otherwise eligible HIV-infected visa applicants is counterproductive, rooted in discrimination, and damaging to U.S. HIV/AIDS credibility and leadership. The original public health rationale on which this policy was built—in particular, fear of an imported epidemic that might swamp the U.S. health system—lacks credibility today, while concerns related to public charge and cost are addressed by other aspects of existing immigration law. This shift of opinion does beg several important questions. Most central is the issue of what menu of choices or approaches might make the most sense in moving beyond a policy of inadmissibility for HIV. To answer that question, in turn, requires defining what approaches will be most consistent with current scientific knowledge, public health “best practice,” and other U.S. government policies designed to prevent the spread of HIV and provide care and treatment for those already infected. In addition to improving systems for the reporting of confirmed HIV infection to state health departments, the latter includes the recently updated U.S. policy²³ focused on expanding knowledge of one’s HIV status, increasing opportunities for HIV screening, post-test counseling, and linkage to care in the United States.

In considering changes to U.S. policy approaches, legislators, public health experts, and policymakers will face several complex and difficult decisions, involving balancing the rights of individuals with the rights of society, as well as balancing the rights of some individuals with the rights of others. It will be important to consider, for example, the optimal way to incorporate HIV screening into the visa application process, in order to maximize the numbers of people aware of their HIV status, and the potential for linkages to counseling and care.

Two major pathways are available to Congress and the administration for addressing the various issues of HIV-infected noncitizens: a legislative approach, which is under the purview of Congress, and an expanded waiver approach, under the purview of the administration.

- *Legislation.* The most comprehensive approach to address the current outdated policies would require congressional legislation. Congress could choose to strike the language contained in the Immigration and Nationality Act that specifically designates HIV as an inadmissible condition. This approach would provide a more expansive and permanent fix and address the

²³ Bernard M. Branson et al., “Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings,” *CDC Morbidity and Mortality Weekly Report*, 55, no. RR-14 (September 22, 2006): 1–17, <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

inadmissibility policy for all categories of noncitizens. Such a change could also include returning authority to the secretary of health and human services to determine whether HIV should be considered a “communicable disease of public health significance,” authority the secretary has for all other diseases. In parallel with that step, Congress could allow DHHS a reasonable but limited period in which to revisit the list of “communicable diseases of public health significance.” This legislative approach would not preclude the administration from implementing a categorical waiver of the inadmissibility requirement for short-term visitors (and any other visa categories that are able to be included).

- *Expanded waivers.* For its part, the administration could choose to systematically expand the current HIV waiver options to include (1) additional categories of visa applicants, (2) additional flexibility in the duration of waiver periods, and (3) nondisclosure of HIV status for short-term visitors. This approach could first be applied to additional categories of nonimmigrants, but it might also be extended to additional categories of immigrants. It would provide one way of enabling at least some additional groups of noncitizens with HIV to enter the United States and would build on a process already underway. Some aspects of this expanded waiver approach may encounter obstacles based on limitations in the legal authority of the executive branch to modify waiver policies for specific groups of noncitizens. Further, it is largely an incremental approach; it may not be able to encompass all categories of noncitizens; it would not eliminate entirely the requirement for disclosure of HIV infection that some observers see as discriminatory; and it would not address the underlying differential treatment of HIV under U.S. public health law. In the meantime, however, the administration’s current and laudable intention to streamline short-term nonimmigrant visa applications through a categorical waiver, as announced on December 1, 2006, could be expedited at relatively low cost.

Although these two approaches are not mutually exclusive, each would undoubtedly raise complex questions about process and implementation. Policy deliberations could benefit from the establishment and input of a working group of relevant experts.

Deliberations will need to take into account the potential costs to the United States and make further study of potential costs a priority. Although exact data on numbers of HIV-infected persons admitted—or denied admission—through the current waiver system are not publicly available, the annual Department of State summaries of immigrant and nonimmigrant visa ineligibilities offer one very rough upper limit approximation.²⁴ During fiscal years 2002 to 2005, an annual average of 695 immigrant visa applications was found to be ineligible on communicable disease grounds. An average of 214 applications was eventually accepted, leaving 481 unaccepted annually. Because these numbers represent

²⁴ Department of State, *[Annual] Report of the Visa Office* (Washington, D.C.: U.S. Department of State), http://travel.state.gov/visa/frvi/statistics/statistics_1476.html. See also <http://travel.state.gov/pdf/FY05tableXX.pdf>.

applications rather than applicants (denied applicants can reapply more than once in a fiscal year), and because some of these ineligibilities undoubtedly involved diseases other than HIV (e.g., tuberculosis), the numbers of HIV-infected immigrants refused admission in these years were well below 500 per year. Beyond those numbers, each immigrant visa category has its own specific eligibility requirements and its own annual quotas on numbers of applicants allowed visas. These requirements and quotas provide a set of preexisting limits on numbers of noncitizens receiving visas. Assuming that current immigrant visa categories remain essentially unchanged, and assuming that affidavits of support and public charge tests continue to be required, it is difficult to envision a large additional economic burden resulting from a more open admission policy for HIV-infected people.

Additional Considerations

Several additional HIV-related issues warrant consideration in the near future, regardless of decisions made by the administration and Congress to move forward on expanding waivers or addressing inadmissibility legislation. (These additional issues could become even more important if decisions are made by the administration or Congress to move forward with changes.)

- *HIV/AIDS Counseling.* The current system's effectiveness in providing adequate HIV/AIDS counseling and referral to care for HIV-infected U.S. visa applicants cannot now be easily verified through any public documents. This issue is particularly relevant when the U.S. visa application process is the mechanism through which many visa applicants first become aware that they are HIV-infected. Because of the critical role HIV/AIDS counseling plays in promoting HIV prevention and AIDS care for individuals and in reducing stigma, the counseling system operating within the current U.S. HIV-screening system needs to be examined to ensure that it meets the HIV/AIDS information needs of visa applicants, both HIV infected and uninfected.
- *Confidentiality and Disclosure, including Sponsor Notification.* In addition to addressing counseling in a more comprehensive way, particular attention must be paid to the issue of U.S.-based USCIS adjudication personnel notifying the U.S. sponsor/petitioner of a visa applicant's HIV status.²⁵ Because of sensitivities around disclosure to third parties of an individual's HIV status, it is advisable to implement a policy that ensures notification to the *applicant* about the intended reporting of the applicant's HIV status to her or his sponsor, as well as provision of a reasonable period of time to allow the applicant himself or herself to personally notify his or her U.S. sponsor first. HIV-infected applicants in affected categories could be provided with—or referred for—specific counseling about disclosure of HIV status to family members. Similarly, it is important to come to terms with the privacy and confidentiality issues around disclosure of an HIV-infected immigrant visa applicant's status to his or her sponsor, who in signing an affidavit of support

²⁵ USCIS, "Waiver of Excludability for Immigrants," *Adjudicator's Field Manual*, chap. 41.

assumes legally binding financial responsibilities for any large and unexpected debts of the applicant for the subsequent three years.

- *Awareness of Serostatus.* For policymakers concerned about HIV-infected immigrant or long-term nonimmigrant visa applicants who are unaware of their HIV infection, the choices are complex in a different way. The value of knowing one's HIV status is clear, in terms of preventing spread of HIV to others²⁶ and accessing appropriate care. But the creation of a system that balances imparting that awareness with respect for applicants' autonomy is likely to require extensive discussion.
- *Centralized and Accessible Information.* Because the current rules and procedures for HIV screening of U.S. visa applicants and for the related waiver processes are complex and not easily accessible in any single electronic or other location, these should be posted in more visible locations on the State Department and the Department of Homeland Security/USCIS Web sites. The administration should also consider posting them on other easy-to-access HIV-related government Web sites, such as DHHS's excellent www.aids.gov or PEPFAR's www.pepfar.gov. These sites could also contain links to the specific Departments of State, Homeland Security, Justice, and other agency Web sites that address HIV/AIDS issues among visa applicants. As policy changes are put in place (e.g., the categorical waiver for short-term visitors), they should be clearly identified on all of these sites.
- *Education and Training of U.S. Personnel.* Employees of the Departments of State, Homeland Security, Justice, Health and Human Services, and other federal agencies that deal with HIV-related immigration issues could benefit from training to enhance their comprehension of the basic technical and social issues associated with HIV/AIDS including, at a minimum, the most recent concepts of HIV transmission.
- *Reporting and Transparency.* As long as an HIV-screening policy for visa applicants is in place, reports could be made available to Congress and to the public at regular intervals. These reports could include numbers of HIV-infected applicants identified, applying for waivers, receiving waivers, and referred for counseling and care (and the numbers who actually received those latter services). In such reports, HIV data should be disaggregated from data on other health conditions associated with inadmissibility.
- *Regular Review.* Because of the rapid progress occurring in knowledge about HIV/AIDS prevention and treatment, federal laws and regulations related to HIV issues of visa applicants could be reviewed, with allowance for a public comment period, no less frequently than every five years. Along with relevant officials from the Departments of Justice, Homeland Security, and Health and

²⁶ A recent review of all earlier studies concluded that persons aware that they are HIV-infected are from 45 to 76 percent less likely to engage in unprotected sex than are persons unaware that they are infected. See Gary Marks et al., "Meta-Analysis of High-Risk Sexual Behavior in Persons Aware and Unaware they are Infected with HIV in the United States: Implications for HIV Prevention Programs," *Journal of Acquired Immune Deficiency Syndromes* 39, no. 4 (August 2005): 446–453.

Human Services, the Office of the U.S. Global AIDS Coordinator could play an important role in this review.

Conclusion

The United States is at the front end of a promising new discussion on what constitutes the appropriate mix of U.S. policies and regulations concerning noncitizens with HIV, one that can move beyond the policy of HIV inadmissibility to a set of policies more aligned with U.S. national interests. The intent of this paper is to set the background context for this discussion and to provide the menu of real choices, as well as some immediate practical steps that can ease the process facing visitors and immigrants today. There will be no quick and easy fix to accommodate the array of complex equities—civil liberties, public health, and U.S. global leadership—that are in play. But it will be vital that this time, in contrast to the late 1980s and early 1990s, policymakers proceed carefully and sensitively and that, in the end, they get it right. U.S. policy should be consistent with the humanitarian principles celebrated in the PEPFAR program and should be aligned with public health best practices. It should not unduly stigmatize or discriminate and should do its utmost to strengthen America's critical leadership position in controlling global HIV/AIDS.

Additional Readings and Information

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