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23 November 1993

Ms. Kristine Gebbie
National AIDS Policy Coordinator
Executive Office of the President
Washington, DC 20500

Dear Ms. Gebbie:

Thank you for taking the time to meet with members of the San Francisco HIV community. It was very helpful to discuss the activities of the Office of National AIDS Policy, and to have the opportunity to express the needs of the San Francisco HIV community.

The meeting was a good first step in developing the San Francisco HIV community's relationship with the Office of National AIDS Policy and increasing the opportunities for us to work more closely together to end this epidemic and to provide care and treatment to the residents of this country that are living with HIV disease.

Please contact us if we can be of further assistance to the Office of National AIDS Policy. We look forward to working with you more closely in the future.

Sincerely,

Patricia M. Dunn
Coordinator, Bay Area HIV
Advocacy Network

Thomas W. Zickgraf
Assistant to the Public
Policy Director

SF AIDS FOUNDATION

SAN FRANCISCO AIDS FOUNDATION

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Tom Zickgraf
Assistant to the
Public Policy Director,
(415) 487-3034

MEMORANDUM

Date: 19 October 1993

To: Ben Merrill, Office of National AIDS Policy

Re: October 15, 1993 San Francisco Bay Area Community Meeting

Per your request, I have listed the items that were discussed at the October 18, San Francisco Bay Area Community Meeting and the action items that you committed to completing. I apologize for the delay in getting this information to you.

Agenda Items:

Needle Exchange	Immigrant Exclusion
Ryan White Reauthorization	Housing
Prevention Reform	Services for the Undocumented
Health Care Reform	Housing
Research	Outreach Workers
Prevention for gay men	TB
Immigration	Medical Marijuana

Action Items:

1. **To advocate appropriate funding of HIV prevention and outreach for immigrants and undocumented residents of the United States to the CDC.**

   Mike Shriver, Executive Director, Mobilization Against AIDS, will contact you with additional information regarding the defunding of latina/o organizations. His telephone number is (415) 863-4676.

2. **To work with the CDC to establish an external review panel that addresses HIV prevention for gay men, and gay men of color.**

3. **To advocate the inclusion of gay men and gay men of color as participants on all relevant CDC external review panels and advisory committees.**

Action Items Continued:

4. **To facilitate a meeting of HIV policy advocates with Dr. Satcher, Director of CDC, to discuss national prevention reform, prevention funding, removal of content restrictions, needs of gay men and gay men of color, and needle exchange.**

5. **To arrange for National AIDS Policy Coordinator Kristine Gebbie to make a public statement of support for the HOPWA program, a flexible housing and support services program for individuals with HIV/AIDS funded through HUD, and to continue to advocate the continuation and expansion of this program.**

6. **To arrange for National AIDS Policy Coordinator Kristine Gebbie to submit a letter to Governor Cuomo in support of the HOPWA program.**

7. **To follow-up with Bob Nelson, Director of the Interreligious Coalition on AIDS/Catholic Charities, for further information about housing services for people with HIV/AIDS.** His telephone number is (415) 575-5732.

8. **To arrange for National AIDS Policy Coordinator Kristine Gebbie to make a public statement in support of the Ryan White CARE Act, particularly in favor of a community based model for planning and appropriating funding for services.**

9. **To facilitate National AIDS Policy Coordinator Kristine Gebbie to make a public statement against any offsets to the Ryan White CARE Act and to advocate against any attempts to reduce funding of the Ryan White CARE Act.**

10. **To increase the communication between the Office of National AIDS Policy and members of the HIV affected community.**

On behalf of the AIDS Foundation Policy staff, thank you for taking the time to conduct a community meeting in the Bay Area and your willingness to complete the action items listed above.

I will forward a summary of the October 15 Community Meeting to you by November 1. If you have any questions please contact me at (415) 487-3034. We look forward to working more closely with you in the future.

Washburn Law Journal

Vol. 32 No. 3 Spring 1993

Lead Articles

Guess Who's Coming to America: An Analysis of United States HIV-Related Immigration Policies — *Chad Baruch* *Franc Hangarter*

Industrial Espionage? Discovery Within the Rules of Civil Procedure and the Battle for Protective Orders Governing Trade Secrets and Confidential Information — *James R. Jarrow*

The Taxation of a Service Partner's Interest in Future Profits After *Campbell* — *Lindsay Johnson* *Gerald A. Madek*

Essays

Joseph Conrad's Heart of Darkness in the Law-Literature Canon — *Gregory J. Pease*

Undo Two: An Essay Regarding Colorado's Anti-Lesbian and Gay Amendment 2 — *Charlene L. Smith*

Notes

Regulation of Lawyer-Client Sex: Codifying the "Cold Shower" or a "Fatal Attraction" per se? — *Jill M. Crumpacker*

Imposing Criminal Sanctions on Pregnant Drug Users: Throwing the Baby Out With the Bath Water — *Patricia A. Sexton*

Guess Who's Coming to America: An Analysis of United States HIV-Related Immigration Policies

Chad Baruch and Franc Hangarter*

> The AIDS epidemic frightens us all. But we should not allow our fear to cloud our judgment. Hasty and indiscriminate screening for antibody to HIV is imprudent and potentially dangerous. . . . If laws are to link our fates to test results, should not due process be brought to the benches where those tests are performed? We will need guarantees not only of the confidentiality of test results but also of the quality of the testing procedure.
>
> Dr. Klemens Meyer and Dr. Stephen Parker[1]

> [Other nations] do not want AIDS to come into their country and neither should we.
>
> Senator Jesse Helms[2]

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I. INTRODUCTION

Despite having more confirmed cases of Acquired Immunodeficiency Syndrome (AIDS) than any other nation,[3] the United States prohibits most foreigners infected with Human Immunodeficiency Virus (HIV) from entering its borders, and denies citizenship and permanent resident status to HIV-infected persons already living here — even those who were uninfected when they legally entered the country. Proponents

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* Chad Baruch, B.A., University of Minnesota (1988); J.D., University of Minnesota (1991). Chad Baruch is an attorney with the law firm of Abbott & Baruch, in Dallas, Texas. Franc Hangarter, B.S., Georgetown University (1987); J.D., Georgetown University (1990). Franc Hangarter is an attorney with the law firm of Conant, Whittenburg, Whittenburg & Schachter in Dallas, Texas. The authors wish to thank Alissa Green and Iris Vallarino for their assistance in typing this article, and Nan Magee, Stuart Ford, Paul Saraceni, Lisa Lochridge, and Shawn Phelan for helping to edit it. Of course, our most special thanks to Kennedy, Mitch, and Julie. Be well, Julie.

1. Klemens Meyer & Stephen Parker, *Sounding Board: Screening for HIV: Can We Afford the False Positive Rate?*, 317 NEW ENG. J. MED. 238, 241 (1987).

2. 133 CONG. REC. S7410-16 (daily ed. June 2, 1987) (statement of Sen. Helms).

3. The United States has more than half of the world's reported AIDS cases. GARY SHANNON ET AL., THE GEOGRAPHY OF AIDS: ORIGINS AND COURSE OF AN EPIDEMIC 1 (1991). The Centers for Disease Control estimates that more than five million Americans are HIV-infected, and approximately half a million of them suffer from AIDS. Centers for Disease Control, *HIV Prevalence Estimates and AIDS Case Projections for the United States: Report Based Upon a Workshop*, 39 MORBIDITY & MORTALITY WKLY. REP. 1, 5-15 (1990).

of this policy cite the desire to curtail the spread of AIDS and the need to insulate an already troubled health care system from an influx of foreign AIDS patients as justifications for the restrictions. This article argues that current immigration policies do nothing to advance these goals, are indefensible from a humanitarian perspective, and could have negative foreign policy consequences.

II. Human Immunodeficiency Virus, AIDS, and Immigration

AIDS: The Disease

Human Immunodeficiency Virus (HIV) is widely believed to cause Acquired Immunodeficiency Syndrome (AIDS).[4] After infection, HIV gradually attacks the body's immune system, leaving it vulnerable to a variety of serious conditions rarely seen in individuals with healthy immune systems.[5] AIDS is diagnosed when an HIV-infected individual develops one of several life-threatening conditions or, under new guidelines promulgated by the Centers for Disease Control in 1993, when the individual's CD4+ T-Lymphocyte (commonly referred to as a "T-cell") count falls below 200.[6] Among the particular illnesses that will give rise to an AIDS diagnosis are Pneumocystis carinii pneumonia (PCP), Kaposi's sarcoma, high-grade B-cell lymphoma, encephalopathy syndrome (AIDS dementia), and wasting syndrome, commonly known in Central Africa as "slim disease,"[7] and several opportunistic infections. HIV is characterized by a period of latency, during which the virus lives in the host cell and grows through cellular division but produces no symptoms.[8]

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4. *See* F. Barre-Sinoussi, J.C. Cherman & F. Rey, *Isolation of a T-Lymphocyte Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome (AIDS)*, 220 Science 868 (1983).

5. Harold Jaffe, *The Medical Facts About AIDS*, *in* AIDS and the Courts 9-10 (Clark Abt & Kathleen Hardy eds., 1990).

6. *See* Centers for Disease Control, *Revision of the Case Definition of Acquired Immunodeficiency Syndrome (AIDS) for National Reporting—United States*, 24 Morbidity & Mortality Wkly. Rep. 373, 373-75 (1985). According to the Centers for Disease Control, AIDS is characterized by certain opportunistic diseases evidencing underlying cellular immunodeficiency, and the absence of all other known causes of the immunodeficiency. *See Special Report: The AIDS Epidemic*, 312 New Eng. J. Med. 521, 522 (1985); Allan Gibofsky & Jeffrey Laurence, *AIDS: Current Medical and Scientific Aspects*, 9 J. Legal Med. 497, 497-98 (1988). Effective in 1993, the Centers for Disease Control revised the classification system for HIV infection to emphasize the clinical importance of the CD4+ T-lymphocyte count in the categorization of HIV-related clinical conditions, expanding the AIDS surveillance definition to include persons with certain counts of CD4+ T-lymphocytes, and persons with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer. Centers for Disease Control, *1993 Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults*, 41 Morbidity & Mortality Wkly. Rep. 1 (1992). This expanded definition of AIDS, which includes individuals with suppressed T-cell counts, will likely lead to a dramatic rise in the number of official AIDS cases in 1993, since many HIV-infected individuals with T-cell counts of less than 200 have not yet developed an opportunistic infection that would otherwise qualify them for an official diagnosis of AIDS.

7. Alexandra Levine, *Acquired Immunodeficiency Syndrome: The Facts*, 65 S. Cal. L. Rev. 423, 424-26 (1991).

8. *See* William Haseltine, *Silent HIV Infections*, 320 New Eng. J. Med. 1487 (1989).

HIV is spread when the virus from one person makes contact with the blood stream or mucous membrane of another,[9] generally by sexual contact, exposure to infected blood or blood products, and perinatal transmission from mother to child.[10] There is no vaccine against HIV and no cure for AIDS.[11] Studies indicate that virtually all people infected with HIV will develop full blown AIDS, which is uniformly fatal within a relatively short period of time.[12] Most people "die within two-and-one-half years after being diagnosed with AIDS, but a few people have lived with AIDS for seven years or more."[13]

The AIDS pandemic continues to spread virtually unchecked. More than 366,000 cases of AIDS from 162 countries have been reported to the World Health Organization (WHO), and an additional estimated ten million adults are infected with HIV. WHO estimates that by the year 2000, more than forty million people will be HIV-infected.[14] Even "the most conservative statistical predictions" suggest that fifteen to twenty million people will have the virus by the year 2000.[15] In the United States alone, medical costs associated with the treatment of AIDS are expected to total between five and thirteen billion dollars annually during the early 1990's.[16]

A. *AIDS: Public Attitudes*

Public attitudes toward AIDS are inextricably bound with attitudes toward homosexuality. Though vast numbers of HIV-infected Americans acquired the infection through heterosexual contact, intravenous drug use, or as a result of tainted blood or blood products,[17] AIDS is still perceived in this country as a "gay man's disease,"[18] and polls indicate

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9. Centers for Disease Control, *Recommendations for Prevention of HIV Transmission in Health-Care Settings*, 36 MORBIDITY & MORTALITY WKLY. REP., Supp. No. 2, at 25 (1987).

10. Warner Greene, *The Molecular Biology of Human Immunodeficiency Virus Type 1 Infection*, 324 NEW ENG. J. MED. 308 (1991).

11. There will not, in all likelihood, be a vaccine before the year 2000. Konrad Miller-Christiansen, *Stymied in the AIDS Struggle*, WORLD PRESS REV., Feb., 1993, at 24.

12. *See, e.g.*, Kung-Jong Lui, William Darrow & George Rutherford III, *A Model-Based Estimate of the Mean Incubation Period for AIDS in Homosexual Men*, 240 SCIENCE 1333 (1988).

13. S. Sheppard, *Medical and Public Health Overview of HIV Infection*, *in* AIDS PRACTICE MANUAL: A LEGAL AND EDUCATIONAL GUIDE 2-1, 2-8 (Paul Albert et al., eds., 3rd ed. 1991).

14. Lawrence Altman, *W.H.O. Says 40 Million Will Be Infected with AIDS Virus by 2000*, N.Y. TIMES, June 18, 1991, at C3. The WHO further theorizes that in many developing nations, AIDS will by the turn of the century become the leading killer of adults in their most productive years. *Id.* In some Central African nations, as much as 50% of the population may be HIV-infected. Leonard Nelson, *International Travel Restrictions and the AIDS Epidemic*, 81 AM. J. INT'L L. 231, 236 (1987) (citing SYDNEY MORNING HERALD, Aug. 16, 1986, at 3). The WHO estimates that by the year 2000, approximately one million adults in Asia will become HIV-infected *each year*—outpacing even Africa. Joyce Barnathan, *The AIDS Disaster Unfolding in Asia*, BUS. WK., Mar. 22, 1993, at 52.

15. Greene, *supra* note 10, at 308.

16. DONALD HERMANN & WILLIAM SCHURGIN, LEGAL ASPECTS OF AIDS 4 (1991).

17. Greene, *supra* note 10, at 308.

18. Thomas Mendicino, *Characterization and Disease: Homosexuals and the Threat of AIDS*, 66 N.C. L. REV. 226, 237 (1987) (citing *AIDS Perceived As "Gay Men's Disease"*, AIDS POL'Y & L., Oct. 22, 1986, at 6). Violence against gay men has increased as "AIDS has provided a green light to

fewer than half of American adults profess sympathy for homosexuals with AIDS.[19]

Disdain for homosexuals is deeply ingrained in the Judeo-Christian psyche. In England, persons engaging in homosexual acts were at one time prosecuted as heretics and burned at the stake.[20] The United States has a long tradition of making homosexual acts illegal. At one time, it was illegal by statute in every state to engage in sodomy.[21] Even today, numerous states classify as criminals those who engage in homosexual activity,[22] and the Supreme Court has upheld the constitutionality of laws criminalizing sodomy.[23]

For many years the federal government discriminated against homosexuals by making it virtually impossible for them to obtain security clearances, thereby foreclosing most employment opportunities with the Central Intelligence Agency, the Federal Bureau of Investigation, and the Department of State, as well as with private employers engaged in defense contract work. Despite some advances, "the rights of a gay person who seeks a security clearance remain unclear."[24] Meanwhile, measures prohibiting discrimination against homosexuals are coming under increasing attack.[25]

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the bashers and bigots." *Open Season on Gays: AIDS Sparks an Epidemic of Violence Against Homosexuals*, TIME, Mar. 7, 1988, at 24.

19. Michael Kagay, *Poll Finds AIDS Causes Single People To Alter Behavior*, N.Y. TIMES, June 18, 1991, at C3.

20. Jorge Carro, *From Constitutional Psychopathic Inferiority to AIDS: What is in the Future for Homosexual Aliens?*, 7 YALE L. & POL'Y REV. 201, 205 (1989).

21. Note, *Survey on the Constitutional Right to Privacy in the Context of Homosexual Activity*, 40 U. MIAMI L. REV. 521, 523 (1986).

22. Many laws refer to sodomy as the "infamous crime against nature." ALA. CODE § 13A-6-65 (1982); ARIZ. REV. STAT. ANN. § 13-1411 (1989); FLA. STAT. ANN. § 800.02 (West 1992); GA. CODE ANN. § 16-6-2 (Michie 1990); IDAHO CODE § 18-6605 (1987); KAN. STAT. ANN. § 21-3505 (1988); KY. REV. STAT. ANN. § 510.100 (Michie/Bobbs-Merrill 1990); LA. REV. STAT. ANN. § 14.89 (West 1986); MD. ANN. CODE §§ 553, 554 (1987); MASS. ANN. LAWS CH. 272, § 34-35 (Law. Co-op 1992); MICH. COMP. LAWS ANN. § 750.158 (West 1991); MINN. STAT. ANN. § 609.293 (West 1987); MISS. CODE ANN. § 97-29-59 (1972); MO. ANN. STAT. § 566.090 (West 1979); MONT. CODE ANN. § 45-5-505 (1991); NEV. REV. STAT. § 201.190 (1991); N.C. GEN. STAT. § 14-177 (1992); OKLA. STAT. ANN. TIT. 21, § 886 (West 1983); R.I. GEN. LAWS § 11-10-1 (1981); S.C. CODE ANN. § 16-15-120 (Law. Coop 1985); TENN. CODE ANN. § 39-2-612 (1991); TEX. PENAL CODE ANN. § 21.06 (Vernon 1974); UTAH CODE ANN. § 76-5-403 (Supp. 1988); VA. CODE ANN. § 1802-361 (1988).

23. *See* Bowers v. Hardwick, 478 U.S. 186 (1986). The Court upheld a Georgia statute making sodomy illegal. While previous cases made clear the existence of certain fundamental rights in the areas of family, marriage, and procreation, the court held that "[n]o connection between family, marriage, or procreation on the one hand and homosexual activity on the other has been demonstrated . . . ." *Id.* at 191.

24. *See* Rhonda Riveria, *Sexual Orientation Law In The Mid-80's*, 11 U. DAYTON L. REV. 275 (1986). Of course, elimination of homosexuals from the military has been official policy since 1943. *Id.* at 287. According to the General Accounting Office, driving suspected homosexuals from the military costs about $27 million each year. Tom Morganthau, *Gays and the Military*, NEWSWEEK, Feb. 1, 1993, at 52, 54. President Clinton pledged to end the military ban on homosexuals, but his attempts to make good on that promise cast a pall on inaugural festivities, and prompted a near crisis with the Joint Chiefs of Staff, who threatened to resign en masse over the proposed change in policy. *Id.* at 53.

25. Christine Wicker, *More Battles Are Expected Over Gay Rights*, DALLAS MORNING NEWS, Dec. 21, 1992, at A1. Voters in Oregon were subjected during 1992 to one of the "most vituperative, violent campaigns" in state history over Amendment Nine, a measure that would have categorized

The horror of AIDS was juxtaposed against already existing attitudes about homosexuality. Not only did people fear AIDS, they were disturbingly ignorant about how the disease spreads.[26] As the AIDS panic grew, theories about its foreign origination abounded as immigrants and homosexuals became scapegoats for the disease. It was in this atmosphere that U.S. immigration policy evolved during the mid-1980's.

III. U.S. Immigration Policies and AIDS U.S. Immigration Policy: Background

The federal government's authority to regulate public health and immigration is implicit in the Constitution.[27] The Supreme Court has made clear the sweeping nature of this power by stating that "over no conceivable subject is the legislative power of Congress more complete than it is over" the admission of aliens.[28]

Congress first barred immigrants for medical reasons in 1879, by enacting legislation to prevent the introduction of infectious or contagious diseases into the country.[29] In 1952, Congress passed the Immigration and Nationality Act (INA),[30] which remains the source of and foundation for current immigration policies of the United States. The initial INA excluded aliens afflicted with tuberculosis or any "dangerous contagious disease."[31] The first proposal to list AIDS as a "dangerous contagious disease" for the purposes of immigration policy was made by the Secretary of Health and Human Services (HHS) in 1986.[32]

On June 2, 1987, the Senate adopted an amendment to the Supplemental Appropriations Act of 1987 stating that:

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homosexuality with sadism, masochism, and pedophilia, and required public schools to teach that it is perverse and unnatural. *Id.* In Colorado, voters approved such a measure and polls indicate that even after national outcry, most of them continue to support it. *Coloradans Still Back Law Against Rights, Poll Says*, Dallas Morning News, Jan. 4, 1993 at A3. Conservative leaders are preparing to place similar initiatives on the ballot in Michigan, Idaho, Ohio, Washington, Iowa, Missouri, Minnesota, Maine, California, and Georgia. *New Moves Against Gays*, Newsweek, Jan. 18, 1993, at 4.

26. According to the National Center for Health Statistics, roughly half the U.S. adult population believed as of 1988 that HIV could be transmitted by eating utensils, coughs and sneezes, or insect bites. Almost one-third of the U.S. adult population believed that simply working with someone with HIV could be dangerous. AIDS Knowledge and Attitudes, Advance Data, No. 151, NCHS (1988).

27. The Constitution grants Congress the power to "establish an uniform rule of naturalization." U.S. Const. art. I, § 8, cl. 4. While this is the only explicit grant of power related to immigration, it has been suggested that the powers to regulate immigration and naturalization are derived from the inherent sovereign powers of the United States, and are "necessary concomitants of nationality." United States v. Curtiss-Wright Export Corp., 299 U.S. 304, 318 (1936). *See also* Chae Chan Ping v. United States, 130 U.S. 581 (1889). The Supreme Court has held that the exclusion of aliens is a fundamental sovereign right. *See* Fiallo v. Bell, 430 U.S. 787, 792 (1977).

28. Oceanic Steam Navigation Co. v. Stranahan, 214 U.S. 320, 339 (1908).

29. Ch. 202, 20 Stat. 484 (1879). The Alien Act of June 25, 1798 allowed the President to expel any aliens he deemed dangerous to the United States. Ch. 58, 1 Stat. 570.

30. Currently codified at 8 U.S.C. §§ 1101-1525 (1988).

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

32. *See* Kerry Voss, *Reevaluating Alien Exclusion in Light of AIDS*, 6 Dick. J. Int'l L. 119, 121-22 (1987).

> On or before August 31, 1987, the President, pursuant to his existing power under Section 21(a)(6) of the Immigration and Nationality Act, shall add human immunodeficiency virus infection to the list of dangerous contagious diseases contained in title 42 of the Code of Federal Regulations.[33]

The amendment was offered by Senator Jesse Helms of North Carolina, purportedly to prevent immigrants from bringing AIDS with them to the United States.[34] Referring to testing requirements imposed by other countries, Senator Helms stated "they do not want AIDS to come into their country and neither should we."[35] HHS published a final rule adding HIV infection to the list of dangerous contagious diseases effective August 31, 1987, and an amendment governing the medical examination of aliens and testing for HIV went into effect on December 1, 1987.[36] The U.S. government then "embarked upon one of the most widespread mandatory HIV antibody testing programs in the world, despite international medical, scientific and human rights protests. . . ."[37]

The policy gained international attention in April 1989, when a Dutch AIDS patient was jailed while attempting to enter the U.S. to attend a health conference in San Francisco. Hans Paul Verhoef, a public health worker, was en route to a gay health conference in San Francisco when customs inspectors at Minneapolis-St. Paul International Airport discovered the drug AZT in his luggage and, upon questioning Verhoef, learned that he suffered from AIDS.[38] Verhoef was told he could return to the Netherlands or remain in jail pending a deportation hearing. The INS refused Verhoef's request for a waiver of the rule excluding AIDS patients, and Verhoef appealed to a federal immigration judge who overruled the INS. The Board of Immigration Appeals rejected an INS appeal of the judge's order.[39] After being held in custody for six days, Verhoef was permitted to travel to San Francisco after he posted a $10,000 bond, promised to leave the country within three weeks, and pledged to avoid "high risk" behavior.

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33. Supplemental Appropriations Act of 1987, Pub. L. No. 100-71, 101 Stat. 391, 475 (1987); CONG. REC. S7410-16 (daily ed. June 2, 1987).

34. According to Senator Helms, "[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 (daily ed. June 2, 1987) (statement of Senator Helms).

35. 133 CONG. REC. S7411 (daily ed. June 2, 1987) (statement of Senator Helms).

36. Final Rule, 52 Fed. Reg. 32,540 (Aug. 28, 1987). The amendment substituted HIV for AIDS and expanded the scope of the medical examination to include serological testing for HIV. That testing was to be performed in the country in which the visa or adjustment to status was applied for. *Id.*

37. Adria-Ann McMurray, *Immigration Consequences of HIV Infection in* AIDS PRACTICE MANUAL—A LEGAL AND EDUCATIONAL GUIDE 17-2 (Paul Albert et al., eds., 3rd ed. 1991).

38. Victor Zonana, *Dutch AIDS Patient Freed, Travels to S.F.*, L.A. TIMES, Apr. 9, 1989, at 3; David Johnston, *U.S. Will Ease Visa Restrictions For Some Who Suffer From AIDS*, N.Y. TIMES, May 19, 1989, at D16.

39. Zonana, *supra* note 38, at 3.

In the wake of incidents such as the one involving Verhoef,[40] criticism of U.S. immigration policy mounted. Attorney General Dick Thornburgh approved a directive easing visa restrictions and permitting HIV-infected individuals to enter the United States on a temporary basis to attend conferences, obtain medical treatment, or conduct business.[41] Despite the change, the National Commission on AIDS, backed by numerous legal and health groups, issued a statement asking President Bush to end the "unjustified" policy of asking visa applicants whether they were HIV-infected.[42] In January 1990, the federal government — in response to threatened travel boycotts by several international organizations — again eased its policy. While still requiring disclosure of HIV-infection by visa applicants, the new policy allowed applicants to complete their declarations of medical condition in confidence.[43] The government further eased the policy three months later by announcing it would grant special ten day visas allowing foreigners to attend professional, scientific, or academic conferences in the United States.[44]

In November 1990, following a storm of public criticism, President Bush signed into law the Immigration Act of 1990, eliminating the automatic HIV exclusion (along with the "dangerous contagious disease" terminology that was its foundation) and enabling HHS to redraw the immigration disease list to define excludable aliens as those with a "communicable disease of public health significance."[45] The change, however, proved to be illusory.[46] When HHS removed HIV from the list and published its proposed rule for comment,[47] it was met with stern resistance

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40. In 1990, many HIV-infected members of the World Federation of Hemophilia could not attend their convention in the United States — even though most had been infected by U.S. blood products exported to their countries. Gorman, *Opening the Border to AIDS*, TIME, Feb. 22, 1993, at 45.

41. Johnston, *supra* note 38, at D16.

42. Marlene Cimons, *AIDS Panel Calls For End To "Stigmatizing" Foreign Visitors Who Are HIV-Infected*, L.A. TIMES, Dec. 13, 1989, at A4. The Commission is an independent panel appointed by Congress and the White House to advise the President on the development of AIDS policies. The Centers for Disease Control also recommended removing HIV from the immigration list. *CDC Urges Major Revision to Excludable Diseases List*, 5 AIDS POL'Y & L. (BNA) No. 4, at 1 (Mar. 7, 1990).

43. Philip Hilts, *U.S. to Ease Passport Curbs on Visitors Infected With AIDS Virus*, N.Y. TIMES, Jan. 17, 1990, at B6. The government also changed its policy on "waiver stamps." Until 1990, any foreigner who was granted a waiver had his passport stamped with large numbers indicating the waiver was for a dangerous contagious disease. The new policy eliminated the stamped code in favor of a separate sheet of paper with a waiver stamp on it. *Id.*

44. *New Visa Policy Not Likely to Avert Boycott of International Conferences*, 5 AIDS POL'Y & L. (BNA) No. 7, at 1 (Apr. 18, 1990).

45. Immigration Act of 1990, Pub. L. No. 101-649, § 601(a)(1)(A)(i), 104 Stat. 4978, 5067 (1990).

46. In the words of one INS official, "Congress giveth away with one hand, then giveth back with another." Edward Lynch, *Medical Exclusion and Admissions Policy: Statutes and Structures*, 23 INT'L L. & POL. 1001, 1009 (1991).

47. *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).

and the federal government issued an "interim" rule preserving the status quo.[48]

The INA now provides that any alien "who is determined (in accordance with regulations prescribed by the Secretary of Health & Human Services) to have a communicable disease of public health significance" is ineligible to receive a visa and shall be excluded from admission into the United States.[49] Federal regulations define HIV as a "communicable disease of public health significance."[50] Both the Public Health Service Guidelines[51] and federal regulations[52] require aliens to undergo a medical examination — including serological testing for HIV — before they are admitted to the United States. As a result, the United States now requires HIV-antibody testing of hundreds of thousands of immigrants, non-immigrants, and refugees each year. In addition, the more than two million aliens already living in this country must be tested in order to qualify for legal residence.

Upon taking office, President Clinton indicated he would lift the ban. In February 1993, however, the Senate dealt Clinton his first legislative defeat with an overwhelming vote to make the ban law. The Senate attached the ban to a reauthorization bill for the National Institutes of Health. On March 11, 1993, the House handed Clinton another defeat on the issue by voting 356-58 to instruct its conferees to accept the Senate language on the ban, virtually assuring passage. In the face of congressional opposition, President Clinton indicated he would likely sign the bill even with the ban. The HIV exclusion, despite repeated challenge and tremendous criticism, had survived.[53]

Although all refugees, applicants for legalization, and applicants for permanent residence must submit to HIV testing, the waiver provisions applicable to each of these groups differ. Applicants for legalization may obtain a waiver similar to that available to non-immigrants if they can establish that (1) they will not endanger the public health, (2) they will not risk spreading the disease, and (3) the government will not incur any cost due to their infection.[54] HIV-infected aliens seeking permanent resi-

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48. Interim Rule, 56 Fed. Reg. 25,000 (May 31, 1991). The Eighth International AIDS Conference scheduled to take place in Boston was then moved to Amsterdam to ensure the attendance of HIV-infected participants. Philip Hilts, *United States Policy on Infected Visitors Keeps AIDS Meeting Out of Country*, N.Y. TIMES, Aug, 17, 1991, at 6.

49. 8 U.S.C.S. § 1182(a) (Supp. 1992).

50. 42 C.F.R. § 34.2 (1991).

51. UNITED STATES PUBLIC HEALTH SERVICE, GUIDELINES FOR MEDICAL EXAMINATION OF ALIENS (1984).

52. 42 C.F.R. § 34.3 (1991).

53. Gorman, *supra* note 40, at 45; *What's News*, WALL ST. J., Mar. 12, 1993, at A1; Marie Puente, *House Endorses AIDS Immigrant Ban*, USA TODAY, Mar. 12, 1993, at 4A; *AIDS Immigrant Ban Passed*, DALLAS MORNING NEWS, Mar. 12, 1993, at 4A.

54. *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).

dence are virtually certain to be excluded, as there are no widely applicable waiver provisions for this group of aliens.[55]

There is no administrative or judicial appellate process available to individuals denied entry to the United States under the foregoing procedures. Even if a procedure were available, courts generally decline to review such decisions[56] under the rationale that medical questions should be resolved by members of the medical profession.[57]

IV. The Efficacy and Propriety of U.S. Immigration Policy

Advocates of restrictive HIV-related immigration policies point to a desire to curtail the spread of the virus and the need to insulate the national health care system from financial burdens associated with caring for non-citizens afflicted with AIDS as justification for such restrictions.[58] Current immigration policies, however, will accomplish neither goal.[59]

A. *Restricting HIV-Infected Individuals From Entering the U.S. as a Method of Curtailing the Spread of AIDS*

The United States is, if anything, an exporter of AIDS rather than an importer.[60] There are an estimated one million persons in the United States infected with HIV.[61] Given the magnitude of these numbers, it is absurd to suggest that denying entry to a handful of HIV-infected individuals will affect the spread of AIDS in this country.[62]

Even if the demographics were different, any hope for success in controlling the spread of the virus would depend upon two presumptions. First, that all individuals entering the country would be tested, and sec-

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55. Both groups are eligible for four narrow classes of waivers. Applicants who obtained lawful temporary residence under the general amnesty legalization program or the seasonal agricultural workers legalization program are eligible for a waiver, as are refugees and asylees applying for adjustment after one year in asylee status. McMurray, *supra* note 37, at 17-1, 17-6. Additionally, the Attorney General may issue a waiver for any alien who is the spouse or unmarried son or daughter of a U.S. citizen or of an alien lawfully admitted for permanent residence. Immigration Act of 1990, Pub. L. No. 101-649, § 9, 104 Stat. 4978, 5076 (1990).

56. *See, e.g.*, United States *ex rel.* Johnson v. Shoughnessy, 336 U.S. 806 (1949).

57. Denise Druhot, *Immigration Laws Excluding Aliens on the Basis of Health: A Reassessment After AIDS*, 7 J. Legal Med. 85, 101 (1986).

58. *See supra* note 34 and accompanying text.

59. The HIV-restricted immigration policy has been compared to unsuccessful attempts to contain smallpox by requiring vaccination as a condition of entry. *See* Okie, *Public Health Experts Raise Doubts on Plan to Test Immigrants for AIDS*, Wash. Post, July 15, 1987, at A14.

60. Gorman, *supra* note 40, at 45.

61. The United States has more than half of the world's reported AIDS cases. Gary Shannon et al., The Geography of AIDS: Origins and Course of an Epidemic 1 (1991). The Centers for Disease Control estimates that more than five million Americans are HIV-infected, and approximately half a million of them suffer from AIDS. Centers for Disease Control, *HIV Prevalence Estimates and AIDS Case Projections for the United States: Report Based Upon a Workshop*, 39 Morbidity & Mortality Wkly. Rep. 1, 5-15 (1990).

62. In fact, this argument is backward. Given the huge number of HIV-infected Americans, it is probably the immigrants who run a serious health risk by coming to this country.

ond, that the tests administered would yield accurate results. Neither presumption is accurate.

1. *Testing Accuracy*

The most common methods of testing to determine HIV exposure are serological tests known as the Enzyme-Linked Immunosorbent Assay (ELISA)[63] and the Western Blot.[64] Under current federal regulations, an applicant is determined seropositive only after an ELISA and confirmatory Western Blot indicate the presence of HIV antibodies.[65] Even the use of both these tests, however, presents serious concerns of erroneous results, since both detect the presence of antibodies to HIV, not the virus itself, and neither is foolproof.[66]

Use of the ELISA test requires the determination of a "cut-point," the level of antibody necessary to constitute infection. The choice of a cut-point is obviously crucial to the test, and is an important determinant of the number of positive results reported. In most commercial ELISA tests, cut-points are set quite low in order to detect as many suspicious units as possible."[67] The result is a particularly high number of false positives — especially in low-risk populations.[68] By being so sensitive, the tests are less able to discriminate between true infection and lack of infection.

One study has suggested that the frequency of false positive test results is as high as 6.8 percent among hospital patients,[69] while another study indicates that in a blood donor population that tests positive on a single ELISA test, anywhere from one-half to two-thirds of those results may prove to be false.[70] An individual who tests positive on the ELISA is usually re-tested with the Western Blot. The Western Blot is more accurate than the ELISA test, but it too is apt to yield false positive or

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63. The ELISA test detects the presence of HIV antibodies through a process that involves placing HIV proteins on plastic beads and adding a sample of blood. If the blood contains HIV antibodies, they will combine with the proteins and the beads will change color. *How Blood is Tested for the AIDS Virus*, N.Y. TIMES, July 13, 1988, at B2. *See also* Michael Barry, Paul Cleary, & Harvey Fineberg, *Screening for HIV Infection: Risks, Benefits, and the Burden of Proof*, 14 LAW. MED. AND HEALTH CARE 259, 260 (1986).

64. In the Western Blot, an electric current is passed through a gel containing HIV proteins, which arrange themselves at different heights on the gel slab. The proteins are blotted from gel onto a special paper and combined with a blood sample. If the paper changes color when exposed to X-ray film, HIV antibodies are present in the blood. *How Blood is Tested for the AIDS Virus*, N.Y. TIMES, July 13, 1988, at B2. *See also* Barry et al., *supra* note 63, at 260.

65. 42 C.F.R. § 34.4 (1991).

66. Even if the tests were accurate, they could have the effect of driving HIV-infected individuals already in this country into illegal status. Without the incentive to seek counseling, they will constitute an even greater public health risk.

67. Barry et al., *supra* note 63, at 260.

68. *Id.*

69. Klemens Meyer & Stephen Parker, *Sounding Board: Screening for HIV: Can We Afford the False Positive Rate?*, 317 NEW ENG. J. MED. 238 (1987).

70. *Acquired Immune Deficiency Syndrome: A Review of Science, Health, Policy & Law*, 4 HEALTH MATRIX 4, 5 (1986).

indeterminate results.[71] Techniques for the test are not standardized, and involve significant interpretation. "[T]he criteria for this interpretation vary not only from laboratory to laboratory but also from month to month."[72] In addition, because the Western Blot is more expensive and labor-intensive than the ELISA test, it is not really practical for the large scale screening of blood.[73] Thus, the potential for false positive results exists even when the testing is performed by an established laboratory.[74] Most immigrants will be tested not in the United States, but in their own countries.[75] Those individuals who must be tested in their native countries run an even higher risk of false positive results due to inadequate facilities and quality control.[76] Thus, for many immigrants the misfortune of living in a country without adequate HIV testing facilities may result in a denial of entry to the United States.

Even more damaging to the objective of controlling the spread of AIDS is the problem of false negative test results. A positive HIV test result is contingent upon the presence of antibodies to the virus. It is now widely known, however, that an individual can be infected with HIV and remain asymptomatic for an unknown period that recent studies suggest may *average* nearly ten years.[77] Moreover, there is a "window" between infection and the production of antibodies that may last as long as six months.[78] Accordingly, regulations requiring HIV-testing of only those tourists and other non-immigrant entrants to the U.S. who "appear" to be infected are cosmetic in nature and completely ineffective.[79] Even if mandatory HIV screening were imposed upon all individuals entering the country, a small but statistically significant number of infected but seronegative persons would elude detection by immigration authori-

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71. Meyer & Parker, *supra* note 69, at 238.

72. *Id.*

73. Barry et al., *supra* note 63, at 262.

74. Of course, many labs lack proper research facilities and personnel, making the chance of false positive results even greater. Meyer & Parker, *supra* note 69, at 239. Since the Helms Amendment was passed, more than three million immigrants have been tested for HIV infection, and it has been estimated that of every 15 positive results rendered, one was a false positive. 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.

75. *See* 42 C.F.R. § 34.3 (1991).

76. Senator Dole addressed this concern during congressional debate, stating: "It is my understanding that there is 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." 133 CONG. REC. S7415 (daily ed. June 2, 1987) (statement of Sen. Dole). Senator Dole did not vote on the HIV-infection substitution. *Id.* at S7416.

77. Centers for Disease Control, *AIDS and Human Immunodeficiency Virus Infection in the United States*, 38 MORBIDITY & MORTALITY WKLY. 1 (May 12, 1989).

78. Christine Cimini, *The United States Policy on HIV Infected Aliens: Is Exclusion an Effective Solution?*, 7 CONN. J. INT'L L. 367, 379 (1992).

79. Additionally, because tests are designed to detect only the presence of antibodies to fight HIV, they can actually only predict infection. *See* Barry et al., *supra* note 63, at 260.

ties — and will do so under the false assumption that they do not carry the virus.[80]

2. *Limited Scope of Screening*

Under current U.S. law, applicants for non-immigrant visas, generally tourists and students, are subject only to discretionary screening.[81] These people are every bit as capable of bringing HIV into the United States and spreading it as applicants for immigrant visas, and many non-immigrants remain in this country for long periods of time.[82] That they are not tested casts significant doubt on the efficacy and intent of the immigration laws. By requiring only the screening of certain foreigners who enter or remain in the United States, current immigration laws make irrational and unjustifiable distinctions, and render themselves ineffective and discriminatory.

B. *Deterring Individuals From Coming to the U.S. to Obtain Medical Treatment*

While attempting to deter HIV-infected persons from entering the United States for medical treatment not available in their home countries might appear to be a valid policy objective (certainly more feasible than preventing the spread of AIDS), closer scrutiny reveals otherwise. The humanity of such an approach aside, there are serious problems with the practical reasoning underlying it.

Initially, the number of persons fitting the purported category is minuscule. Very few poor and infected aliens are likely to possess the financial resources that will enable them to immigrate to the United States.[83] Those few that do may be covered by foreign health insurance or foreign

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80. The only way to prevent these people from entering the country would be to require all persons to be tested once to determine their "baseline" negativity, and then again at regular intervals for a period of several months in order to insure that they had not seroconverted in the interim period. Logistically, this type of testing is not feasible because of the prohibitive financial and practical cost of its administration, the inability to monitor adequately testing procedures or results, the almost certain emergence of a cottage industry specializing in "AIDS-free" certificates, and other practical considerations. Most importantly, however, the effectiveness of periodic testing is based upon a vital assumption: that the individual in question has not participated in any high-risk activity between the time of the original test and the final HIV-screening some time later. Short of placing individuals in solitary confinement for an extended period of time while the periodic tests are administered, it would be absolutely impossible to ensure that no HIV-infected individuals enter the country.

81. 42 C.F.R. § 34.4(a)(iii) (1991).

82. "An L-1 intracompany transferee visa recipient, for example, may be admitted initially for three years and have the visit extended an additional two or three years. Foreigners on H-1 visas may also stay for three years. Students may be allowed to stay in the United States for eight years while investors may extend the initial one year granted almost indefinitely." Lynn Starr, *The Ineffectiveness and Impact of the Human Immunodeficiency Virus (HIV) Exclusion in U.S. Immigration Law*, 3 GEO. IMMIGR. L.J. 87, 96-97 (1989).

83. Jerome Groopman, *Insult to Injury: A Doctor Protests; Bush Reneges, Bars HIV Patients from Emigrating*, THE NEW REPUBLIC, June 24, 1991, at 13. The three underdeveloped nations with the highest AIDS rates (Uganda, Kenya, and Brazil) have per capita gross national products of $250, $380, and $2434, respectively. THE WORLD ALMANAC 1992 734-821 (1992).

government-sponsored programs that will pay for their treatment.[84] More important, there does not appear to be any objective data suggesting that the United States would experience an influx of HIV-infected individuals seeking immigration for AIDS treatment.[85]

In reality, the lack of a national health care system and the FDA's reluctance to approve experimental AIDS drugs and treatments suggests that the interests of HIV-infected foreigners would be better served if they were to immigrate elsewhere. In fact, many HIV-infected Americans travel *abroad* in search of progressive treatments for HIV-related illnesses, or join organizations that facilitate the wholesale purchase of drugs not yet available in the United States. There simply is no evidence that lifting the HIV-restrictive policy will result in a flood — or even a trickle — of HIV-infected foreigners who will require government assistance to obtain AIDS treatment in this country.[86]

C. *International Relations and Global Unity Against AIDS*

Not surprisingly, the AIDS pandemic has provoked a variety of legislative responses from various nations. One significant area of AIDS legislation is immigration. Some countries have enacted laws subjecting certain persons to HIV testing and subsequent exclusion.[87] These laws appear to run afoul of standards established by the United Nations and the World Health Organization.

As a member of the United Nations, the United States is bound by the provisions of the U.N. Charter.[88] Drafted in 1945, the Charter establishes a framework for the recognition of human rights by calling for member nations to respect fundamental human rights and freedoms.[89]

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84. Groopman, *supra* note 83, at 13. According to a 1991 report by the National Commission on AIDS, the economic contributions of HIV-positive immigrants are likely to outweigh the cost of their treatment anyway. Gorman, *supra* note 40, at 45. On February 26, 1993, France announced it would pay all medical bills involving HIV or AIDS incurred by French residents. *AIDS Care: Free to Nonexistent*, THE ADVOCATE, Apr. 6, 1993, at 32.

85. This discussion obviously relates only to those individuals seeking the right to immigrate. Due to the capitalistic nature of the U.S. health care system, individuals seeking to enter the country temporarily in order to receive treatment for HIV-related illnesses would not place a burden on the system. They would be able to obtain treatment in much the same way they could obtain any other good or service in a capitalist economy. On the other hand, if a temporary visitor could not afford the costs associated with treatment, the individual would be unable to obtain treatment because only permanent residents are eligible to receive government assistance in the form of Medicare or Medicaid.

86. In fact, if the United States must have disease-restrictive policies, other diseases are better candidates. According to a Canadian study, HIV-infected foreigners entering Canada during 1988 will cost the government $18.5 million through 1998, while immigrants with heart disease will cost the government $23.2 million over the same period. Delores Kong, *HIV Positive Immigrants Find Their Lives Caught in Limbo*, BOSTON GLOBE, June 17, 1991, at A1.

87. Among the nations with formal or informal policies permitting such actions are Saudi Arabia, Thailand, Iraq, Cuba, China, Russia, and Great Britain. *See* Nancy Allin, *The AIDS Pandemic: International Travel and Immigration Restrictions and the World Health Organization's Response*, 28 VA. J. INT'L L. 1043, 1052 (1988).

88. U.N. CHARTER (adopted June 26, 1945).

89. U.N. CHARTER arts. 55, 56, 57.

In 1987, the U.N. adopted a General Assembly Resolution urging global unity in the fight against AIDS and cautioning "against the excessive parochialism which has so far characterized the discussion of AIDS in many countries."[90] The U.S. HIV-restrictive immigration policy appears clearly to violate these U.N. policies.

Additionally, the U.S. policy violates recommendations of the World Health Organization (WHO), a specialized agency of the United Nations founded in 1946 at the International Health Conference.[91] Based in Geneva, WHO seeks to assure the highest possible level of health for all peoples of the world, and the organization's policy-making arm, the World Health Assembly, meets annually to allow delegates from member nations to exchange research, experience, and ideas.[92]

The WHO constitution provides that the World Health Assembly "shall have the authority to adopt regulations concerning . . . sanitary and quarantined requirements and other procedures designed to prevent the international spread of disease . . . ."[93] In 1948, WHO adopted a set of principles to guide it in its endeavor. Principle Two states that "each country should develop its internal resistance to disease, rather than rely on measures taken at its frontiers."[94] Principle Three states:

> Measures taken at frontiers should be the minimum compatible with the existing sanitary situation. Excessive measures not only entailed [sic] undue interference with traffic and severe economic consequences but might, by their very excess, lead to deliberate evasion of the sanitary control and thereby defeat the object.[95]

Although these principles do not expressly address the AIDS pandemic, they contain the key to understanding WHO's current stance on AIDS.

WHO's policy on AIDS and immigration is guided by the organization's position that public health needs "do not provide a blanket exemption from observance of human rights obligations."[96] Recognizing the need for global cooperation in the fight against AIDS, WHO suggests that member nations should promote the protection of the human rights and dignity of HIV-infected individuals and avoid discriminatory action in such areas like employment and travel. This policy is based upon the belief that HIV screening will only briefly, and at great social and eco-

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90. G.A. Res. 31232, U.N. GAOR, U.N. Doc. A/42/L.7/Rev.1 (1987).

91. *Report of International Health Conference*, New York, 19 June-22 July 1946, U.N. E/772 (1947).

92. WHO CONST. art. 1, 10-23.

93. WHO CONST. art. 22.

94. Expert Commission on International Epidemiology and Quarantine, *Report on the First Session*, 19 OFFICIAL RECORDS OF THE WORLD HEALTH ORGANIZATION at 5, 7 WHO 5/of 2/14-21 (1949).

95. *Id.*

96. *Global Programme on AIDS, Report of the Global Commission on AIDS First Meeting*, (Mar. 21-31, 1989), World Health Org. at 1, GPA/GCA (1) 89.1 (1989).

nomic cost, deter the spread of AIDS, while diverting scarce resources away from more effective education and research programs.[97]

While several nations have policies that run afoul of the U.N. and WHO recommendations, none has been more notorious than the well-publicized and malleable border policy of the United States. From an international diplomatic perspective, if the country with the highest number of reported AIDS cases[98] closes its borders to HIV-infected persons from other countries, it is likely that retaliatory restrictions will be placed on U.S. citizens living or traveling abroad.[99] This likelihood could be strengthened by the perception that the U.S. is to blame for the spread of AIDS.[100] These retaliatory restrictions would not only affect vacationers, they could also hamper international business and trade, and undermine U.S. foreign policy initiatives.[101] Ultimately, rather than international cooperation in the fight against AIDS, there will be rivalry and tension. As nations compete in "testing wars," the costs of implementing and maintaining testing programs will escalate and desperately needed economic resources will be diverted from treatment, research, and international programs directed to both national and international travelers.[102]

The imposition of travel and immigration restrictions undermines the basic premise of global cooperation in combatting AIDS. Such policies suggest that AIDS is a problem each country must deal with on its own. In truth, however, AIDS is a global phenomenon, and only through global cooperation can it be combatted successfully. It is the failure to reflect this self-evident truth that is the greatest shortcoming of U.S. immigration policy:

> U.S. government agencies have thus far 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.[103]

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97. *Consultation on International Travel and Human Immunodeficiency Virus (HIV)*, 62 WEEKLY EPIDEMIOLOGICAL RECORD 77 (1987); *Global Programme on AIDS, Statement on Screening of International Travellers for Infection with Human Immunodeficiency Virus*, World Health Org. WHO/GPA/INF/883 (1988).

98. *See supra* note 3 and accompanying text.

99. Okie, *supra* note 59.

100. Among the countries openly blaming the U.S. for spreading AIDS are Turkey, Haiti, Mexico, and several Latin American nations. *See* Starr, *supra* note 82, at 109.

101. Cimini, *supra* note 78, at 392; Starr, *supra* note 82, at 109. Access to military bases and shore leave for military personnel abroad could be affected as well. Lori McHugh, *AIDS: International Problems & Issues*, *in* AIDS: LEGAL, LEGISLATIVE AND POLICY ISSUES (Ed Norman Quist ed. 1989).

102. World Health Organization, *Acquired Immune Deficiency Syndrome (AIDS): Consultation on International Travel and Human Immune Deficiency Virus (HIV)*, 62 WEEKLY EPIDEMIOLOGICAL RECORD 77 (1987).

103. Paul Kriesberg & Harry Blaney, *AIDS A Foreign Policy Issue Too: It Affects Travel, Business, National Security*, WASH. POST, Oct. 12, 1987, at A19.

D. *Humanitarian Concerns*

Its potential for success in controlling AIDS aside, the HIV-restrictive immigration policy presents serious humanitarian concerns. Above all else, U.S. policymakers must remember that their fight should be "against AIDS, not against people with AIDS."[104] That is a distinction current policies fail to reflect. Because those who test positive and are excluded must return to their home countries, there is a serious risk they will receive little or no care.[105] Even worse, some nations may exclude HIV-infected persons,[106] or admit them but persecute them.[107]

Many persons affected by the HIV-exclusion policy may have contracted the disease while in this country legally. Millions of amnesty applicants, some legally in this country under agricultural programs,[108] others in illegal status but eligible for adjustment to permanent resident status,[109] who have continuously resided in this country for years but upon applying for adjustment may be excluded if HIV-positive. Excluding these people is particularly inhumane and unjust:[110]

> The HIV infection exclusion demonstrates that the United States feels no responsibility, moral or otherwise, to aliens who have made the United States their home and who probably contracted the AIDS virus here. Having benefited from the presence of these workers, largely undocumented workers, the United States will require them to return to their native countries, where they will burden a health system they have not contributed to in at least six years and will die of a disease contracted and better treated in the United States.[111]

The vast majority of those affected by the exclusion policy are likely to be Hispanic, since more than eighty percent of amnesty applicants fall into that category.[112] Because AIDS education programs in this country failed to target the Hispanic population sufficiently, there is growing concern that the United States essentially neglected to warn the Hispanic

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104. Lynch, *supra* note 46, at 1009.

105. For example, Haiti has total resources for AIDS equivalent to only two percent of U.S. resources for battling the disease. Cimini, *supra* note 78, at 392-93.

106. Senator Alan Simpson addressed this issue during discussion of the Helms Amendment:

> [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? Or are you talking about detention or areas where they will be quarantined? That is really where we are headed here.

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

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

108. *See* 8 U.S.C. § 1160 (Supp. V 1988).

109. *Id.* § 1255a.

110. The callous attitude of many people was evidenced by one U.S. congressman who, upon being questioned about the possibility that foreign children dying of AIDS would no longer be able to visit Disneyworld responded, "Let them go to Disneyland in France." Gorman, *supra* note 40, at 45.

111. Starr, *supra* note 82, at 101.

112. "Because the majority of persons wishing to immigrate to the United States come from developing countries, the impact of HIV testing falls heavily on people of color." Fernando Chang Muy, *HIV/AIDS and International Travel: International Organizations, Regional Governments, and the United States Respond*, 23 INT'L L. & POL. 1047, 1058 (1991).

population about AIDS and is now trying to expel the results of its neglect.[113]

V. CONCLUSION

The only way to combat AIDS effectively is through global research and education, not superficial travel restrictions. In their efforts to quell AIDS hysteria, governments are often more apt to impose cosmetic measures than to educate the public. By artificially allaying public fears, governments do a disservice to efforts of education. AIDS is a frightening disease and people should be frightened by it. But the most logical and beneficial way to allay those fears is education about the disease and its transmission. Only then will AIDS be controlled.

The United States government has the authority to determine those applicants for citizenship it will approve. But this decision should no more be based upon one's HIV status than it should be based upon one's color, religion, serum cholesterol level, or nicotine use. For much of its history, the United States has represented a beacon of hope for those with nowhere else to turn. Current U.S. immigration policies work injustice not only upon prospective immigrants, but also upon the principles that guided this country's development. In the end, it must be our faith in and adherence to these principles — not fear and emotion — that will guide us through the AIDS crisis:

> The question is whether or not this Nation in a time of extreme crisis, a crisis which will become even more extreme over time, will respond out of fear and emotion, in which case we are going to lose the fight, or whether this Nation is going to use the tools that we uniquely have with the greatest scientific and educational establishment known to man. If we use those tools, we are going to win. If we react to our fear and emotion, not only will we lose our own Nation, but indeed the world, and the crisis is just that serious.
>
> Senator Lowell Weicker[114]

113. For a thorough discussion, see Starr, *supra* note 82.
114. 133 CONG. REC. S6956 (daily ed. May 21, 1987) (statement of Sen. Weicker).

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Excluding Travelers & Immigrants with HIV Infection

Lawrence O. Gostin, JD

Global strategies to control infectious disease have historically included the erection of barriers to international travel and immigration. In recent years, however, keeping people with infectious diseases outside national borders has come to be thought of as outmoded, with modern science discovering more effective and humane ways to prevent, control, and treat communicable diseases. Screening and excluding persons with diseases that are not transmitted casually, like HIV infection, has seemed particularly unnecessary. Widely varying estimates have been made of the number of countries with restrictions on travel or immigration. Between 29 and 50 countries are reported to have introduced border restrictions on HIV-positive foreigners, usually those planning an extended stay in the country, such as students, workers, or immigrants.

The country with the broadest policy of testing and excluding foreigners is the United States. Since December 1, 1987, when the United States first classified HIV infection as a dangerous contagious disease, more than 5 million people seeking permanent residence have been tested for HIV. National and international organizations have sharply criticized the U.S. policy as contrary to public health goals and human rights principles. The policy resulted in the transfer of the 1992 international AIDS conference from Boston to Amsterdam.

During the presidential election campaign, President Bill Clinton promised to reform the policy of excluding "outsiders." He also undertook to individually assess persons fleeing from Haiti to determine if they have just cause for fearing persecution in their home country. Regrettably, no changes have occurred in either policy. Earlier this year, the U.S. Senate voted overwhelmingly to continue the policy of testing and exclusion, basing its decision on supposed public health and financial cost grounds. Human rights were barely mentioned.

Moreover, some members of Congress have expressed concern that the United States could become a haven for HIV-infected persons seeking low-cost medical care. While persons with adequate health insurance or private means can often obtain excellent medical services in the United States, it is a fallacy that poor people can obtain anywhere near the equivalent services. The United States is virtually the only country in the developed world without a plan guaranteeing universal access to healthcare. Rarely, if ever, would a person immigrate to the United States to obtain low-cost healthcare. If low-cost healthcare were a main goal of persons seeking to immigrate, many industrialized countries, such as France or Canada, would likely become havens long before the United States.

Current law

The Immigration and Naturalization Act requires the Public Health Service (PHS) to list "dangerous contagious diseases" for which aliens can be excluded from the United States. By 1987, the list contained seven designated diseases—five sexually transmitted diseases and two nonvenereal diseases (infectious leprosy and active tuberculosis). On June 8, 1987, as required by the Helms Amendment, the PHS added HIV infection to the list.

International travelers and temporary visitors to the United States are not routinely tested for HIV, although they can be if suspected of infection. Suspicion in the past has been triggered by the possession of ZDV, a medical alert card for hemophilia, or even an intention to attend an AIDS conference. The Immigration and Naturalization Service has issued a directive stating that it will waive these requirements for HIV-positive visitors if there is a public health benefit, such as attendance at an academic or business meeting. In practice, travelers are rarely tested or excluded, but legally they still can be.

All persons applying for permanent residence (a green card), however, must undergo a medical examination that includes an HIV test. Those who test positive must be denied permanent residence. Waivers cannot be granted, no matter how severe the human hardship.

Human rights burdens

A public health program should adhere to basic principles of justice. The testing and exclusion of foreigners is based on serological status, not their risk to others. Restrictions based on infection rather than risky behavior are discriminatory and overly inclusive, penalizing the great majority who will behave safely, as well as the few who will not. The policy is arbitrary, because it does not include lawful visitors without visas and returning nationals who may be as, or more, likely to spread infection. Millions of people, for example, travel to the United States lawfully each year from countries such as Canada where no visa is required for entry into the United States. The net effect of mandatory screening and deportation is that many people visiting or

living in the United States may forgo the testing, counseling, and education that are so important in encouraging safer behavior.

Furthermore, the U.S. policy violates international law and global health guidelines. The International Health Regulations—enacted by the World Health Organization—provide that the only document that can be required in international traffic is a valid certificate of vaccination against yellow fever. The World Health Organization has stated that "no country bound by the Regulations may refuse entry into its territory to a person who fails to provide a medical certificate stating that he or she is not carrying the AIDS virus."

Restrictions on the freedom to move between countries because of serologic status interfere with a wide range of human endeavors including business enterprise, cultural and scientific exchange, access to specialized medical care, and personal relationships.

The immigration policy affects only people who otherwise have a right to live in the United States because of family or other close ties. The policy, therefore, interferes with personal aspiration and family unity. Moreover, as governments enact restrictions on entering their countries, it becomes more likely that other governments will impose retaliatory restrictions, escalating the social and human costs to the global community.

Refugees and asylum seekers

The human rights impact of testing and exclusion falls harder on refugees (those applying from abroad to enter a country) and seekers of asylum (those already in a country), who have a well-grounded fear of persecution in their own countries. Forcible return home may result in danger to their health or even death. Hundreds of Haitians confined at the U.S. military base in Guantanamo Bay, Cuba, fear grave harm in their home country. Yet, many may be refused entry to the United States solely because of their HIV status. It is callous, inhumane, and unlawful to repatriate legitimate refugees who will surely face political repression simply because they have HIV infection. A global outcry would arise if refugees were systematically returned to death in their home countries because they had, say, cancer or heart disease.

The U.S. policy violates the Universal Declaration of Human Rights, including the right to life. The U.N. High Commissioner for Refugees opposes programs for mass HIV testing of refugees and urges that refugees be granted access to the same levels of counseling and healthcare available to a country's nationals.

Public health

The U.S. government is conducting one of the largest HIV screening programs in the world, but without any plans for evaluating its appropriateness or effectiveness. From a global perspective, the testing and exclusion of foreigners is a specious public health policy. It will not reduce the reservoir of infection in the world and may promote a false sense of security in the population. This could lead to more infections as people fail to modify behaviors that put them at risk of infection.

The only potential global effect of restrictions on international travel and immigration might be to shift the geographic distribution of infection marginally. The United States, with a reservoir of infection of more than 1 million people, has even more difficulty in demonstrating the public health benefits of screening and exclusion. Notably, the United States does not provide resources for counseling and education for travelers or immi-



grants. There is also no attempt to identify and educate infected citizens who leave the United States to travel abroad, suggesting that the U.S. program is not intended to reduce the global prevalence of HIV infection.

It is ironic that the United States, which has probably exported more cases of HIV infection than any other country, should set up an exclusionary policy. The majority of persons excluded have lived in the United States for years, and many were infected here. They have to return to countries with U.S.-acquired HIV infection, facing wrenching separations from their loved ones and often no healthcare in their home countries. This is a policy borne not out of genuine concern for public health, but out of irrational fear and prejudice.

Immigrants testing positive are disqualified from Medicaid and other public benefits. Identifying cases with the express intention of excluding, rather than including, people from benefits and services runs contrary to the traditions of medicine and public health. The essence of both public health and human rights is to empower people and populations by providing the education, counseling, and treatment necessary to protect their own health, well-being, and dignity.

Financial costs

The cost savings claimed by the U.S. Senate are exaggerated. The mass HIV screening program being conducted by the Immigration and Naturalization Service entails its own costs, with millions of dollars spent each year on testing and retesting. Even though current HIV antibody tests are highly reliable, positive test results require a repeat ELISA, together with a confirming Western Blot test. In addition to the significant costs of these tests, there will be a number of false positives because testing is occurring in a very large, often low-risk, population. Many persons applying for U.S. residency status come from areas of the world where HIV prevalence is relatively low. Other applicants are very old or very young. The predictive value of HIV screening is lower in populations with a lower prevalence of HIV infection. Persons excluded from the United States based on a false-positive test result suffer virtually irremediable discrimination and hardship.

Federal regulations specify that immigrants may not place a financial burden on U.S. services and programs. If cost were the true reason for the policy, the United States would exclude all those with chronic costly diseases such as heart disease, cancer, diabetes, hemophilia, and kidney disease. All of these are at least as costly as HIV disease.

Many defend the exclusion of persons with HIV infection on the grounds that all persons with serious diseases should be systematically excluded from the United States on cost grounds. Those policy makers who make this argument have lost sight of the humane principles of immigration. The idea that an elderly man with heart disease could not live with his daughter, or a husband with diabetes or hemophilia could not join his wife or children is thoroughly repugnant to U.S. and international ethical standards. Would policy makers truly exclude a person from living in the United States because he or she used a wheelchair and required expensive respiratory and other life assistance? Excluding persons with disease or physical disabilities constitutes an invidious and cruel form of discrimination and violates the U.N. Declaration on the Rights of Person with Disabilities.

Many persons with HIV infection who immigrate to the United States have personal resources and insurance and so would not pose a financial burden on U.S. benefits and services. Immigrants, moreover, bring expertise, energy, and ingenuity. The United States should not see people first, and only, as a charge on our welfare system. Rather, we should view immigrants as the potential business leader who employs workers, the healthcare worker who cares for the ill, or the scientist who may discover the next vaccine or pharmaceutical for an incurable disease.

A global approach to the HIV pandemic

President Clinton is seeking to overturn a discriminatory and ineffective policy, and the CDC has already advised that the policy is not necessary to protect public health. A just and efficacious travel and immigration policy would not exclude people because of their serologic status unless they posed a significant risk to the community through casual transmission. U.S. regulations should list only active tuberculosis as a contagious infectious disease. A more enlightened approach would provide well-funded programs to protect the health of travelers, immigrants, and their partners through properly targeted counseling and education, appropriate immunizations, prophylaxis, and health care.

Rather than arbitrarily restricting people's movements on account of their health status, we must dedicate ourselves to the principles of justice, scientific cooperation, and a global response to the HIV pandemic. □

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Director of Clinical Research

American Foundation for AIDS Research

The American Foundation for AIDS Research (AmFAR), the nation's largest private funder of HIV/AIDS research, is seeking a physician to lead its community-based clinical trials (CBCT) in New York. Since 1985, AmFAR has provided more than $50 million in grants for more than 700 AIDS research, education, and public policy projects. AmFAR's CBCT network currently includes 45 trials at 24 sites nationwide. More than 1,500 physicians participate, with 155,000 patients enrolled. Seventeen of these trials are funded by the National Institutes of Health.

AmFAR is seeking an MD with a license in pediatrics, internal medicine, infectious diseases, or a related field. The candidate must have experience in protocol development, implementation, and the interpretation of clinical prophylactic and therapeutic trials. A background in NIH-sponsored research is important, and experience in dealing with the FDA would be a plus. Experience in media relations and public speaking is highly desirable.

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Medical and Political Aspects of Travel for HIV Positive Persons

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ABSTRACT

People face serious threats to their mobility and to their health when travelling, when they are HIV infected. Health risks include reactions to live virus vaccines required for travel to or from some countries; exposure to infectious agents to which they might otherwise not be exposed at home; and reduced accessibility to their usual health care and support because these are unavailable or not affordable in some countries.

Travel to, or residence in, more than 50 countries has been restricted for many travellers who are HIV infected or who have AIDS but who are otherwise admissible to these countries. Resident aliens, foreign workers and students are excluded most often (and sometimes deported) whereas tourists are seldom excluded, presumably because of the economic benefits from tourism, and nationals returning home are rarely subject to such scrutiny or restrictions. Some countries actively exclude by screening or questioning all travellers; others do so passively, responding only when informed a traveller is infected or when a traveller is suspected to be infected because of illness, country of residence, or stereotypes associated with HIV transmission such as homosexuality. Infected people are also vulnerable to discrimination when abroad, and their employment may be jeopardized because they cannot travel abroad.

Claims that exclusion will substantially reduce HIV transmission or the economic impact of HIV appear unfounded. The proportion of potential immigrants to the USA and to Canada who are infected appears to be small (probably 0.3%) whereas that of tourists and returning nationals is unknown. HIV infected travellers are not a risk to a country's nationals (and *vice versa*) unless nationals expose themselves to HIV, emphasizing the primacy of education. Exclusions divert resources from this education, interfere with commerce and tourism, discriminate against infected travellers who are not a transmission risk or a potential economic burden, and establish worrisome precedents for other diseases. Exclusions have been widely denounced, and have elicited vigorous political action to stop such governmental responses.

INTRODUCTION

More than fifty countries now deny entry to otherwise admissible travellers or migrants who are infected with HIV or who have AIDS because they are infected with HIV or have AIDS.[1,2,3,4,5] Some of these countries expressly exclude HIV infected travellers or migrants by law, whereas others exclude them by policy or simply do so in practice.[6] Most often excluded are people seeking prolonged or permanent residence in a country such as migrants; tourists and other short-term visitors are seldom excluded. The bases for these travel exclusions include efforts to control the importation of infectious diseases by HIV infected travellers and migrants, in addition to HIV itself, and efforts to minimize the health care burden presented by HIV infected travellers and migrants, those who are immunodeficient, and those who have secondary diseases because of their immunodeficiency.

There is consensus that excluding HIV infected travellers and migrants in order to prevent HIV transmission is not effective, is often counterproductive to prevention efforts, and is unlikely to be cost-beneficial.[7] In addition, being denied entry can result in personal hardship for HIV infected travellers and migrants, force disclosure that they are infected, make them vulnerable to stereotyping, stigmatization and discrimination, and prevent them from working in, studying in or visiting foreign countries.[6]

THE IMPACT OF TRAVEL ON HIV TRANSMISSION AND DISEASE

The Modes of HIV Transmission

The modes of HIV transmission differ from those of many infectious agents for which the mobility of infected persons may be restricted when they are infectious. Among these diseases, pulmonary tuberculosis is, perhaps, the best known.[8] Unlike these diseases, HIV transmission requires "direct" exposure, that is exposure through sexual intercourse, by parenteral inoculation, or by pregnancy when a woman is infected. Other modes of HIV transmission have never been convincingly demonstrated,[9,10] including biting[11] or simply living with someone who is infected.[12,13,14] Consequently, physical proximity to HIV infected people

is not a source of exposure;[15] HIV-infected travellers and migrants are not a risk for transmitting HIV to others except by these recognized exposure-producing activities; and travel itself does not pose a risk of HIV transmission for travellers or for travel industry personnel.[16]

Impact of Travel on Susceptibility to HIV Infection, Disease Progression and Survival

When HIV infected people travel, they face a triple jeopardy: risks to their health not ordinarily encountered at home; risks to their mobility; and, risks arising from restricted mobility such as discrimination, unemployment and loss of scholarships.

The health of HIV infected travellers and migrants may be endangered because of vaccination requirements[17] or diminished responsiveness to vaccinations when immunodeficient;[18,19,20] because of exposure to infectious diseases to which they might not otherwise be exposed,[21] and increased susceptibility to infectious agents when immunodeficient; and because health care they might need may be unavailable or inaccessible.

The outcome of HIV infection may also be modified by travel. In one study[22] but not in another,[23] a history of travel to the United States where HIV was very prevalent was associated with faster progression to AIDS for HIV infected men exposed there than for men without such a travel history.

Survival of HIV infected people may be jeopardized by travelling. They may be exposed to infectious diseases to which they might not otherwise be exposed, and when immunodeficient, their increased susceptibility may result in infection itself, may aggravate it, prolong it or may prevent its clearance.[24] In addition, if care or treatment cannot be obtained when it is needed, survival may be further jeopardized.

HIV and the Importation and Exportation of Disease

Eight to ten million people are now believed to be infected with HIV,[25] and no region or country can be considered to be free of HIV infection.[26] By the end of this century it is estimated that, worldwide, more than forty million people will have been infected with HIV, ten million people will have developed AIDS, and more than ten million children will be orphans of parents who died from AIDS.[27]

Very early in the AIDS epidemic, it was recognized that the movement of people contributed to the initial spread of HIV.[28] This included HIV infected people travelling to or residing in another country, as well as those returning home.[29,30,31,32,33] More recently, HIV-2 has also been shown to have been transmitted by travellers. Some HIV-2 infected people entering a country have left it behind.[34] However, this was dependent upon the behaviour of the citizens of those countries.

A history of exposure to HIV when abroad has been observed for HIV infected adults from North America,[35] South America,[32,36] the Caribbean,[37,38] western Europe,[39,40] Russia,[41] Africa[24,50] and India.[42] In Cuba, where more than 60% of the population has been screened, the prevalence of HIV infection among returning nationals is 25.8/100,000 compared with only 4.8/100,000 among non-travelling nationals.[43] Travellers have been exposed by sexual intercourse, by sharing of injection equipment during non-medical drug use,[44,45] and by the receipt of unscreened blood transfusions.[50]

People often travel with the intent to behave as they might not otherwise behave at home, and such behaviour may expose them to HIV. A quest for adventure may lead to trauma or disease necessitating treatment with unscreened blood; seeking drugs may lead to needle-sharing behaviour; sex tourism and prostitution, aided by intoxication and the loss of social inhibitions when away from home, may lead to sexual exposure.[24,26,31,46,47] For uninfected travellers and migrants, susceptibility to HIV infection may be increased by mucosal barrier dysfunction due to ulcers that would facilitate exposure to HIV and its transmission when exposed;[48,49] by trauma or the development of diseases endemic in a foreign

site which require treatment either with incompletely cleansed medical or injection equipment or unscreened blood transfusions;[50,51,52] and unavailability or inaccessibility of materials necessary to reduce HIV exposure such as condoms, bleach, or clean injection equipment.

Travel itself does not spread HIV; it is spread by exposure-producing activity between people, regardless of whether they are travellers or nationals. The rapidity and distribution of HIV spread in any country is primarily determined by the exposure-producing activities of its citizens, regardless of whether HIV is introduced by HIV-infected travellers, migrants or returning nationals.[6]

It is not the gender, sexual identity or geographic origin of one's partner nor the geographic site where one is exposed to HIV that is as important to the spread of HIV infection as whether or not one's partner is infected with HIV and the specific activities engaged in, including whether or not the risk inherent in these activities is minimized. Consequently, excluding HIV infected travellers and migrants would be unnecessary if nationals would not engage in exposure-producing activities with travellers.

It is illogical to blame foreign travellers for the spread HIV when nationals at home have not refrained from exposing themselves and others to HIV, and when excluding countries fail to prohibit its HIV infected nationals from travelling to other countries. Countries such as Australia,[53] Japan,[54] Norway[55] and Sweden[56] have recognized that their nationals may be exposed to HIV when abroad, and have provided exiting nationals with educational information and, sometimes, condoms.

ENTRY RESTRICTIONS IN GENERAL

Classes of Travellers

There are at least ten classes of travellers and migrants based upon the legal instruments, in general, that regulate their mobility. These include: returning nationals; immigrants; applicants for long-term residence; foreign residents who may

or may not work in the country; migrant workers; foreign students; applicants for asylum; refugees; and short-term visitors such as tourists and travellers in transit.

The application of HIV-related entry restrictions varies for each of these classes, although in some jurisdictions they may apply to all of them. However, most often they are applied to people who will reside in a country permanently or for a prolonged time such as immigrants or to those who will work or study there such as foreign workers, migrant labourers or students. Refugees and persons seeking asylum differ from other classes of travellers and migrants in that return to their country of origin would endanger them, and there are international conventions designed to protect them. Tourists are usually exempted from these restrictions in most countries, although they apply to all travellers and migrants seeking to entry or residing in the United States.[5]

Entry is a Privilege

It is a privilege, not a right, to enter a country other than one's own.[6] Everyone is not automatically admissible to a foreign country. However, by international law and more often by custom, travellers, and sometimes migrants, are often permitted entry. One example of this approach is that member states of the European Community have agreed there should be minimal interference in the movement of its nationals within the Community.[15] Furthermore, exiting or returning to one's country is a right enshrined in the Universal Declaration of Human Rights.[57]

Entry is Conditional

Entry to a country is also conditional. Countries often require a visa for entry of some and, sometimes, all travellers and migrants seeking entry from all or some countries, or that travellers or migrants respond satisfactorily to enquiries before entering the country. Sometimes, they may be required to declare they do not have AIDS, are not infected with HIV, and have not been exposed to HIV which may be formulated as not belonging to a so-called "high risk" group.[58,59]

Apart from political, ideological or criminal concerns, the criteria for denying entry to, or removing someone from, a country is often based upon national public health and safety or economic concerns, or both.[60] Wide discretionary powers are given to border officials to be able to react quickly to real or perceived threats to safety, health or the economy. Decisions to deny or permit entry may sometimes be arbitrary. For example, hepatitis B virus carriers are seldom denied entry whereas HIV carriers are. Mandatory testing is required of students from some countries and those found to be HIV infected are excluded whereas such testing is not required of students from other countries.[1] Arbitrary application of entry requirements may be limited by international covenants and by human rights standards, in particular those relating to non-discrimination.[61]

Since entry is a privilege, the burden of proof usually rests with the traveller or migrant. Appeals are often impractical and proving a person is not inadmissible may, in practice, be impossible.

Medical Requirements for Entry

Countries may require international travellers and migrants to undergo a medical examination or to provide evidence that they are healthy, or more specifically, that they will not import diseases that will threaten the country and its citizens. Such a requirement is often waived or not applied for short-term visitors, but it is seldom, if ever, waived for those seeking work or indefinite or permanent residence in a country. International Health Regulations do not require certification that a traveller or migrant is not HIV seropositive, and any national requirements for such certification would contravene the Regulations.[62] In lieu of a formal examination or presenting proof that the traveller or migrant is not infected, some countries may require travellers or migrants to declare they do not have AIDS, are not infected with HIV, or unlikely to have been exposed to HIV, before permitting their entry.[58]

Economic Requirements for Entry

International travellers or migrants may be denied entry if they are likely to require or use health or welfare benefits that are restricted to residents of the country they are seeking to enter.[63] Some HIV infected travellers and migrants, in particular those who have developed AIDS, might be an economic burden if they were to reside indefinitely or permanently in a country. However, excluding them as a class, solely on an economic basis, fails to recognize their potential individual economic and social contributions to that country.[64] For those who will not be such a burden, excluding them would be discriminatory. Applying this economic criterion only to HIV-infected travellers and not to travellers with other comparable life-threatening diseases would also be discriminatory.[65] For most short-term visitors and travellers and migrants with health insurance, such a criterion is irrelevant.

Detection of Excludable Travellers and Migrants

Detection of HIV infected travellers or migrants may be active or passive. Some countries actively seek to determine whether or not international travellers and migrants are infected. Others require proof, before entry, that the traveller or migrant is HIV antibody seronegative, even though such a requirement contravenes International Health Regulations.[62] Some countries, such as Australia or Canada, require potential immigrants to declare they are not infected or do not have AIDS.[58,59] Other countries take a passive approach, responding only when informed that the traveller or migrant is infected, such as when the traveller appears to have an illness suggestive of AIDS or is found to be carrying zidovudine (AZT).[66]

Entry restrictions may be applied before a traveller or migrant enters a country, that is when applying for a visa; at the time of entry when the traveller or migrant is found to be infected; or after entry when the infected person may be deported.

Bases of Restrictions: Law, Policy and Practice

Many nations have adopted laws expressly addressing HIV/AIDS. Dr. K. Tomaševski at McGill University is compiling data on these laws. 104 countries have adopted legislation and their content includes laws on notification (68 countries), compulsory testing (47), blood safety (44), restrictions (25), and non-discrimination (12). The peak year of enactment of these laws was 1987.

Some of these laws expressly exclude one or more classes of HIV infected travellers or migrants. In some countries, they may be denied entry by the application of laws that exclude travellers and migrants who have a category of infectious disease which would include HIV infection. In the worst situation, some countries may simply exclude HIV infected travellers and migrants in practice. Furthermore, HIV infected travellers and migrants may be excluded as a class, as had happened in the United States,[5] or as individuals subject to an assessment of their public health risk or their potential economic burden to the country.[63,67]

Exceptions to Laws, Policies and Practices Restricting Entry

Laws, policies or practices that exclude HIV-infected international travellers and migrants, simply because they are HIV infected but otherwise admissible, are considered to be inherently, and often by design, ineffective.[6,68] While most migrants may be denied entry if they are HIV infected, tourists and other short-term visitors are seldom excluded or subjected to scrutiny. People belonging to certain occupational categories may be exempted from exclusion. Most often exempted are diplomats, journalists, children and the elderly. For example, any foreign visitor to Iraq who will remain in that country for less than five days, or who is 65 years of age or older, or who is an accredited diplomat is exempted from undergoing testing at a government hospital shortly after entering Iraq.[1] Cuba is screening all of its citizens and returning nationals; only visitors or tourists who will reside in Cuba less than three months do not have to provide evidence that they are HIV seronegative.[1,4] Such exceptions are both illogical and discriminatory.

Modelling the Direct Health Care Costs of HIV Infected Immigrants to Canada

In an effort to determine the potential direct health care costs attributable to HIV infection of immigrants to Canada, my colleagues and I at McGill University have been developing a model of these costs. Since immigrants to Canada are not screened for HIV infection, the number of HIV infected immigrants admitted to Canada was estimated, using seroprevalence data from their countries of origin.[64] This model estimated that, in 1988, 0.3% or 484 immigrants would probably have been infected with HIV before they entered Canada. In the ten years following their entry, the model estimated an additional 54 people would be infected sexually and there would be two cases of perinatal infection. The direct health care costs attributable to HIV infection for immigrants entering Canada in 1988 was estimated to be CAN $18.5 million (range $12.7 to $26.1 million).

At the same time, modelling the potential direct costs for care and treatment of coronary heart disease among the 1988 immigrant population showed 1.6% of these immigrants would be expected to develop coronary heart disease in the ten years following their entry to Canada. This would represent a direct health care cost of $21.6 million.[69]

These models suggest the exclusion of HIV infected immigrants solely on the basis of their health care costs attributable to HIV, would at best be arbitrary and at worst it would be discriminatory.

CURRENT STATUS OF TRAVEL RESTRICTIONS

In another study by colleagues at McGill University, 72 of 122 countries surveyed in 1989 reported they did not have laws or policies expressly restricting the entry of HIV infected travellers and migrants (59% of the countries responding to the survey).[1] Thirty-six countries (30%) reported they excluded HIV infected foreign workers; 34 countries (28%) excluded HIV infected foreign students; and 16 countries (13%) excluded HIV infected tourists or short-term visitors. Thirty-two countries stated they had either refused entry to or deported HIV infected travellers or

migrants. Only 11 countries had policies that apply to returning nationals. However, the re-entry of returning nationals cannot be prohibited.

This survey and other sources of information on HIV-related entry restrictions showed restrictions often appear illogical and are characterized by stereotypical, symbolic or arbitrary reasoning. This is, perhaps, best illustrated by requirements for HIV antibody testing of travellers and migrants. For example, non-national cabaret workers are required to undergo HIV antibody testing in order to enter or reside in Cyprus; similarly, foreign defence contractors must have a certificate of HIV seronegativity to work in Egypt; accredited journalists and diplomats are exempted from such a requirement in South Korea and in the Soviet Republic; only seronegative migrant labourers can work in South Africa mines; and non-national seamen are required to be tested before being permitted entry to Venezuela.

Some countries have denied entry to and sometimes have deported HIV infected non-nationals in the absence of law or policies that expressly authorize this practice. Thirteen countries also denied having laws or policies that restrict the travel or residence of HIV infected non-nationals, but contrary findings have been reported in the literature or by the media.[1,2]

At the same time, many countries have responded to the HIV epidemic with laws and policies that demonstrate their respect for the human rights and dignity of HIV infected people. For example, the European Community prohibits travel restrictions based on HIV infection by its Member States,[15] and Jamaica and Zimbabwe have stated their endorsement of the policies of the World Health Organization relating to HIV/AIDS and international travel.[1]

IMPACT OF HIV-RELATED ENTRY RESTRICTIONS

Impact on Public Health Efforts to Control HIV Transmission

Since there is no vaccine to prevent HIV infection and no cure for it, the only effective way to stop the transmission of HIV is to prevent exposure to it.[70] Exclusionary approaches are simply that: approaches designed to keep out infected people. They are not inherently designed to promote exposure-avoiding behaviour

through education and counselling, or through the provision of risk-reducing programmes such as the screening of blood donors, making HIV antibody testing available, and making accessible the materials necessary to reduce risk such as condoms, clean needles and syringes or bleach.

Excluding HIV infected international travellers cannot produce an HIV-free environment[5,6] and may be counter-productive to national prevention efforts.[71] They may drive travellers underground, away from the health care system, lead to denial of HIV infection, and promote falsification of and a market for counterfeit certificates of seronegativity.[2,?] They are likely to divert, or make unavailable, scarce resources that are necessary for effective national prevention efforts[2,5,6] Foremost is the diversion of resources from programmes that screen blood donors.[43,72] And from a global perspective, restrictive policies unlinked to effective prevention efforts, will have little or no effect on the reservoir of HIV infection, other than to re-distribute it.[5,6,63]

Discrimination against HIV Infected Travellers and Migrants

Discrimination is another major harm of HIV-related entry restrictions,[73] in particular for travellers and migrants who are excluded even though they would not engage in exposure-producing activities with the nationals of the excluding country, nor consume health care or welfare benefits of the excluding country. Furthermore, the laws and policies sometimes discriminate against travellers and migrants on the basis of their country of residence, that they are sick or disabled, or their sexual orientation.[61]

Other Harmful Consequences of Entry Restrictions

Other harmful consequences of excluding HIV infected international travellers are the cost of screening travellers when this is required, the risk of erroneously labelling a traveller seronegative when infected (false negative) or seropositive when uninfected (false positive), the risk of breach of confidentiality, and through interference with travel, the loss of economic productivity, labour migration,

educational exchange, and other activities essential for some countries.[5,6,64] Such approaches may abrogate human rights, erode respect for persons and the law, are likely to establish unwanted precedents[74], and marginalize those who are infected or at increased risk of infection, or are identified as belonging to these groups or populations.[75]

COMMENTARY ON UNITED STATES IMMIGRATION LAW AND POLICY

On 11 July 1987, the United States Congress[76] directed the Department of Health and Human Services to list HIV infection as a "dangerous contagious disease".[77] Any alien with a disease on this list is excludable from the United States, and so, all HIV infected aliens whether residing in the United States or seeking to enter it became excludable.[78] As a result of this law, the United States was considered to have had the broadest law and policy excluding HIV infected people.[5] This law has been vigorously criticized. In protest over this law, several governments and many international and national organizations boycotted the VIth International Conference on AIDS in San Francisco in June 1990, and many people who attended the meeting demonstrated against this law.[3,73,79,80,81,82]

On 28 October 1990, Congress passed a new immigration law which eliminated this list of "dangerous contagious diseases", and directed the Secretary of Health and Human Services to establish a new list of diseases ("communicable disease[s] of public health significance").[83] Subsequently, the Secretary proposed that "infectious tuberculosis" should be the only disease listed as a health-related exclusion.[7] However, on the day before the proposed regulation would have taken effect, it was withdrawn and an interim rule was published.[84] This rule established the earlier list of "dangerous communicable diseases" as continuing in force until 1 August 1991 when final regulations would be announced. The possibility that HIV infection and AIDS might remain as excludable conditions has elicited very strong responses.[85]

The new immigration law made it possible to remove HIV infection and AIDS as health-related grounds for exclusion. This change appears to make the United

States the first nation to repeal an express law excluding people with HIV/AIDS. This has been a victory for people with HIV/AIDS and an important symbol for controlling the HIV epidemic. Whether HIV infection will or will not be included in regulations required by this law remains uncertain. Changing the United States law may, in the end, not have changed the problem that lead to governmental, organization and community solidarity and protest. If HIV/AIDS remains an excludable disease, then the victory may indeed have been a pyrrhic one.

CONCLUSION

Just as HIV infected travellers and migrants face triple jeopardy from threats to their health, from entry restrictions, and from the harmful consequences of these restrictions, so there is a challenge for governments and society to prevent, care for and protect HIV infected people, including travellers and migrants.[86]

While uninfected travellers and migrants face threats from unscreened blood transfusions, from uncleaned medical and injection equipment, and that condoms and clean injection equipment may not be available or accessible in some countries, infected travellers face different threats. These include threats from infectious diseases to which they might otherwise not be exposed at home, and that care and treatment may be unavailable or inaccessible to them when it is needed abroad. These obstacles, like those confronting uninfected travellers and migrants, are surmountable but only in the context of providing care for everyone in the countries to which they are travelling to or from.

Examining laws, policies and practices that restrict the mobility of HIV infected people, simply because these people are infected with HIV or have AIDS, shows exclusionary approaches cannot be justified as an effective or efficient means of preventing HIV transmission. It also shows the introduction and spread of HIV in any country is primarily determined by the risk-producing activities of its citizens and residents, regardless of whether HIV is introduced by HIV-infected travellers or returning nationals.

Over fifty countries now exclude some or all international travellers or migrants who have HIV infection or AIDS. The number of excluding countries may be increasing, despite strong and repeated criticism that such exclusionary approaches are ineffective, inefficient, wasteful, harmful and discriminatory. The situation of exclusion by policy and by arbitrary practice may be even worse. However, the recent repeal of restrictive legislation in the United State while authorizes public health authorities to determine excludable diseases is an important success. If HIV/AIDS is removed as a medical ground for exclusion from the United States, this will be an example that people with HIV/AIDS are to be respected. And, it implies that controlling this epidemic requires cooperation, not coercion or isolation. Exclusionary laws, policies and practices send a message to other countries that excluding HIV infected travellers is acceptable, and they send a message to the nationals of the excluding country that discrimination against HIV infected people is also acceptable. It is only a small step from the borders to the front doors of any country, and what is done at borders may well be done at home, work, school and at play. Preventing the enactment of such laws, or working to repeal them when enacted, is a strong message that HIV-related entry restrictions are unacceptable, that discrimination is unacceptable, and that HIV infected travellers and migrants will be treated like everyone else but that they too are welcome.

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3 **A Model-Based Approach to US Policy on HIV-1 Infection and Immigration**
Rupert E.D. Whitaker and Richard K. Edwards

A Model-Based Approach to US Policy on HIV-1 Infection and Immigration

Rupert E.D. Whitaker and Richard K. Edwards

Introduction

For almost a century, applicants to the United States have been subject to a medical examination to determine their physical eligibility to become permanent residents. This policy was embodied in the Immigration Act of 1891 and arose out of a well-orchestrated effort to blame foreigners for the increasing incidence of sexually transmitted diseases in the United States, which were argued to threaten family values.[1,2] In particular, certain applicants were excluded on the grounds of having a "loathsome or dangerous contagious disease." With advances in medical knowledge, the list of such diseases has changed; for many years prior to 1987, the list contained only diseases that were currently curable and thus, theoretically, no irrevocable bar to admission. However, in May 1987, AIDS was added to the list by then-President Ronald Reagan. Less than three months later, human immunodeficiency virus (HIV) infection was substituted for AIDS. The stated aim of this screening policy has been to stop the transmission of HIV-1 from foreigners to US residents.

This program has a multitude of ethical and policy ramifications, most of which have been analyzed elsewhere.[3] While, in reality, issues of ethics and public policy cannot be divorced from the issues of program feasibility and efficacy, it is these latter two issues that are addressed independently here. This article aims to answer two specific questions: 1) Are the techniques used in the screening of applicant immigrants adequate? 2) If so, would the screening program be adequate in achieving its stated goal? It has been noted that "an important policy role of models is to permit evaluation of potential intervention steps and especially to project negative consequences";[4] furthermore, a second value of models, in terms of public policy, concerns their ability to define additional data requirements.[4] While "AIDS models" have previously focused on evaluating test performance,[5] the demographic impact of HIV spread,[6] or even HIV pathogenesis,[7] few have been designed specifically for evaluating policy, as is the model described here. This article analyzes technical and methodological issues underlying the HIV testing program; develops the model in terms of its specified data premises, the sources of which are assessed; and presents the results of an analysis using the model, which are evaluated in terms of their adequacy in answering the policy questions posed. Finally, some conclusions are drawn regarding the efficacy of the screening program and its policy ramifications. By pursuing this evaluation, the article both assesses the efficacy of the current HIV-1 screening policy and points out the need for certain data before the feasibility of any such program may be rationalized.

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Technical Aspects of Determining HIV-1 Infection

There are many ways of testing for HIV-1 infection,[8] including antigen tests, antibody tests (enzyme-linked immunosorbent assays, or ELISAs), and the polymerase chain reaction (PCR) technique. Antigen tests directly detect the presence of viral proteins in the host. However, once dormant, HIV-1 is very difficult to detect. Thus, failure to detect antigen in a person with antibodies to HIV-1 does not indicate whether the person is free of infection,[9,10] the virus is dormant, or the antibody test result is false. Furthermore, several studies[11,12] have shown that antigen testing is no more useful in identifying HIV-1 infection than are antibody tests, although the efficacy of testing may vary by risk group. Thus, antigen tests are not the test of choice.

Antibody tests indicate whether one has ever been infected, and antigen tests indicate whether a person has a detectable amount of the viral proteins in his or her body. Antibodies are taken to be a highly reliable indicator of the presence of the virus and, in turn, of infectiousness. Although the question of infectiousness was open for some time, research[13] has shown that seropositivity does not predict infectivity, and so the assumption that seropositive people are uniformly infectious is invalid. Similarly, the diagnosis that an individual is an HIV "carrier" is based on a positive antibody test result, even though true carriers are considered to be consistently infectious. Furthermore, and most importantly, there is no direct relationship at a given time point be-

tween a positive antibody test result and AIDS.

Certain biochemical or behavioral factors unrelated to HIV-1 infection can confound the results of antibody testing. False test results have been documented among people with rheumatoid arthritis,[14] rheumatoid factors,[15] hepatitis,[16,17] Q fever,[18] multiple sclerosis and dermatological disorders,[19] and certain fairly common genetic or immunological makeups,[20-25] as well as in patients receiving hemodialysis (in whom false test results are more common than true results).[26] Reactivity to specific proteins does not indicate infectiousness, although antibodies to gag-encoded proteins (p24, p55, p64) can develop in recipients of blood from people with persistent or intermittent reactivity to viral core proteins only,[27] without any conclusive indication of HIV-1 infection; the medical significance of such indeterminate reactivity is not known.[28] Furthermore, false results can occur if the reagents used in the assay contain any of a number of unrelated contaminants.[29] Obviously, people and laboratories from different parts of the world are likely to differ significantly in the distribution of such confounding conditions, and no analysis can account adequately for these problems. The tests also differ in terms of the type of reagents used (for example, natural versus recombinant antigen), and they are time consuming and prone to poor reproducibility.[30] Such limitations apply to all antibody tests, no matter how rapid they are or how well they perform.

Given all of these possibilities for false test results, there is a great need to ensure that the result of a first test is accurate. This is accomplished using what are inappropriately termed "confirmatory" tests; for our purposes, tests subsequent to the ELISA will be called "backup" tests. In relation to the initial assay, backup tests usually involve a different technique[31] and a different sensitivity in detecting antibodies.[32] The techniques used in backup testing include the Western blot and immunofluorescence (IFA) and radioimmunoprecipitation assays. The Western blot is the most commonly used confirmatory test and the one with which new techniques are compared, although its usefulness can be limited relative to other tests in early HIV-1 infection.[33] The relative applicability of these various test types to samples from different regions, defined geographically or culturally, is not known, although it is known that the concordance between different types of tests using exactly the same sera can vary according to the geographical region from which the sera were derived.[34]

All of the techniques used for HIV-1 testing are technically demanding and difficult to standardize,[35] and their sensitivities and specificities can vary significantly in practice. Technical sources of error include measures undertaken to protect laboratory personnel (for example, heat-treatment of samples, which affects certain techniques[36,37] but not others); other factors include incubation time, temperature, humidity, and the use of serial dilutions and cutoff ratios.[38] Furthermore, test performance has been found to vary between different tests[39] and even batches of the same test kit.[40-42] A US Army evaluation of the reliability of testing by commercial firms[43] showed a false-positive rate of more than 40 percent, which may be argued to be a best-case scenario. Similarly, US laboratory performance studies[44] have revealed that ELISA correctly identified 98 percent of strongly positive sera and as few as 74 percent of negative sera, although the authors did not discuss weakly positive sera.

There is clearly no gold standard by which to independently evaluate these tests. This means that the determination of some positive or negative results is arbitrary.[45,46] For the ELISA, there is a cutoff point along a continuum of results above which the sample is almost certainly positive and below which it is almost certainly negative, providing a gray area in between. When using the ELISA, the investigator can modify the cutoff point according to the known prevalence of the condition in a test group. For HIV-1 infection, this cutoff point should be set differently for different populations according to the prevalence of infection in the group or the different consequences associated with false results; that is, the higher the prevalence of infection, the lower the cutoff point.[47] However, because the prevalence of HIV infection is unknown in many groups, the choice of a cutoff point is arbitrary. In laboratories used by the US Public Health Service (PHS) around the world, the cutoff points are likely to vary enormously, given that a laboratory may be set up to test blood from donors who have a low prevalence of infection; hospitalized African patients, who have an enormously high prevalence of infection; or urban gay men, who also have a very high prevalence of infection.

A similar problem arises in reference to the Western blot, in terms of which bands constitute a positive blot.[48] The Consensus Recommendations of the Association of State and Territorial Public Health Laboratory Directors and the Centers for Disease Control[49] represent the latest thinking on HIV-1 antibody testing using Western blot. These recommendations specify, somewhat tautologically, that a "reactive" (positive) blot includes bands that represent the proteins of major diagnostic significance (that is, either p24 or gp41 and either gp120 or gp160). The Centers for Disease Control (CDC) uses the same criteria. Furthermore, the Western blot should include three control sera: one strongly reactive for all nine protein bands, one weakly reactive with p24 and one *env* protein, and one nonreactive. If any of these control sera is imprecise, the whole assay must be considered invalid. In contrast, the US Food and Drug Administration-licensed Dupont kit specifies a positive blot as one containing bands for p24, p31 plus one *env* protein (gp41, gp120, or gp160). A negative blot is one with no bands at all, and an indeterminate blot is one with any other mixture of bands. The American Red Cross specifies that a positive blot contains bands for at least one *env* protein, one *gag* protein (p18, p24, p55), and one *pol* protein (p31, p51, p66).[50] Some controversy has arisen over whether reactivity to *gag*- and *env*-encoded proteins necessarily constitutes seropositivity for HIV-1,[51] and differences in interpretive criteria lie at the

center of this controversy.[52,53] It is a concern that, according to the CDC and the Consensus Recommendations, a positive result can consist of a mixture of anti-*env* antibodies; gp41 is known to exist in both monomeric and polymeric forms, and thus, theoretically, a positive result could be recorded for a person with anti-gp41 antibodies alone but in both forms. Both gp41 and p18 are known to cross-react with normal human tissues, and the production of autoantibodies is possible.[54-59]

Thus, there are various criteria for a positive Western blot, and some are more stringent than others. The criteria for a positive blot are also quite independent of the issue of false results. The Western blot is complex and labor-intensive, and its techniques have not been standardized. Furthermore, the magnitude and consequences of intralaboratory and interlaboratory variation have not been widely measured,[60] but it is known that the Western blot is far from uniformly accurate.[61] Furthermore, the performance of a test can vary between groups, whether defined by risk behavior or by geography or culture. Africans are known to develop much stronger anti-core antibody responses than Europeans and Americans,[62] and African sera, in particular, are much more likely to produce both false-positive[63,64] and false-negative results. Even using both ELISA and Western blot, 0.6 percent of adult and 1.9 percent of pediatric cases of full-blown AIDS were seronegative in one study.[62] Given such differences in antibody responses between geographically defined groups, concomitant differences in criteria for a positive Western blot are likely to have unknown, inconsistent, and potentially very important effects on seroprevalence estimates across such groups.

The rate of indeterminate Western blots has been reported to be as high as 18 percent[65] and the reproducibility of the indeterminate blots as low as 40 percent.[66] These "problem sera" are more common in testing with the Western blot than with the IFA technique.[67] In one study of indeterminate Western blots,[68] 25 percent were due to p18 bands alone, 27 percent were due to p24, alone, 35 percent were due to p18 with or without p24 or p55, and 34 percent were due to other, non-*gag* bands. In such cases, the Consensus Recommendations specify that the Western blot should be repeated on a freshly drawn specimen and that a supplementary test such as the IFA technique also be performed. However, although repetition of a given test is better than no repeat testing, repetition not only reduces the test's sensitivity, but biological factors that cause initial false results are also equally likely to affect subsequent results.[69] Similarly, studies that show, for example, that the ELISA is as useful as the Western blot as a confirmatory test are more likely reflecting the lack of independence of the tests than their efficacy,[70] even though most researchers assume independence both within and between tests and test types.[5]

The Dupont Western blot kit is the only one that is licensed for HIV-1 antibody testing by the US government, yet it is not certain that this kit is always used when screening applicant immigrants, or which criteria for positivity are used (the ones defined for the PHS by the CDC, the ones provided by the kit's manufacturer, or in-house criteria). The testing laboratories are not required to report the bands that constitute a positive result or to be able to perform the IFA backup test at all. The Consensus Recommendations state, further, that all HIV-1 antibody testing should be performed in laboratories that meet state or federal certification standards, and that these standards should be evaluated specifically, not as part of a general laboratory evaluation. The standards of proficiency of the various laboratories in which testing is performed are not specified in the regulations concerning the screening of applicant immigrants. Even the availability of testing facilities is not ensured, to wit:

> For the few visa posts that do not have local testing facilities, the Department [of Justice] *believes* that there will be regional laboratories available where sera can be transported for testing [emphasis added].[71]

To put it bluntly, this is no way to run a screening program. Even if all of these conditions were required, one cannot be certain that they would be enforced or even enforceable. Above all, it is important to remember that, while the significance of a test result may be a procedural question for a laboratory, it may have enormous personal consequences for the individuals tested.

The problem of HIV-2 infection, also considered to be a cause of AIDS, has been raised.[72] HIV-2 was identified in 1985 and has mainly remained confined to West Africa. If the spread of HIV infection into the United States is to be prevented, a screening program must also be able to detect HIV-2. Although tests are currently being developed to detect either HIV-1 or HIV-2 infection, they are not as developed as the tests specific for one or the other virus. In any case, the US screening program does not consider the issue of HIV-2.

A new assay, the polymerase chain reaction (PCR) is used to detect genetic sequences of HIV-1 inserted into the host genome, thus relying on a direct index of infection. The performance characteristics of this difficult method are currently emerging, but it is likely that there will be some technical problems as well as confounding by the endogenous virus-like sequences that have been found in both murine and human genomes. The availability of this assay also raises questions similar to those raised by screening for genetic diseases, previously proposed by insurance companies, which has been widely rejected as too tenuously related to the outcome in question.

Regardless of the test involved, it cannot be refuted that

> there is an urgent need for well characterized reference materials for use in defining the reliability and sensitivity of the tests, for quality control of batches of kits or reagents, and as common reference between laboratories.[41] Recently, the development of quality control procedures has been receiving special attention.[73]

Methodological Aspects of Identifying HIV-1 Infection

A 1988 analysis[74] examined the statistical properties of three HIV-1 antibody tests (the ELISA, the IFA, and

Table 1
Definition of Terms Used in Describing the Performance Characteristics of a Screening Tool*

Precision	The inverse of variability, reflecting the degree to which a test gives consistent or replicable results; sources of imprecision include procedures, materials, equipment, the technician's experience and consistency, and interpretation; assessed by repeating the test on standard samples
Accuracy	The degree to which a test detects the condition in question: tests can be precise but consistently measure the wrong thing
Sensitivity	The degree to which a test yields positive results when the property in question is present
Specificity	The degree to which the test yields negative results when the property is absent. Sensitivity and specificity are established by knowing whether the property under study is present
Predictive Value	The relationship between what is known and what is to be determined

*For most tests, the sensitivity and specificity of a test are not absolute but are relative to the performance characteristics of other tests. Such comparisons give rise to the working definitions of a test's characteristics; thus, the above definitions are mathematically precise but belie the working approach to all tests.

the Western blot) as regards their precision, accuracy, sensitivity, specificity, and predictive value. Each of these terms is defined in Table 1. The properties of sensitivity and specificity are generally inversely related, and, importantly, they depend on the cutoff point between positive and negative results. With the ELISA, as noted above, as the cutoff point is decreased, a greater percentage of positive results occur; this increases sensitivity while reducing specificity. High prevalence entails lower sensitivity. Further, the sensitivity and specificity of different techniques, and different versions of those techniques, vary. For example, sensitivities of between 93.4 percent and 100 percent, and specificities of between 94 percent and 100 percent have been reported with the ELISA; sensitivities and specificities of between 97 percent and 99.6 percent and between 99.2 percent and 99.4 percent, respectively, have been reported for the Western blot.[32,75-77] The IFA has a reported sensitivity of 98.9 percent and a specificity of 99.6 percent.[74] Sensitivity in early infection can be as low as 50 percent for the ELISA and 95 percent for the Western blot.[10] Recent studies have reported a sensitivity of 95 percent and a specificity of 92 percent for two Western blot kits[78] and a sensitivity of between 91.6 and 100 percent and a specificity of between 27.5 and 100 percent for ELISA, particle agglutination, and cytoimmunoenzymatic assays.[79] Through Bayesian theory, predictive values can be determined given the sensitivity and specificity of the test in question and the prevalence of the property of interest in the population tested. Different prevalences in different populations can distort the predictive value of a test, especially in low-prevalence populations. It must be remembered, above all, that

> precise estimates of specificity and sensitivity can have no general validity, as results depend on the specimens and on the conditions under which they were tested.[80]

Methods

Seroprevalence of HIV-1 Around the World

Approximately 70 percent of the known worldwide cases of AIDS have been reported from the United States for the past several years. Per capita, Bermuda, French Guyana, and the Bahamas have much higher rates than the United States. However, data from many areas are lacking or incomplete, making comparisons between different areas unreliable. Even within the United States, the data are not easily interpreted, requiring careful consideration of the size of the various risk groups in the population and the degree to which results of studies of selected cohorts within a risk group can be generalized to the whole of that population. Reporting has always been inadequate, partly due to political issues on a national level, reporting fatigue,[81] and the diversity of the presenting symptoms of AIDS. The criteria for disease diagnosis have changed several times, and the diagnostic procedures required by the CDC definition of AIDS, which are often invasive, are followed less and less, thus making a definitive diagnosis difficult.[82] Such diagnostic criteria have always been difficult for countries with few technological resources to meet them. Finally, there are no comprehensive studies of any kind that document the estimated prevalence of HIV-1 infection in the population of applicants for immigration to the United States, although a recent study analyzed applicants for naturalization in one clinic in San Jose, California.[83] Nevertheless, to assess the efficacy of the screening program in pursuing its objective both efficiently and fairly, we have used the following methods to estimate the seroprevalence of HIV-1 infection among immigrants from the seven continents described by the World Health Organization (WHO).

Sources of Data

This project required that data on three variables be collected. First, statistics on AIDS had to be obtained for every country in which cases have been recorded. Second, we sought to ascertain the most recent population figures available, both for those countries in which AIDS has been reported and for others that (at the time of writing) have yet to record their first case. Finally, an attempt was made to obtain reliable information on immigration and foreign tourism in the United States.

Data on AIDS are those reported to the WHO and were obtained from the Pan American Health Organization in Washington, DC, and from the data provided monthly in the journal *AIDS*. The figures used in this analysis are those reported as of March 1990. While the WHO statistics are undoubtedly the most reliable source for global in-

formation on AIDS, they also entail problems that must be taken into account. The most notable of these concerns the reporting of AIDS in Africa and the Caribbean region. Although better reporting methods have allowed more precise assessment of AIDS in these two regions, there continues to be a reporting lag in comparison to Europe and North America. Population statistics were obtained from the *World Population Data Sheet*, 1989.[84]

As far as data on immigration are concerned, we attempted to elicit information directly from the Immigration and Naturalization Service (INS), both by letter and telephone. Our efforts were frustrated, however, when several enquiries failed to elicit a response; finally, an INS representative informed us that the data could be obtained from the PHS, a contact with which resulted in a referral back to the INS. This pattern was repeated several times. It was determined that a search for secondary sources should be undertaken. *The Statesman's Yearbook*[85] provided the most recent data available on the number of immigrants and foreign tourists *admitted* to the United States in 1989. For the purposes of this analysis, we used the number of immigrants admitted in 1989 and assumed that the likelihood of exclusion for non-HIV-related reasons was equal across geographic subgroups; thus, we assumed that the proportion of total applicants from any given region would be the same as the proportion admitted. Lacking any information on the numbers of applicants from specific regions who were excluded, we have assumed that the applicant pool is the same size as the number of people actually admitted, for the sake of argument. It is important to note that we are less concerned with absolute numbers than with the patterns that may emerge as a result of HIV-1 antibody testing of immigrants.

Two estimates of seroprevalence were obtained, based on the reasoning of Sivak and Wormser[86] about the number of seropositive persons per AIDS case in the United States. We premised our model on the assumption that there are 25 and 50 seropositive persons for each case of AIDS. Based on the reasoning of Sivak and Wormser, the ratio of AIDS cases to non-AIDS seropositive cases in the United States is approximately 1:15. These estimates are rather conservative (that is, high) in terms of the policy implications of the model and in light of the fact that the United States has a relatively high standard of health care; in Third World countries, sanitary and medical conditions, for example, are often such that fewer people are likely to survive an infection as long, thus lessening the ratio of seropositive persons to AIDS cases. Furthermore, even in the absence of screening, a higher prevalence of symptomatic disease would reduce the rate of successful entrance into the United States. Similarly, we assumed that a true-positive test result is independent of other medical conditions that would by themselves result in the exclusion of the applicant. Thus, our estimates are likely to be somewhat higher than if we were able to account for comorbidity.

The estimates of the sensitivity and specificity for each of the tests were obtained, one being low and the other high, in accordance with Cleary *et al.*[87] We assumed that the sensitivity and specificity of a Western blot would be 91 to 96 percent and 94 to 99 percent, respectively, and for the ELISA, 93.4 to 99.6 percent and 99.2 to 99.8 percent, respectively. These sensitivities and specificities were paired into extreme cases of low with low and high with high. These estimates of sensitivity and specificity were derived from analyses of the literature assessing HIV-1 antibody screening programs, from the levels of sensitivity and specificity published by test kit manufacturers, and through extensive discussions with public health experts. The discrepancy between manufacturer claims and independent reports[88] may most easily be explained by a given laboratory staff's technical performance and the quality and epidemiological characteristics of the samples used.

Given the estimated prevalence of HIV-1 in a given continental population, the estimated percentages of true- and false-positive and true- and false-negative results for each continent's immigrants were calculated as follows:

True positives =
prevalence X sensitivity

True negatives =
(1 - prevalence) X specificity

False positives =
(1 - prevalence) X (1 - specificity)

False negatives =
prevalence X (1 - sensitivity)

These percentages were then applied to the given number of immigrants to produce the absolute number in each category. Since only the positive applicants, both true and false, were tested by Western blot, these two categories were added and formed the population that underwent confirmatory testing. As this population is a subset of the original population, the estimated seroprevalence changed, becoming equivalent to that of the percentage of true-positives results in the second population (see below). The percentages of true- and false-positive and true- and false-negative results were again calculated and the absolute numbers derived. The total number of positive results on the Western blot was also derived. Several ratios were calculated (see Table 7), particularly 1) false-positive to false-negative results, to determine the number of people falsely excluded for every person falsely permitted entry; and 2) false-positive to true-positive results, to estimate how many people were falsely identified as positive for every person correctly so identified. Finally, we determined what percentage of all positive results on irmatory testing were false-positive results. The results were summed over the continents to provide a total number of people identified as positive, the ratios of total false-positive to total false-negative results and of false-positive to true-positive results, and the percentage of total positive results that were false-positive results.

From these estimates, we derived a best-case and a worst-case scenario of the number of positive and negative

results and the proportion of these that are true and false. We made the assumption that both false-positive and false-negative results may have traumatic personal consequences, although neither will be likely to have an impact on the course of the AIDS epidemic in the United States. The best-case scenario reflects the lowest number of false-negative results that could be found and is based on low test sensitivity and specificity and the higher seroprevalence estimate. Conversely, the worst-case scenario reflects the highest number of false-negative results found and is based on the higher test sensitivity and specificity and the lower seroprevalence estimate.

Table 2
The Relationships Between True Serostatus, Test Results, Serostatus Designation, and Admission to the United States

True Serostatus	Results from ELISA	Results from Wb*	Designated Serostatus	Admitted
Positive	Positive	Positive	True Positive	No
		Negative	False Negative	??
	Negative		False Negative	Yes
Negative	Positive	Positive	False Positive	No
		Negative	True Negative	??
	Negative		True Negative	Yes

*Wb, Western blot.

Results

The two tests, the ELISA and the Western blot, were arranged so that low-performance ELISA (sensitivity, 93.4 percent; specificity, 99.2 percent) and low-performance Western blot (sensitivity, 91 percent; specificity, 94 percent) were paired and that the high-performance ELISA (sensitivity, 99.6 percent; specificity, 99.8 percent) and Western blot (sensitivity, 96 percent; specificity, 99 percent) were also paired. These two sets of pairs were then used to derive extreme estimates of true-and false-positive and true- and false-negative results. Table 2 tabulates the possible permutations of true- and false-positive and true- and false-negative results, for clarity in the following discussion. Table 3 lists the estimated seroprevalences of each continental region used in this model. In Table 3, seroprevalence 1 is the estimated seroprevalence among the general population undergoing ELISA testing (that is, the total applicant population), which is assumed to be the same as the continent's general seroprevalence. As noted above, given that only persons with positive (both true and false) results undergo confirmatory testing, the relative proportion of people who undergo such confirmatory testing *and* who are truly positive represents seroprevalence 2. This seroprevalence estimate depends on the performance characteristics of the ELISA, in that a low-performance ELISA will produce a different proportion of true-positive results than a high-performance ELISA. This estimate also assumes that the two tests are entirely independent. This question has not been adequately broached in most evaluations of sequential testing protocols.[80] Further, Table 3 is split into two columns, low and high estimated seroprevalence, reflecting the two ratios of AIDS cases to cases of seropositivity (1:25 and 1:50, respectively). Table 3 also shows that Asia/Oceania is the greatest source of immigrants (approximately 42 percent of the total) and has the lowest seroprevalence of all of the regions. The Caribbean is the next largest (approximately 18 percent), just a third of that of Asia/Oceania but with the highest estimated seroprevalence (almost 218 times that of Asia/Oceania). Africa, with the third highest seroprevalence estimate, provides the fewest immigrants, less than 3 percent of the total. This seroprevalence is certainly grossly underestimated.

Table 4 presents the total numbers of people who test positive or negative after both ELISA and Western blot and the numbers and percentages of these totals that are false, based on the lower ratio of AIDS cases to cases of non-AIDS seropositivity (1:25). Table 5 presents the same derivations, based on the higher ratio (1:50). Just as the ratio doubles between low and high seroprevalence estimates, so do the total percentages of false results, positive and negative. However, the absolute numbers of false results do not change significantly. Table 6 reports the proportion of false-positive and -negative results using the ELISA alone and the ELISA and Western blot jointly.

Table 7 presents the ratios of true-positive to false-positive, true-negative to false-negative, false-negative to false-positive, true-positive to false-negative, and true-negative to false-negative results. The meaning of each of these ratios is listed in the table. The data from Table 7 indicate that, with increased seroprevalence (regardless of test performance and continent of origin), the number of seropositive persons admitted (false-negative) for every seronegative person excluded (false-positive) rises by more than twofold. Further, in comparing the ratios of true-positive to false-positive and true-negative to false-negative results (to assess the accuracy of the tests with increasing seroprevalence), we find that, with a continued growth of the pandemic, the proportion of true-positive results doubles and the proportion of true-negative results falls by more than half. This comparison shows that, proportionally speaking, the program excludes half as many seronegative persons and admits twice as many seropositive persons, as fewer seropositive persons are identified by the ELISA and undergo backup testing. This dynamic can also be seen by comparing the percentages of false-positive and false-negative results, over the two seroprevalence estimates; jointly, these percentages drop by as much as elevenfold by continent (data not shown). The

Table 3
Estimates of Seroprevalence by Continent, with Variable Test Performance

Seroprevalence Estimates by Continent (test performance)*		No. of Applicants	Estimated Seroprevalence Low		High	
Asia		268,304				
Seroprevalence 1			0.002		0.004	
Seroprevalence 2	(low)			0.1896		0.3192
	(high)			0.4995		0.6667
Caribbean		112,357				
Seroprevalence 1			0.4348		0.8695	
Seroprevalence 2	(low)			0.9890		0.998
	(high)			0.9974		0.9997
North America		106,822				
Seroprevalence 1			0.1530		0.306	
Seroprevalence 2	(low)			0.9547		0.9809
	(high)			0.9890		0.9955
Europe		64,797				
Seroprevalence 1			0.0998		0.1995	
Seroprevalence 2	(low)			0.9282		0.9668
	(high)			0.9822		0.9920
South America		41,007				
Seroprevalence 1			0.1003		0.2005	
Seroprevalence 2	(low)			0.9286		0.9670
	(high)			0.9823		0.9921
Central America		30,715				
Seroprevalence 1			0.0903		0.1805	
Seroprevalence 2	(low)			0.9205		0.9626
	(high)			0.9802		0.9910
Africa		18,882				
Seroprevalence 1			0.1563		0.3125	
Seroprevalence 2	(low)			0.9558		0.9815
	(high)			0.9893		0.9956
Total Immigrants		642,884				

*Seroprevalence 1 is the estimated seroprevalence among the general population undergoing ELISA testing (i.e., the total applicant population), which is assumed to be the same as the continent's general seroprevalence. Given that only persons with true- and false-positive results undergo backup testing, seroprevalence 2 is the relative proportion of people who undergo such testing *and* who are truly seropositive. Estimates of seroprevalence 2 will vary according to the performance characteristics of the tests (low or high, as indicated in parentheses; see Results section for a definition). The low and high estimated seroprevalences reflect the two ratios of AIDS cases to seropositive persons without AIDS (1:25 and 1:50, respectively).

percentage of seropositive persons who are admitted does not vary with seroprevalence in any manner, but it does vary with the tests' performance. Finally, it is worth noting that, as expected, the ratios of true-negative to false-positive and true-positive to false-negative results do not change with increased seroprevalence (Table 7).

As the pandemic grows, the program becomes less effective and concomitantly less unjust; over time, the testing program will become significantly more ineffective in achieving its goal. It seems clear that not only is the program inadequate to begin with, it is unjust, unethical, and an inappropriate use of screening. In light of the fact that the epidemic is expanding more rapidly in the United States than in any other geographic area (with the possible exceptions of Africa and the Caribbean, which jointly provide less than one-fifth of all immigrants), it is clear that the proportion of US AIDS cases who are immigrants would decrease over time. Again, the screening program would become increasingly ineffective over time.

Discussion

Despite the length to which we have gone to determine regional seroprevalences and the accuracy of HIV testing in identifying truly seropositive foreigners, several points should be kept in mind regarding their validity. First, given the epidemiological uncertainties in recording cases of AIDS, especially in the Third World, and the uncertainty of the ratio of AIDS cases to cases of non-AIDS HIV infection, our estimates of seroprevalence are bound to be inexact. These estimates generally seem to be high in comparison to some estimates of HIV seroprevalence in the general population in nonendemic areas of the United States but are low in comparison to other estimates.[89] Further, as is usually the case with infectious disease, the ratio of AIDS cases to cases of non-AIDS HIV infection may be smaller in Third World countries, because of cofactors, such as inadequate nutrition and medical care, that increase morbidity and mortality. Thus, our ratio would again be an overestimate. It may be that the underreporting for the Caribbean, for example, may be offset by the exaggerated ratio of AIDS cases to cases of non-AIDS seropositivity, whereas in Africa the underreporting is likely to be so large that an exaggerated ratio may not have the same effect. Given the small proportion of immigrants from Africa, the significance of this effect is moot. Moreover, given that Third World countries have the highest seroprevalence (apart from the United States, of course), there may be a positive selection for individuals who can afford to emigrate and who have a nonrepresentative risk for HIV-1 seropositivity. Again, the opposite may be true, and the question merits attention.

The second point that must be remembered in interpreting our data is the variable performance of the diagnostic tests in different populations.

Table 4
Final Antibody Screening Results by Continent, According to Test Performance: Low Prevalence Estimate*

Continent/Test Performance	Total Pos.	False Positive No.	%	Total Neg.	False Negative No.	%
Asia						
Low	585	129	21.99	267,719	81	0.003
High	519	32	6.2	267,786	50	0.019
Caribbean						
Low	41,547	31	0.7	70,809	7,330	10.35
High	44,281	8	0.02	68,076	4,574	6.72
North America						
Low	13,945	43	0.31	92,887	2,453	2.64
High	14,824	11	0.07	91,998	1,530	1.66
Europe						
Low	5,522	28	0.51	59,275	970	1.64
High	5,865	7	0.12	58,932	605	1.03
South America						
Low	3,512	18	0.5	37,495	617	1.65
High	3,730	4	0.12	37,277	385	1.03
Central America						
Low	2,370	13	0.57	28,346	416	1.47
High	2,516	3	0.13	28,199	260	0.92
Africa						
Low	2,515	8	0.3	16,367	443	2.71
High	2,676	2	0.07	16,206	276	1.71
Total						
Low	69,985	270	0.38	572,898	12,310	2.15
High	74,411	67	0.09	568,473	7,681	1.35

*The test results are based upon sequential ELISA and Western blot testing. Results have been rounded. For a description of test performance characteristics, see the Results section.

Table 5
Final Antibody Screening Results by Continent, According to Test Performance: High Prevalence Estimate*

Continent/Test Performance	Total Pos.	False Positive No.	%	Total Neg.	False Negative No.	%
Asia						
Low	1,040	128	12.33	267,264	161	0.06
High	1,005	32	3.19	267,299	101	0.038
Caribbean						
Low	83,041	7	0.01	29,316	14,660	50.00
High	88,548	2	0.00	23,809	9,148	38.4
North America						
Low	27,818	36	0.13	79,004	4,905	6.21
High	29,636	9	0.03	77,286	3,061	3.97
Europe						
Low	11,012	25	0.23	53,785	1,940	3.61
High	11,723	6	0.05	53,074	1,211	2.28
South America						
Low	7,004	16	0.22	34,003	1,234	3.63
High	7,456	4	0.05	33,551	770	2.3
Central America						
Low	4,724	12	0.26	25,991	832	3.2
High	5,028	3	0.06	25,687	519	2.02
Africa						
Low	1,591	8	0.51	17,291	279	1.62
High	5,350	2	0.03	13,532	553	4.08
Total						
Low	136,231	232	0.17	506,653	24,011	4.74
High	148,745	58	0.04	494,139	15,362	3.11

*The test results are based upon sequential ELISA and Western blot testing. Results have been rounded. For a description of test performance characteristics, see the Results section.

Reported false-positive rates on ELISA testing have varied greatly, from 7 percent in hospitalized patients[90] to 38 percent in intravenous drug users,[91] to a highest possible joint false-positive rate of 0.01 percent in two series of blood donors.[92] In comparison, a study of seropositivity among intravenous drug users[91] estimated the probability of a false-positive Western blot to be between 7 percent and 16 percent.

The predictive value of the ELISA has also been reported to range from 2 percent for a weakly positive test in a low-prevalence population to 99 percent for a strongly positive result in a high-risk group[90]; these figures are equivalent to false-positive rates of 98 percent and 1 percent. As the data in Table 6 indicate, our false-positive rates (1 - predictive value) for the ELISA vary in Asians from 81 percent (low seroprevalence/low test performance) to 33 percent (high/high); for people of Caribbean origin, the false-positive rate for the ELISA ranges between 1.1 percent (low/low) and 0.03 percent (high/high). The false-negative rates for the ELISA range between 0.027 percent (high/low) and 0.00075 percent (low/high) for Asians and between 30.7 percent (high/low) and 0.31 percent (low/high) for people from the Caribbean.

Joint ELISA/Western blot false-positive rates are the product of two false-positive rates; this assumes that the tests are independent and provides the highest joint false-positive rate. For Asians, our data (Table 7) indicate that the joint false-positive rates range between 1.1 percent (high seroprevalence/high test performance) and 17.7 percent (low/low); for people from the Caribbean, they range between 6×10^{-7} percent (high/high) and 8.2×10^{-4} percent (low/low), effectively 0 percent. For Asians, the joint false-negative rates are between 0.0012 percent (high/low) and 6.5×10^{-5} percent (low/high); for people from the Caribbean, the rates range between 30.3 percent (high/low) and 0.3 percent (low/high). For comparison, Meyer and Pauker[92] note that in a high-risk American population (gay men), 2.8 percent of negative results were false. From these results, it is difficult to determine the conceptual validity of our estimates of seroprevalence or of test performance characteristics; how-

Table 6
False-Positive and -Negative Results of the ELISA and ELISA/Western Blot, by Regional Seroprevalence and Test Performance*

Test Performance	False-Positive, %				False-Negative, %			
	Asia Seroprevalence		Caribbean Seroprevalence		Asia Seroprevalence		Caribbean Seroprevalence	
	Low	High	Low	High	Low	High	Low	High
Low ELISA	81	68	1.1	0.13	0.013	0.027	4.9	30.7
High ELISA	50	33.4	0.26	0.03	0.00075	0.0015	0.31	2.6
Low ELISA/Wb	17.7	8.4	8.2×10^{-4}	1.1×10^{-5}	2.9×10^{-4}	0.0012	4.4	30.3
High ELISA/Wb	3.1	1.1	4.7×10^{-5}	6×10^{-7}	6.5×10^{-5}	2.4×10^{-4}	0.3	2.6

*For a description of test performance characteristics, see the Results section.

Table 7
Ratios of True- and False-Positive and True- and False-Negative Test Results

Ratios	Seroprevalence*	Test Characteristics† Low	Test Characteristics† High	Differential
True positive	Low	77	327	~4.3
False positive**	High	161	685	~4.3
	Differential	~2.1	~2.1	
True negative	Low	154	246	~1.6
False negative	High	74	118	~1.6
	Differential	~2.1 (neg)	~2.1 (neg)	
False negative	Low	14	34	~2.4
False positive	High	28	71	~2.4
	Differential	2	~1.9	
True negative	Low	2,082	2,082	0
False positive	High	8,331	8,335	0
	Differential	~4	~4	
True positive	Low	6	6	0
False negative	High	10	10	0
	Differential	~1.6	~1.6	

*Low seroprevalence, one AIDS case for every 25 non-AIDS seropositive people; high seroprevalence, one AIDS case for every 50 non-AIDS seropositive people.
†See Results section for a description of test performance characteristics.
**True positive: false positive, the total number of truly seropositive people, both excluded and admitted, for every seronegative person excluded. True negative: false negative, the total number of truly seronegative people, both excluded and admitted, for every seropositive person admitted. False negative: false positive, the total number of truly seropositive people admitted for every truly seronegative person excluded. True negative: false positive, the total number of truly seronegative people, both excluded and admitted, for every truly seronegative person excluded. True positive: false negative, the total number of truly seropositive people, both excluded and admitted, for every truly seropositive person admitted.

ever, our assumption that the tests are independent may be inappropriate.

A third caveat concerning our analysis is that, given our inability to obtain information from the INS, the exact number of applicant immigrants cannot be known. Therefore, we do not know the proportion of applicants who are denied entry for reasons unrelated to health and the relationship between HIV-related and -unrelated disease that qualifies an applicant for exclusion. It is unlikely that these issues would alter our findings, except perhaps that, on a population level, applicants from Third World countries would be more likely to be excluded on the basis of HIV-unrelated disease and so might increase the validity of our estimates from these areas. We are also unable to determine the proportion of applicants who are under fifteen, who are not required as a matter of course to undergo antibody testing.

Finally, it is most important to note that no matter how numerically imprecise the data, the patterns they present are reasonable in light of current knowledge. Specifically, it is the patterns and dynamics of the data that represent the significance of the model, and it is these that shed the greatest light on the value of the testing program.

Conclusion

It can be seen that the screening program is highly inefficient in itself and, over time, will become relatively more inefficient. Indeed, the data show that the attempt at barring seropositive persons is not only futile but will become even more so as the pandemic grows. Even if the tests improve, as they already have, the screening program will remain inappropriate, for it cannot nullify the established prevalence of disease in the United States. It is equally unreasonable to change the policy with every new test or even new test formats.[42] In itself, the program is an effete but damaging attempt to stop infected people from entering the United States and thereby to reduce HIV transmission. For instance, applicants for immigration are vastly outnumbered by the number of nonimmigrants who enter the country each year and who are equally capable of infecting or being infected by Americans. In 1988, ten times as many nonimmigrants entered the United States from Africa and the Caribbean than were admitted as immigrants, while the total number of visitors was almost 15 million.[85] In the United States, where the pool of infection is the largest in the

developed world and among the largest of any country, the belief that a major threat to public health comes from outside of the country is sadly misguided. Clearly, Americans are much more likely to become infected by other Americans than by foreigners, and the same is true for immigrants entering the United States.

In contrast to the American belief, the prevailing attitude outside the United States is that Americans represent a greater risk to foreigners entering the United States than vice versa. A recent report[93] indicated that British heterosexuals are more likely to become infected while overseas, and since the prevalence of HIV-1 infection among Americans exceeds that found in most other countries, tourists to the United States would face a particularly high risk of infection. If, as the British study also suggests, travelers are more likely to behave "promiscuously," seropositive tourists pose a greater threat than infected immigrants. Thus, if the goal of testing is solely to obstruct the spread of infection from foreigners to Americans, the federal government, by its own terms of reference, ought to screen all visitors to the United States regardless of their length of stay. In this respect, the federal government suggests that a testing program for tourists and other temporary visitors is superfluous because it would create "unnecessary and undesirable complexities and problems, including expenses and delays in travel."[71] Unfortunately, these complexities and problems were not described in the *Federal Register*. It may be that a testing policy for tourists would entail additional bureaucracy at the INS; it would certainly add time to the often tortuous process of applying for a tourist visa and would involve some extra administrative costs at US embassies and consulates overseas. However, the major reason for not requiring HIV-1 antibody tests for tourists is probably that it would discourage foreigners from visiting the United States and would thus diminish the income generated by tourism. In 1986, there were 25.4 million foreign visitors to the United States, who contributed almost $13 billion to the nation's economy.[85] More immediately, perhaps, the extension of screening to all travelers would point up the ludicrousness of the screening program as a whole.[1]

The United States is a leader in medical research, but within the American research community there have been complaints that the funding for AIDS-related research is completely disproportionate to its importance compared to other chronic diseases (as measured by annual death rates). While, on the one hand, such complaints fail to appreciate the epidemic nature of HIV-1 infection, on the other hand, they also raise an important question of why immigrants are not screened for other chronic diseases that can be equally costly. Thus, not only is the screening program incapable of fulfilling the task ascribed and roundly unethical in the absence of screening for much more prevalent chronic diseases and susceptibilities to those diseases, but also the current program cannot be justified on the grounds of saving the money of US tax payers.

In AIDS research, the current hope is for a curative treatment and a vaccine. If such a treatment should be developed, HIV-1 infection would presumably join the others on the list of "loathsome diseases" that are not an automatic bar to residency. However, a more important policy issue is that, as Bayer notes,[94] it is easy to imagine the development of expensive therapeutics that are effectively reserved for those in industrialized societies. Furthermore, the development of treatments and a vaccine involves the cooperation of the populations most affected by the disease, which, to date, have received the shoddiest of responses to their needs by the medical and political communities. The screening policy also works directly against the establishment of fruitful working relationships between the United States and the regions hit hardest by the HIV epidemic, including Africa and the Caribbean.[95] Similarly, subjects in vaccine trials must be protected from discrimination stemming from vaccine-elicited antibody responses. Which foreign countries will unreservedly cooperate in vaccine trials with American companies when such cooperation opens their citizens to discrimination in travel and immigration?

In terms of international policy, the screening program is a counterproductive measure that wastes resources needed to deal with this global health emergency. On scientific grounds, there remains no doubt that the policy should be changed and the program eliminated.

NOTES

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An Ethical Analysis of the US Immigration Policy of Screening Foreigners for the Human Immunodeficiency Virus
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An Ethical Analysis of the US Immigration Policy of Screening Foreigners for the Human Immunodeficiency Virus

Rupert E.D. Whitaker and Richard K. Edwards

Introduction

Since 1981, when it was first recognized as a distinct syndrome, AIDS has emerged as the major public health problem of this century. Although AIDS has yet to claim as many lives per year as, for example, cancer or heart disease, it is a pandemic with effects, both current and potential, that are devastating. As the medical problem has grown, the social, political, and economic ramifications of AIDS have also assumed their own global dimensions.

With the development of the pandemic, there have been increasing efforts to combat the spread of human immunodeficiency virus (HIV) infection. In the US, the earliest sufferers were blamed for their disease, while only a modicum of responsibility was taken for identifying the cause and preventing a wider dissemination of infection. As a consequence, and despite the remarkable achievements of the gay community, the American epidemic has grown out of all proportion, and the chances of dealing with it effectively have been significantly reduced.

Thus, the primary concern in the response to this epidemic, after identifying the putative cause, has been to restrict the spread of the disease and to minimize its toll. To this end, various policies have been considered or adopted, including sexual health education and HIV antibody testing. For largely political reasons, these two approaches have been pitted against each other as alternatives or, on occasion, as diametric opposites. On the one hand, the first of these public health strategies has been characterized by some as a civilized approach to maximizing individual self-control and by others as a license to engage in unrestricted sexual activity. The second of these approaches, antibody testing, has been described, on the one hand, as a barbaric effort at paternalistic population control and, on the other, as a necessary blanket measure to protect the public. Antibody testing is necessary to prevent the spread of HIV by blood products and for purposes of family planning, but, given that it targets as a population for intervention only those who are already infected, it is only one in a series of steps that would be needed to achieve the overall public health goal.

As a consequence of the politicization of public health in the United States, major practical and ethical issues have arisen in relation to AIDS. These issues are usually seen as a conflict between effective policies and human rights, and nowhere is the conundrum more evident than in the case of testing applicant immigrants.

In May 1987, at the Third International Conference on AIDS, then-President Reagan announced that all applicants for residency or citizenship would be tested for HIV infection. Responding to cries of disgust from the audience, the president sought to avoid controversy by stressing that AIDS (not HIV infection) was simply being added to the list of contagious diseases for which foreigners might be excluded from the United States. On June 8, 1987, AIDS was added to that list. It was replaced by HIV infection less than three months later, on August 31, 1987. At the Fourth International Conference on AIDS in Stockholm, the US national AIDS prevention program was presented for discussion[1]; the program did not list the screening of immigrants at all. Nevertheless, this move has been touted by the US Department of State as part of a "comprehensive policy of international cooperation" against AIDS,[2] even though 1) it was implemented against the advice of the former surgeon general and the World Health Organization (WHO), 2) it defies other precedents of international cooperation,[3] and 3) it implicitly contravenes Article 81 of the International Health Regulations of 1969. However, commentary published in the *Federal Register* stated that "this rule does not conflict with the report of a World Health Organization consultation on international travel and human immodeficiency [sic] virus held in Geneva March 2-3, 1987.... This consultation addressed issues relating to international travel, but it did not address decisions individual countries might make with respect to the issue of a visa."[4]

However, in the public discourse about AIDS in the United States, remarkably little attention has been paid to the issue of screening immigrants. It would appear that the idea of controlling the spread of AIDS by excluding HIV antibody-positive aliens has met with at least tacit approval on the part of US public health authorities, many physicians, and the population in general. This issue merits considerably greater--and more detailed--discussion than has been undertaken to date. This article examines the logical and moral aspects of the screening policy. Furthermore, the authors consider the social consequences of identifying specific groups of people as the "carriers" of disease.

Etiology of AIDS and the Uses of Antibody Testing

AIDS is a clinical diagnosis, while HIV infection is a laboratory one.

Despite significant concerns about the sufficiency of HIV in causing disease as well as opposition to naming it as the causative agent of AIDS,[5] little consideration had been given to other possible causes until recently.[6] Its precise role in the pathogenesis of AIDS-related disease and the mechanisms thereof are not well understood.

HIV is not highly contagious and has well-delineated means of transmission.[7,8] These modes of transmission have been documented repeatedly in studies in Europe, the Americas, Africa, and Oceania and thus are not culturally or geographically defined. These modes include sexual intercourse; contact with blood, blood products, or donated tissues; and perinatal transmission. Given such clear (and restricted) means of transmission, there exist equally clear means of avoiding infection. The transmission of HIV by sexual activity or intravenous drug use is preventable as long as those at risk have access to educational materials about the risks of infection and have effective means and the motivation to reduce or eliminate those risks.

Tests for antibodies to HIV have been available since 1985; their primary use and original purpose in most countries has been to screen donated blood and plasma. However, in a manner common to epidemics, the antibody test is now used to screen people.[9] Such a screening tool may be used at either the population or the individual level. When used on the population level, testing is instrumental in determining who has been exposed to HIV, and the antibody test has been used by epidemiologists to assess the prevalence and incidence of infection in various geographical areas and populations. Such seroepidemiology is essential in understanding the nature of an epidemic.

On an individual level, the test is useful in helping people to determine whether or not they have been infected, for the purposes of family planning and early treatment; however, the personal issue of early treatment is largely irrelevant to governmental policies, especially in countries without national health insurance systems. Furthermore, given the current lack of curative interventions, an HIV antibody test is useless on an individual level. The decision to initiate zidovudine (AZT) therapy is governed primarily by the number of CD4-positive cells in the peripheral blood, not by one's antibody status. It is important to note that the antibody test does not predict the development of clinical disease, particularly when HIV infection occurs through sexual contact (although the test is apparently much better in predicting disease in persons with blood product-related infections)[10]; therefore, a positive test result indicates infection with HIV rather than current or future clinical disease, a point made in the directions for all commercial test kits but almost universally ignored.

There is a significant difference between voluntary and/or anonymous testing and mandatory testing; the former has been characterized as "testing to discover the extent of the epidemic" (as in unlinked seroepidemiology[11]), while mandatory testing has been termed "testing to discriminate" and written off as a misguided approach to protecting public health and the private interests of insurance companies.[12] Mandatory testing legislation has been introduced in many countries; in several US states, these bills cover such populations as teachers, health care workers, barbers, prisoners, applicants for health and life insurance, marriage license applicants, and even the entire state population (e.g., Lyndon Larouche's Proposition 64, which was defeated in California). Cleary *et al.* have noted that "many people believe that compulsory screening is a way to stop the spread of HIV, but such attitudes reflect a misunderstanding of the epidemiology of HIV infection and the performance of diagnostic tests."[13] The epidemiology of AIDS and the nature of the antibody test are misunderstood even by health care workers and health policy analysts. Anonymous testing, on the other hand, can provide some definite benefits when used as a tool for epidemiological, clinical, or transfusion-related purposes, as suggested by the assistant surgeon general.[14]

The epidemiology of AIDS and the nature of the antibody test are misunderstood even by health care workers and health policy analysts.

Why Screen Foreigners?

Dickens has found that "governmental responses to the AIDS epidemic, at least in the United States, have in part been punitive, reinforced by a conviction that infection comes from outside and that only a few citizens bear responsibility for causing infection."[15] True as this is, the idea that infection comes from "outside" has also been used to implicate the United States in the AIDS epidemic of other countries. For example, Biggar[16] has reported that Danish AIDS patients identified in 1981-1982 had histories of exposure to Americans and that immunodeficiency in 1982 and seropositivity in 1981 were associated with visits by Danish men to the United States. The United States has also been cited as the source of infection for other Europeans.[17] In the United States, early efforts to identify the origins of the present epidemic focused on Haitian immigrants and American tourists returning from "a sexual paradise."[18,19] In return, the Haitian authorities sought to blame visiting US citizens for bringing AIDS to Haiti. So commonplace have such accusations become that, in a recent

article about the supposed infiltration of American institutions by Canadians, the satirical American magazine *Spy* found it convenient to subscribe to the view that AIDS was brought into the United States by a Canadian flight attendant who crossed the "undefended border" into the United States and "wilfully infected" Americans.[20]

Restrictive immigration policies have been proposed and enforced in several countries, including the United States. For example, Bulgaria, Cuba, Iraq, and the Soviet Union have implemented testing programs not only for foreign nationals but also for citizens returning from extended visits overseas. To date, more than 50 countries have restricted the entry of HIV-seropositive persons in some way.[21] As of January 1988, the Soviet authorities had acknowledged four cases of AIDS and 32 cases of seropositivity, of whom 18 "probably" acquired the virus through sexual contact with foreign nationals. Of the 98,000 applicants for tourist visas to the Soviet Union tested by February 1988, 221 (or 1 in 443) were found to be seropositive. The Soviet Union has been quick to accuse "decadent" Westerners of inflicting AIDS on Soviet citizens whose own decadence the authorities apparently overlook. In China, AIDS was diagnosed in two tourists and a Hong King citizen who had previously lived in the United States, where, the Chinese authorities assumed, he had contracted the infection. At the 1988 International AIDS Summit in London, one Chinese delegate informed his audience that "AIDS was transmitted into China, and the risk of import still exists."[22]

The restrictions are often symbolic and stereotypical. For example, Cyprus focuses on screening cabaret artists, Korea on sailors and entertainers, Egypt on foreign defense contractors, and South Africa on foreign mine workers, black immigration applicants, and returning black nationals. It has also been proposed, in India, that sex between nationals and foreigners be outlawed.[23] There is no association between HIV seroprevalence and the presence or absence of such policies, and there is little uniformity among existing policies. Iraq, for example, demands that all foreigners entering the country for more than five days produce evidence of a negative HIV antibody test result. Some countries (e.g., Bulgaria and Japan) require testing of all visitors staying for more than 30 days; others (e.g., Cuba, Kuwait, the Philippines, Turkey, and the United States) have mandated testing for long-term foreign workers, permanent residents, and applicants for citizenship. Both Belgium and West Germany test non-European students receiving government scholarships, and India has adopted mandatory tests for all incoming students.

No less ominous is the fact that public opinion polls in Canada, France, and Great Britain have shown considerable support for testing foreign visitors. Furthermore, several governments have denied having specific policies, while exclusion or deportation was known to have occurred. British immigration officials have reportedly denied entry to several Americans who were found or assumed to be seropositive.[24] The same has been known to occur in West Germany.[21] While the government denies that any policy of exclusion operates at points of entry into the United Kingdom, it admits that immigration officials may exercise broad discretionary powers when reviewing the documents of foreigners. This situation illustrates an important point, namely, that different branches of the same government may have separate, even conflicting, policies on AIDS. In West Germany, for example, the federal government is prohibited by European community law from denying entry to citizens from other countries within the European Community. However, the government of Bavaria has passed legislation to prohibit seropositive people who are not members of the European Community from visiting the state for extended periods. Despite opposition from the federal government, the policy remains in effect.

It is indeed puzzling that the United States should find itself in the company of countries from the Soviet bloc and the Middle East, many of which have (at best) questionable records on human rights. While Americans clearly take pride in the protection offered by their constitution and generally resist repressive or totalitarian solutions to problems, it is clear that both the Bush and Reagan administrations have been willing to place the blame for AIDS upon groups that are largely unable to defend themselves. It is ironic that immigrants, many of whom come to the United States seeking the civil rights protections afforded by its constitution, may be denied entry by the very country they regard as the best guarantor of freedom.

Historical-Cultural Approaches to Disease and AIDS, or Why Not Screen Foreigners?

Historians have noted that the view of diseases as problems of "the other" has arisen frequently when the diseases are incurable and of questionable origin. The present furor over AIDS is the most recent in a series of attempts to identify immigrants as the carriers of a disease. As Brandt[25] has pointed out, the last decade of the 19th century witnessed a well-orchestrated effort to blame immigrants for increasing the incidence of sexually transmitted diseases in the United States. A physician of the time noted that the "tide of venereal disease has been raising [*sic*] continually, owing to the incessant impouring of a large foreign population with lower ideals." The idea that sexually transmitted diseases were being brought into the United States by immigrants whose promiscuous behavior threatened American family values seems naive, if not ridiculous, today. In the 19th century, however, this notion was sufficiently powerful to encourage Congress to pass the Immigration Act of 1891. The act specifically forbade entry to the United States by anyone "suffering from a loathsome or dangerous contagious disease."[26] If such thinly disguised xenophobia might seem less likely to affect administration policy

today, it is worth pointing out that the decision of the present government to adopt HIV testing of immigrants was based upon the precedent set at the turn of the century.

If the origins of mandatory testing for immigrants lie in a deeply rooted desire to blame foreigners for AIDS, then it is hardly surprising that neither the former nor the current president nor their most vociferous supporters have been willing to engage themselves in a debate concerning the efficacy of mandatory testing. It goes without saying that attempts to exclude immigrants in the 19th century had no impact on the incidence of sexually transmitted diseases in the United States. It seems likely that efforts to close off the borders of the US to stem the spread of AIDS will be equally ineffective.

Disease and Immigration: Policy and Procedure in the US

Under the provisions of the immigration legislation, the federal government established guidelines in 1987 for HIV antibody testing of immigrants in order to "prevent the importation and related further spread of HIV into the United States."[4] The testing program requires that all aliens over 14 years of age seeking permanent residency, refugee status, or citizenship be tested for antibodies to HIV and states that, with possible exceptions, members of these groups will be admitted to the United States only if the test result is negative. Other groups, including tourists, businesspeople, and temporary residents, can be tested arbitrarily. Registry applicants are not screened. Refugees and some applicants for legalization can apply for waivers of exclusion on the grounds of family unity, humanitarianism, or when a waiver would otherwise be in the public interest. One must assume that, since waivers are not automatic, seropositive refugees and illegal aliens are deported. Some countries quarantine seropositive returning nationals.[23] A waiver may also be issued to temporary non-immigrants entering the United States, such as those attending scientific conferences, and these waivers must also be in the public interest. Exclusions may also be waived for aliens with mental disorders, for example, when the alien is the spouse, unmarried son or daughter, or lawfully adopted, unmarried, minor child of a US citizen, permanent resident alien, or immigrant alien. Such waivers are issued at the discretion of the attorney general, after consultation with the US Public Health Service (PHS), and a bond may be required. Furthermore, the attorney general may waive exclusions based on medical grounds for lawful permanent residents who went abroad voluntarily and temporarily. Waivers were designed to be granted liberally; most often, however, they depend on the alien proving that he or she poses minimal danger to the public health and that no cost will be incurred by the United States. The type of evidence required in this process does not seem reasonably obtainable.

According to S. Farer, former head of the Division of Quarantine at the Centers for Disease Control (CDC), the PHS's policy is to exclude an alien only for diseases the alien actually has and not for those he or she may develop in the future.[27] He further explained that an alien with a "dangerous contagious" disease is excluded not because of concerns about disease transmission but to protect the United States from having to provide necessary medical care. Thus, the PHS policy seems to oppose directly the regulations in the *Federal Register*, which exclude seropositive aliens on the grounds that they may develop a disease; while the *Federal Register* states that the goal of the testing program is to reduce the transmission of HIV from immigrants to US citizens.

Although the Department of Justice is responsible for the Immigration and Naturalization Service (INS), the secretary of health and human services is the person responsible for making and implementing immigration laws governing medical examinations of applicant immigrants. Immigrant visas are issued to immigrants in foreign countries, and the applicant must undergo a physical and mental examination; a non-immigrant may also be required to have a medical examination at the consul's discretion. A panel of PHS physicians, maintained overseas by the INS for such purposes, is authorized to conduct medical examinations of aliens in foreign countries and at various ports of entry. Each medical examiner is responsible for establishing internal office procedures for conducting the medical examination, a policy that minimizes the opportunity for fraud. Aliens who have had complete medical examinations before obtaining their visas may be subject to further, though limited, medical examination.[27]

It is during such an examination that HIV antibody tests are performed. The federal regulation does not specify what test(s) will be used: This decision is left to the CDC, which distributes medical screening manuals to examining physicians. Currently, the first test is an enzyme-linked immunosorbent assay (ELISA); if this test is negative, the immigrant visa is issued. If the first test is positive, however, the ELISA is repeated; if the repeat test is negative, the visa is issued. However, a second positive result on the ELISA requires a Western blot test. A positive result on this test leads to the exclusion of the applicant under section 212(a)(6) of the Immigration and Nationality Act (INA). It is interesting that the INS has issued no definitive statement delineating the course of action if a negative or even an indeterminate Western blot is obtained after two positive ELISAs. It cannot be assumed that the applicant would be admitted to the United States without hindrance. Likewise, the CDC guidelines for interpreting the Western blot are in disagreement with the guidelines developed in 1989 by the Fourth Consensus Conference on HIV Testing[28] and make it more likely that an indeterminate result would be reported as a false positive.[29] However, provision is also made for further, if limited, physical examinations[27]; whether or not this procedure would entail a second Western blot or even a third test, such as an immunofluorescence assay, remains unresolved.

Exclusion on medical grounds covers several classes of persons, including those with psychopathic personalities (including homosexuality) or sexual

deviations (mental defect), those with physical defects that may affect their ability to earn a living, and those with any dangerous contagious disease. This last category consists of chancroid, gonorrhoea, granuloma inguinale, infectious leprosy, lymphogranuloma venereum, syphilis (infectious stage), active tuberculosis, and HIV infection; aliens with such diseases may be admitted to the United States if they can afford and will receive curative treatment. In every case but HIV infection, these conditions are treatable and exclusion can therefore be circumvented.

According to the *Federal Register*, when an applicant tests positive for antibodies to HIV, information about counseling resources will be offered. Test results will be delivered to the applicant by the examining physician, regardless of his or her competence in sexual health education in a transcultural setting. Beyond this information, however, the policy states only that all seropositive persons will be referred to agencies and organizations that can offer counseling services, whether or not they be affordable. The *Federal Register* notes that "considering the complexity of the many different cultures around the world, CDC will explore the feasibility of preparing training manuals on post-test counseling, such as a short video-tape, for medical examiners."[4]

The civil surgeon's report is incorporated into the record, and appeals go to the Board of Medical Officers of the PHS. If an applicant is certified to have a physical defect, disease, or disability under section 212(a)(1)-(5) of the INA, he or she may make an administrative appeal against the certification to the attorney general and may introduce one expert witness before the board at personal expense. There appears to be no administrative appeal against a medical certificate based on the existence of a dangerous contagious disease under section 212(a)(6).

Should the administrative appeal fail, there is no judicial appeal; the courts have no jurisdiction to determine whether or not the reasons given for exclusion under the INA are in accordance with the terms of the act. Therefore, petitions may not go beyond the medical certificate, which pretends to be conclusive as to both the existence and nature of the disease.

The situation is slightly different for applicants in the legalization program (now terminated) established by the Immigration and Nationality Reform Act of 1986.[30] Seropositive applicants who revealed their HIV infection status in the preliminary application were not eligible but could not be deported, because of the confidentiality clause in the act; presumably, these applicants remain in the United States today as illegal aliens. If the applicant were found to be seropositive upon testing, he or she could apply for a waiver. However, the availability of waivers was apparently not widely known. Seropositive persons identified by this program currently await deportation.

The above discussion outlines how the testing policy is intended to operate. The significant deficiencies and complications that arise in the application of the policy frame the authors' analysis.

The decision to deny a visa is not subject to review in the courts, a practice that has been called an unjustified, if not unprecedented, aberration of the principles of American justice.

Analysis

Avenues of Appeal

Recourse Within the United States

The decision to deny a visa is not subject to review in the courts, a practice that has been called an unjustified, if not unprecedented, aberration of the principles of American justice.[31] Furthermore, while certificates of defect such as a handicap are issued "only if the presence of such...has been clearly established,"[32] there is no requirement for the PHS to establish clearly that HIV infection constitutes a dangerous contagious disease. The INS avoids an appeal by finding HIV-seropositive people unfit for immigration under section 212(a)(6), even though the contagiousness *per se* and dangerousness of the condition have not been established. As Dickens has noted, "dangerousness is a legal status rather than a psychiatric disposition or a condition of infectiousness."[15] Druhot[27] has pointed out that the PHS's definition of a dangerous contagious disease may not be challenged as long as the classification has some rational basis. If HIV infection is, in fact, a dangerous contagious condition, then a double standard clearly exists, in that seropositive foreigners are considered to have a contagious condition through which they are potentially dangerous while infected US citizens are not. Nevertheless, an alien is prohibited from attacking the substantive provisions of the immigration laws on constitutional grounds, because the constitutional rights of aliens are limited: Only aliens who are lawful permanent residents of the United States (i.e., those who have green cards) have an opportunity to oppose an order mandating exclusion. As always, the burden of proving admissibility lies with the alien.

The issue of waivers seems to reflect a confused and inconsistent attitude toward the value of immigrants. Humanitarian purposes and the public interest are such vague conditions for granting a waiver that one must question what they would mean in practice. For example, would the attorney general issue a waiver of exclusion to a

refugee seeking medical care for AIDS under the rationale of humanitarian purposes? Why is the family unity of a refugee more valuable than that of an illegal alien or a professor who has been a non-permanent resident in the United States for several years? What action would be taken in the case of someone who applied for permanent residency or legalization after residing in the United States for several years and who may have been infected while in the United States? Would a seropositive alien married to a (possibly seropositive) US citizen be allowed to settle in the United States? This may be the only instance in which an alien might have cause for action. The Fourteenth Amendment protects fundamental American rights, including the right to marry and the right to privacy (including privacy of information). This amendment calls for *strict* scrutiny of laws that create suspect classifications (i.e., those based on race or national origin) and for *heightened* scrutiny of laws pertaining to sensitive classifications such as seropositive status.[33] Furthermore, the Supreme Court has repeatedly ruled that marriage is a fundamental human right, protected by the Constitution,[34] that can be compromised only if it is the least restrictive means of achieving a compelling public health goal.[35] Even if the current policy were deemed constitutional on its face, it would still have to satisfy the means-end requirement, which includes the evaluation of less intrusive alternatives. The only effective policy that is likely to pass such a test is compulsory education and voluntary, confidential testing (see below). Other alternatives might include screening for drug use or homosexuality, already grounds for exclusion,[36] or screening on the basis of country of origin (which would primarily affect aliens from Africa, the Caribbean, and certain South and Central American countries). The *vox populi* would drown out the proponents of such National Socialist-style laws, even though discrimination against the handicapped already exists within the current INS provisions. It seems increasingly apparent that the exclusion of seropositive aliens is not the least restrictive means of achieving the public health goal, and it is doubtful that its purpose, as defined, is at all compelling.

Recourse from Outside the US

The INS requirement that most, if not all, individuals apply from outside the United States effectively quashes any recourse through the American legal system. Any legislation that is ethically unsound normally sinks into a quagmire of legal hassles; however, given that such legislation is effected in international waters, under diplomatic protection, the legal recourse diminishes severely as the ethical problems increase. Practically speaking, an applicant immigrant will be powerless under international law to seek legal redress against a US consular official or representative of the US government who has allegedly breached the confidentiality of medical information. Under existing American tort law principles, the false or unjustified communication of a patient's "AIDS status" would most likely be considered defamation *per se*, because it alleges that the person has a "loathsome disease."[37] Furthermore, there may be a risk of liability to third parties following inadequate information about the meaning of test results.

Assessment of Screening Programs

Screening for indicators of infection or disease has long been useful in a variety of public health efforts. When used to detect treatable diseases that are otherwise difficult to recognize, screening is clearly beneficial to the person screened as well as to the community at large. Screening for untreatable diseases may still be useful for public health interventions to impede the spread of infection. However, HIV screening provides few of these advantages. There has been a great deal of screening but no concerted battle plan. The use of screening in this way raises many complex ethical questions, and definite criteria for assessing the function and effectiveness of such a program must be developed. The goals of screening programs have not always been clearly defined and the costs--practical, economic, or social--of effecting such programs have rarely been examined adequately. Furthermore, screening programs may be implemented for purposes other than those publicized, and it is important to assess the real reasons for targeting a certain population. For example, the WHO has suggested that "...screening efforts may be driven by...a need to appear to be taking visible action against the HIV problem."[38]

It has been recommended widely that screening programs be approached with great caution, given the extremely restricted modes of HIV transmission, the privacy of the behavior usually involved in transmission, and the lack of any intervention except education. Screening programs may be intrusive and may divert resources, of whatever kind, away from the educational programs that, according to the WHO, are currently the most effective preventive measures available. Several such sets of assessment criteria have been independently developed, by public health experts of the WHO,[38,39] and by US[40] and other health policy analysts.[41] The criteria for assessing a screening program may be better understood as requirements that must be met for a program to be both effective and just. These assessment criteria are summarized below in the form of two lists, the first addressing technical and practicability requirements and the second the ethical requirements of screening programs.

Practical Requirements of Screening Programs

Whatever screening system is used, access to a national or regional reference laboratory is an essential prerequisite for any screening or testing program, in order to evaluate and assess the appropriateness of assay systems for the particular setting or proposed use; to provide supplemental (i.e., confirmatory) testing; to oversee quality control at screening centers; and to train staff for local screening centers. Furthermore, the type and source of

test materials (e.g., cell lines used to test for virus replication) should be consistent. The technical aspects of screening should be manageable in terms of complexity and consistency between laboratories and over time. The criteria for interpreting the tests (e.g., sensitivity and specificity) should be stipulated and consistent. As far as the authors have been able to determine, the 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. There are no quality control procedures, which must be independent of general quality control procedures in a given laboratory, nor are there means to enforce quality control guidelines, should they be established. The technical demands of a test may be of great importance when it is used to screen people. In sub-Saharan Africa, for instance, there is no way to assess the validity of the test results because of the inconsistency and inferiority of at least some local laboratory conditions. The quality of laboratory support common in the United States does not exist, and some facilities cannot depend on the consistency of the procedures and their results. Thus, a nation's initial economic status may affect an applicant's chances to better his or her condition, which is obviously discriminatory. This information must be kept in mind when interpreting African seroepidemiological studies, discussing the screening of blood donors,[42] or assessing the risk that immigrants from undeveloped nations pose to the North American public.

Cost-benefit analysis should be included in the initial study. The appropriateness of cost-benefit analysis in the context of AIDS has been discussed.[43] There is no doubt that the screening program is beneficial from the US government's narrow viewpoint, since the cost of testing is laid upon the applicant for immigration. The applicant must bear not only the financial burden of an inappropriate test but also the enormous psychological and financial ramifications of a positive result.

Recently, a Canadian group has undertaken cost-benefit analyses of screening potential immigrants to Canada.[44] The researchers concluded that such screening would prevent the Canadian government from paying several million dollars over several years for the care of HIV-infected foreigners. However, these analyses have failed to account for the direct and indirect benefits that such immigrants bring to the Canadian economy, and so such research should be considered "cost analysis" in its strictest sense. Furthermore, the Canadian research has failed to consider the ethical ramifications of such a program, which may override purely financial objections.

There can be no doubt that the financial cost of the US screening program would be insupportable, were the government to pay for it, and that cost would far outweigh the benefits, as has been true of screening programs for marriage license applicants[12]; yet some state governments have deemed that latter expense a justifiable one. Direct analogies can be drawn between screening marriage license applicants and immigrants. The American Medical Association supports the testing of immigrants, while at the same time opposing testing for marriage license applicants on the grounds that "testing in low prevalence populations would result in a high proportion of false positive results and would not be cost-effective."[45] The rationale for screening marriage license applicants is to stop HIV transmission. Given that people do not have to be married to have sex or bear children, the most efficient tool for preventing virus transmission is education of all sexually active people, in conjunction with voluntary, anonymous antibody testing. The screening of marriage license applicants is more like genetic screening than like screening for sexually transmitted diseases; screening for genetic diseases is widely rejected on the grounds that it involves too much uncertainty and poses too great a threat to privacy and autonomy relative to its expected benefits. Similarly, relative to its discernible benefits to the United States and the individual applicant, the current HIV screening program involves unacceptable degrees of uncertainty and poses an even greater threat to privacy and autonomy than the screening of marriage license applicants.

Ethical Requirements of Screening Programs

The use of test results must be appropriate to the goal of the screening program. Medical information must be kept confidential, and the disclosure of test results must not occur without the person's authorization or in the absence of a clear public health benefit. First, the reliability of the current program is a necessary but not a sufficient condition for the use of the results being appropriate to the goal; the efficiency of the program is analyzed in a related paper.[29] Second, the current screening program has no confidentiality provisions. The *Federal Register* states that "in a world-wide testing program, the United States Government can neither guarantee confidentiality of all HIV test results nor assume responsibility for any possible consequences of a positive test result."[4] The examining physician may be legally obliged to release positive results to officials of the country in which the medical examination took place, and there is no legal structure for ensuring the humane treatment of seropositive individuals in their home country. Given that a positive test result may bring anything from minor stigma to loss of life, this program works directly against the public health and may endanger the applicant's personal safety. Furthermore, a recent US study[46] has shown that mandatory reporting of seropositive persons in South Carolina resulted in a reduction in the number of high-risk persons presenting for testing and counseling. This observation suggests that, by supporting foreign governments' mandatory reporting policies, the US government may unwittingly help to increase the epidemic in some countries. Clearly, the ramifications of testing applicants for

immigration extend far beyond the boundaries of US public health policy.

An ethical analysis of HIV testing[47] indicates that mandatory notification of the person tested is justified only when it is absolutely necessary to prevent grave harm to others. The INS ruling allows no discretion in communicating individual test results. Applicant immigrants do not have the right to refuse to be informed, a right that also hinges on the right to privacy. The implication of the INS ruling is that Americans have claims to human rights but that foreigners do not.

Testing should be justified for each individual within a population and should be applied fairly, and testing should be voluntary unless exceptions are warranted by a clear public health benefit. Given the relatively low seroprevalence in the immigrant population, mandatory screening does not appear to be warranted. The program might qualify as a justifiable exception to voluntary testing if it could be shown to achieve some clear public health benefit. Although such a benefit has been assumed to exist, it has not been specified or demonstrated. The present analysis seeks to show that mandatory screening achieves no public health benefit and that, on the contrary, the program endangers international public health. Furthermore, because countries differ in the extent of their testing resources, quality control is impossible and testing is unlikely to be either uniform or fair.

The selected population should have a large enough reservoir of infection that disproportionate numbers of uninfected persons do not have to submit to intrusive testing procedures. As a whole, the population of applicants for immigration has a lower seroprevalence rate than the American population.[29] By region, only Africa and the Caribbean have significant reservoirs of infection; testing of people from these areas alone would be more efficient but is politically unviable. Furthermore, approximately 55 percent of the applicants from such endemic areas settle in New York City or Miami, where seroprevalence rates may be still higher than the rates in the pool of immigrants.[48] Targeting immigrants from certain countries would affect those nations' willingness to report AIDS cases; as a WHO report has stated, "if reporting of AIDS cases is likely to lead to the imposition of screening requirements by other countries, some governments may be reluctant to report openly; a similar reluctance has been evident for cholera reporting in recent years."[49] Any effort that impedes AIDS case reporting will certainly handicap the international effort against AIDS.

The environment within which the population operates must pose a significant risk of HIV transmission. According to a Harvard School of Public Health report, the "public health necessity" that must form the basis of screening programs requires the existence of a setting where transmission is likely to occur.[50] Given that the United States accounts for approximately 70 percent of all AIDS cases reported to the WHO, immigrants to this country are at a greater risk of acquiring HIV infection than of transmitting it to Americans. As shown above, gay and bisexual men who have visited the United States as tourists or on business have been disproportionately at risk of being infected by Americans. Foreigners do not have to be immigrants to transmit HIV to or, more likely, acquire the virus from Americans. Furthermore, many applicant immigrants have already either visited the United States or have lived here as non-immigrants and should be excluded from analyses of immigrant-related HIV transmission.

The consequences of testing should not be disproportionate to the benefits, and confidential and supportive counseling must be available; test results should be delivered by a trained counselor. It has been argued that screening may seem a minor intrusion in the face of a deadly disease, but its consequences can be dramatic and damaging for the individual.[51] The problems associated with seropositivity include social and psychological isolation, the involuntary disclosure of test results or associated stigmatizing actions, and the loss of livelihood and eligibility for insurance.[47]

The implication of the INS ruling is that Americans have claims to human rights but that foreigners do not.

For many, emigrating to the United States is a step up in life's circumstances; to be refused on the basis of an antibody test may expose an individual to punitive measures from his or her national government or social milieu, as already noted.

Results are communicated by the examining physician, whose skill as a sexual health educator and professional counselor may be questionable in this difficult setting. Despite its importance in reducing the burden of a positive test result, counseling is optional for would-be immigrants, and the applicant must bear the cost. Studies of the response to positive test results have found significantly increased levels of depression and stress, with a greater likelihood that relationships will dissolve,[52] and cases of clinical depression and even suicide are not uncommon among seropositive persons. Indeed, the most common reaction to a positive test result is anxiety, sometimes to the point of debility.[53] Not unlike the US government, most people incorrectly understand a positive test result to be a diagnosis of AIDS, which they equate with a death sentence and ghastly suffering. Indeed, the PHS supports such a misunderstanding in its INS ruling, by

assuming that all infected persons will die. Such distress, in and of itself, is likely to reduce the quality of life considerably. Uncertainty about one's ability to cope with a positive test result has been cited as a major reason why people decline to be informed of their test results.[54,55] Levine and Bayer have concluded that "screening programs which fail to plan for appropriate follow-up services fail to meet the ethical standards of justice and beneficence."[56]

The program must be effective in controlling or reducing HIV transmission to a degree that less restrictive or intrusive programs would not be able to achieve, particularly if the risks associated with the program are substantial or outweigh its benefits. The data detailed in a companion paper[29] indicate unequivocally that the INS testing program is ineffective in controlling or reducing HIV transmission from foreigners to US residents. It is also clear that the costs of testing, both psychological and financial, outweigh the benefits to the individual. Alternative avenues of prevention are available, but each has been judged by its cultural or political implications rather than its efficacy.

It should be clear by now that the most effective way of controlling the spread of infection is to promote voluntary behavior changes, such as those that have occurred among gay men in the United States.[57,58] Such changes, based upon what one commentator has called "the responsibility and informed decisions of free individuals,"[47] will undoubtedly prove more effective in the long term than coercive and repressive measures. However, educational campaigns have been hindered by bigotry against gay men, intravenous drug users, the poor, and non-whites. The WHO has asserted that

> readily accessible counselling and testing for antibody to HIV, provided on a voluntary basis, are more likely to result in behavior changes that contribute to the public health goal of reducing the spread of HIV than are mandatory screening initiatives. There are more effective, less intrusive and less costly measures for preventing HIV transmission than the use of mandatory screening initiatives.[38]

Nevertheless, the means used to halt HIV transmission must satisfy the moral requirements of well-being, justice, and respect for autonomy, where *well-being* is defined as the outcomes, pro and con, of the policy; *justice* as the distribution of the outcomes within a population; and *respect for autonomy* as the civil liberties of those affected by the policy.[59] Education that appeals to the rational capacities of the hearer respects his or her autonomy; if it also reduces risk behavior, it promotes health and thus well-being. Sexual health education is also moral in that it helps the hearer to see clearly the possible effects of his or her behavior on others. Indeed, many of the measures are also self-protective.

An uninfected person has the right to be protected or to protect himself or herself. Sexual health education is more effectively focused than antibody testing, because it affords an opportunity for infected persons to protect themselves and for uninfected persons to exercise a means of social responsibility, regardless of the individual's knowledge of infection status. These two results of sexual health education are independent, for an uninfected person does not "get" infected by an infected person, rather he *infects himself* by consenting to risky behavior. Short of rape, an infected person cannot behave irresponsibly and infect any competent adult without that person's consent. It should go without saying that any American can infect himself or herself through consenting adult behavior (sexual, drug related, or other) with an HIV-infected foreigner. However, the blame for virus transmission is placed on the foreigner, who must thus be denied entry to the United States. It is an obvious but overlooked fact that there can be no public health risk without personal health risk. Refusing to take risks is a personal choice and responsibility and depends on the personal integrity of the infected and/or the uninfected parties, preferably both. Testing does not prevent a person from having sex irresponsibly; thus, it treats the consequences of risk taking but not its cause. Gevers has pointed out that "in the last resort, prevention and control of the disease are a matter of individual choice and responsibility. A public health policy which does not respect this basic fact is bound to fail."[47] Ethical analyses suggest that the only acceptable policy is one that relies on voluntary efforts by informed and motivated persons.[60]

Under the provisions of the immigrant screening program, physicians are advised to recommend counseling solely for applicants who test positive. It seems ironic that those who are to be denied entry are advised to undergo counseling and education, while those who are admitted will neither receive counseling and education nor be referred to such services. This is an important point, since truly seronegative immigrants may be in danger of becoming infected while in the United States, and applicants with false-negative test results, while potentially infectious, will be unaware of how to avoid HIV transmission. If the aim of the INS screening program is to prevent the further spread of HIV within the United States, counseling and education of seronegative persons are also essential. If the federal government deems it necessary to "protect" Americans from infection by foreigners, then surely it has a responsibility to offer similar protection to newly admitted immigrants. This raises the question of whether or not the United States has a moral duty to warn immigrants of the dangers they face in encountering Americans on a daily basis, especially since it is moot how informed applicants are when they consent to undergo testing.[41] The question remains why foreigners are not owed the same sort of consideration as Americans. Again, the implication of the INS ruling is that Americans have claims to human rights but that foreigners do not.

Discussion

Walters has recommended that "proponents of any screening policy should be required to demonstrate with convincing data that the program would be more efficacious than alternatives,

such as educational programs, in reducing the spread of infection."[59] For example, in the controversy over the closing of bathhouses,[37] the courts required that health officials prove beyond reasonable doubt that such action would reduce the spread of HIV; they were unable to do so, and some bathhouses remained open.[61] The essential premise of the current screening policy is that would-be immigrants threaten Americans by their sexual or drug-use behavior. To date, there have been no data at all to support the absolute or relative efficacy of screening of immigrants in terms of reducing HIV transmission.

Moreover, this analysis has made it evident that the screening of immigrants is an unethical policy. In a sense, the United States is exercising its limited power to isolate foreign seropositives from Americans; this policy is as indefensible as the suggestion that seropositive Americans should be quarantined from seronegative Americans. The current screening policy does not try to slow the overall spread of HIV, even within the United States; instead, it is an attempt to ensure that if further virus transmission occurs, it occurs elsewhere.

We must ask then, what is the real purpose of this screening program? It cannot have been motivated by a fear that the United States will become a haven for people with AIDS, because the requirements for immigration are difficult to meet. Perhaps the policy is an effort to prevent the US medical system from having to bear the costs of AIDS care for immigrants. The exclusion of seropositive foreigners then becomes an issue affecting the American medical and insurance industries, the most socially primitive in any developed country, and how they meet the basic human right to medical treatment. It could be argued that screening for the purpose of exclusion from Medicaid could go toward solving this problem. But this policy would be no different than screening to exclude someone from the country or from medical care; these alternatives are equally repugnant. Furthermore, the decision to exclude an African national, for example, from entering the United States must be considered in light of the fact that African countries have an enormously higher AIDS death rate, with only a fraction of the resources necessary to tackle HIV disease. The cost of a single HIV test exceeds the annual per capita health spending of many AIDS-affected African countries.[30] Efforts to combat AIDS in the developed world will be completely wasted unless countries such as the United States help poorer nations to fight AIDS. As Lee and Moss have suggested, testing "should probably be undertaken only in the context of an international negotiation that recognizes the overwhelming problem of African AIDS, and the immediate need of many developing countries for international support...."[63] Clearly, until the AIDS crisis is resolved for all of us, it is resolved for none of us.

A government should be responsible for minimizing the spread of disease within its own borders. But blaming Africans, Europeans, or any other foreigners for imposing AIDS upon the United States is a way of disclaiming responsibility for reducing the spread of HIV within the country--among socially marginal groups such as gay men, intravenous drug users, and illegal aliens--as well as reducing virus transmission *from* the United States. This tendency to place blame is evident within American society in the use of the word *innocent* to describe AIDS in children and hemophiliacs; such distinctions extend to the idea of "guilty" foreigners infecting "innocent" Americans with HIV. More than 80 percent of the 3 million illegal aliens seeking amnesty were Hispanic, a group with a disproportionately high seroprevalence rate in the United States and one of the fastest growing rates of infection of any group. Having failed such minority communities, the US government feels no responsibility when it deports or excludes seropositive illegal aliens. Ironically, and tragically, aliens who were excluded must remain illegal and may feel forced into jobs that place them at greater risk for HIV transmission (such as drug pushing and prostitution), creating even larger problems for public health.[30]

In October 1987, United Nations Secretary General Javier Perez de Cuellar noted that AIDS "raises crucial social, humanitarian, and legal issues, threatening to undermine the fabric of tolerance and understanding upon which our societies must function."[62] He concluded that "we must unequivocally establish that our battle is against AIDS, and not against people." It would appear that a growing number of governments are willing to ignore such an exhortation in favor of symbolic measures that offer little more than an illusion of security against AIDS and that have been substituted for less palatable but more effective means of prevention.

It might be expected that blanket measures of this kind would arouse public indignation, as has been suggested.[63] However, the vast majority of Americans will not feel the injustice of this policy directly, and foreigners, without any legal recourse in the United States, will have no choice but to suffer its effects. It can surely be no coincidence that the two groups initially selected for such measures--immigrants and inmates of federal prisons--are effectively without a political lobby through which to defend themselves. AIDS is increasingly seen as a challenge to our social and political systems and, as AIDS researcher Mathilde Krim has noted, "the atmosphere of doom and total helplessness surrounding the problem of AIDS threatens to push us back into a medieval society complete with the equivalent of colonies of pariahs and lepers;...the way in which the US and other countries deal with AIDS may measure the extent to which such nations have the right to call themselves civilized."[64]

US politicians are fond of referring to America's role as a leader in world affairs; in this capacity, the United States sets an example to others in relation to AIDS. Policies adopted in this country may be imitated in other parts of the world. Even the most ardent supporter of the federal screening policy may be

led to question its validity if the tables are turned and other countries rush to impose travel restrictions on US citizens. For instance, Saudi Arabia requires certificates from nationals of countries where AIDS is endemic, such as the United States, and Sri Lanka has considered openly retaliatory measures against countries with offensive policies, again including the United States. Such consequences can hardly have been intended by the US government when the policy was introduced.

It is ironic that the United States prides itself on its respect for individual liberties, while the analysis presented here indicates that this country is now employing the very kind of draconian measures it so often decries in less "enlightened" societies. In the final analysis, it might be hoped that a policy that is so evident a failure will wither in the light of public scrutiny. However, one should not underestimate the degree to which the US government may attempt to mollify public concern about AIDS by introducing programs of largely symbolic value, apportioning blame outside of its own borders, and so generating a smoke screen behind which to conceal its failures.

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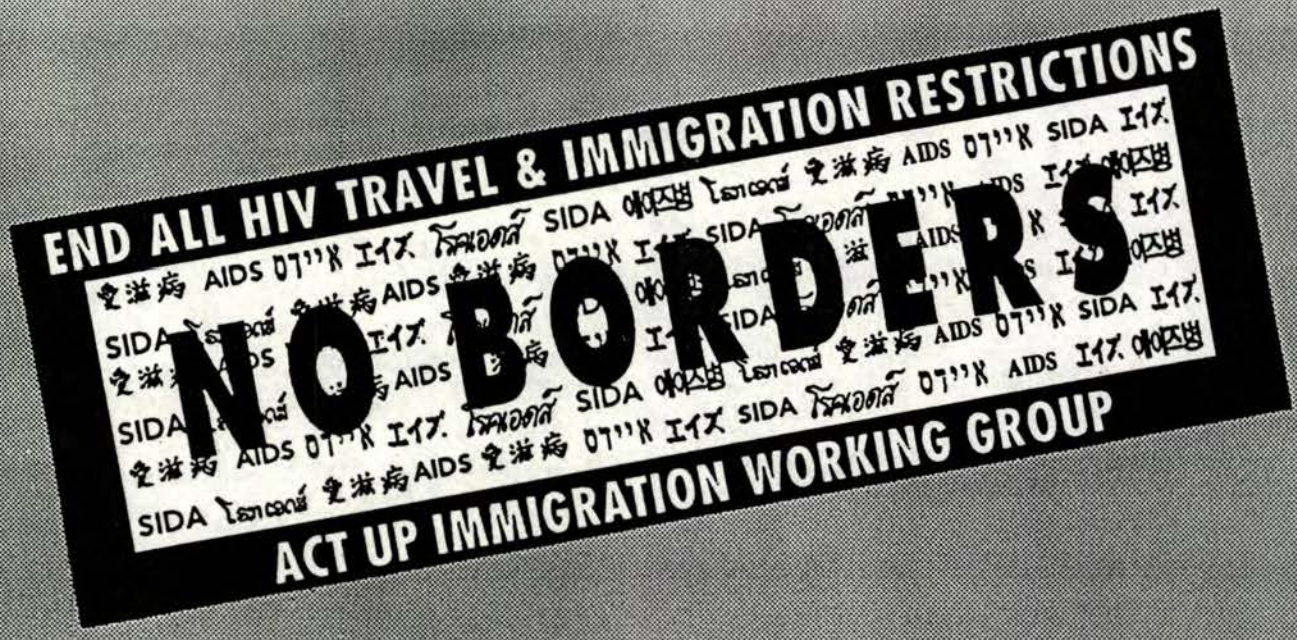
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RESTRICTIONS ON IMMIGRANTS AND TRAVELERS WITH HIV

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Botswana, China, Iraq, Libya, Thailand, United States, South Yemen.

Countries that allow tourists, but have restrictions on those seeking longer stay:

Arab Emirates, Australia, Belgium, Belize, Bulgaria, Chile, Colombia, Costa Rica, Cuba, Czechoslovakia, Dominican Republic, Egypt, El Salvador, Finland, Germany, Hungary, India, Israel, South Korea, Kuwait, Liberia, Mauritania, Mexico, Mongolia, New Zealand, Pakistan, Papua New Guinea, Paraguay, Philippines, Poland, Qatar, Saudi Arabia, Singapore, Spain, St. Christopher Nevis, Syria, Taiwan, Turks and Caicos, Uruguay, Zimbabwe.

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Facts about...

IMMIGRATION AND TRAVEL RESTRICTIONS

- HIV Immigration and Travel Restrictions are a gross violation of human rights. They deny people with HIV the internationally recognized right to freedom of movement.

- Immigration restrictions perpetuate dangerous myths about people with HIV (that there are "contagious" or a threat to public health) and therefore incite bigotry and violence.

- Punitive mandatory testing creates fear and misinformation. It discourages people from getting informed and taking the test. It drives people underground and isolates them. It creates the conditions that beg further transmission of the virus, not its containment.

- The undisputed consensus of public health experts is that only voluntary testing, combined with guarantees of nondiscrimination and access to medical follow up, will help this pandemic.

- Immigration restrictions against people with HIV hamper the free flow of scientific information and interfere with research and study.

- Through its Travel and Immigration restrictions, the United States government conducts the largest mandatory testing program for civilians in the world.

- The U.S. Department of State estimates that the cost of administering the HIV antibody test to refugee applicants alone is $4 million annually. This does not include the costs of testing more sizable immigrant categories.

- The U.S. Immigration and Naturalization Service's (INS) testing program includes no guarantees of confidentiality or pre and post test counseling.

- The vast majority of immigrants in the U.S. who test positive are actually long term residents and were undoubtedly infected in the United States - the country with the largest reported AIDS caseload in the world.

- Most HIV positive undocumented persons in the U.S. have worked and paid taxes in that country for years. Denying them legal status means denying them access to services that they have paid into but never used. Services they need to stay alive.

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An Abbreviated Chronology of U.S. Immigration Exclusion

1875: First restrictive Immigration Act barring "obnoxious immigrants" as immigration is barred for lewd or immoral purposes, convicts and prostitutes.

1882: Chinese Exclusion Act barred all Chinese immigration for 10 years. Chinese people already in the United States were barred from citizenship.

1891: First immigration law excluding persons for public health reasons excludes those with a "loathsome or contagious disease."

1961: Amemdment changes exclusion to "dangerous and contagious disease." Removes statutory references to any specific diseases and gives the U.S. Public Health Service authority to establish an exclusion list to "permit flexibility so that changes as related to specific diseases might be made by regulation in the future as medical progress may indicate."

1970: Without any opposition, the Public Health Service deletes 14 diseases from the list, leaving TB, leprosy and several sexually transmitted diseases on the exclusion list.

June 1987: Under pressure from President Reagan, the Centers for Disease Control adds AIDS to the list but notes that exclusion is not based on any "new scientific knowledge about the transmission or natural history of AIDS," that "AIDS is not spread by casual contact which is the usual public concept of contagious," and that AIDS was added only because other sexually transmitted diseases remained on the list.

July 1987: Helms amendment" signed, directing the President to add HIV infection to the exclusion list by August 31, 1987. The Centers for Disease Control substitutes HIV for AIDS on August 28, to become effective December 1, 1987, thereby creating the largest mandatory civilian HIV testing program in the world.

March 1990: The Centers for Disease Control sends an internal proposal to Louis Sullivan, M.D., Secretary of Health and Human Services, deleting all diseases except infectious TB from the exclusion list; proposal retains HIV on the list because of HHS interpretation that the Helms amendment prevented its deletion, but HHS supports legislation to allow deletion of HIV; HHS never acts on the internal proposal.

May 1990: Comptroller General legal opinion concludes that notwithstanding the Helms amendment, CDC could delete HIV infection (or any other disease) from the exclusion list.

November 1990: Immigration Act of 1990 signed; changes language of the exclusion to "communicable disease of public health significance," directs CDC to establish new exclusion list by June 1, 1991, based solely on "current epidemiological principles and medical standards."

January 1991: CDC proposes list of "communicable diseases of public health significance" removing all disease xcept infectious TB; HHS receives 40,000 pieces of Republican generated mail opposing the change.

May 1991: HHS invites additional public comment until August 2 and receives over 100,000 comments supporting the January proposal to remove all but infections TB from the list.

August 1991: The Harvard AIDS Institute announces that the VIII International Conference on AIDS will be moved from Boston because of the continuing immigration exclusion of HIV antibody positive people.

March/April 1992: Haitian refugees undergo mandatory testing; HIV antibody positive refugees repatriated.

ACT UP IMMIGRATION WORKING GROUP

POSITION PAPER on HIV IMMIGRATION & TRAVEL RESTRICTIONS

The facts have been laid bare for years now. HIV immigration and travel restrictions do nothing to contain the spread of the virus. HIV is not transmitted casually, but through specific behaviors: the sharing of needles and particular types of unprotected sex. Education, access to clean syringes and condoms, and voluntary testing programs without punitive consequences are the proven means of addressing public health concerns around HIV transmission. These survival tools in this pandemic must be made available to everyone; wherever they are, wherever they may go. The virus knows no borders and neither should treatment and prevention efforts. Health professionals know this. Service providers know this. The AIDS activist movement knows this. And medical researchers know this. The governments of the world which attempt to exclude people with AIDS must stop participating in the increased spread of HIV and learn this as well.

Health Exclusion or Bigotry?

Governments have often turned to immigrant populations as scapegoats in times of crisis. For example, the Black Death epidemic that ravaged Europe in the 14th and 15th centuries was commonly considered to have been introduced by Jews and this belief led to the annihilation of much of the European Jewish community. Even a summary glance at United States history books will reveal that immigration restrictions have consistently been based on the worst types of bigotry and hatred. From George Washington prohibiting immigrant service in the armed forces in 1775 (one has to wonder what he considered himself - native?) to the Chinese Exclusion Act of 1882, to the "Helms Amendment" of 1987 which put the current HIV exclusions in place, arbitrary discrimination against minority groups had been a mainstay of U.S. immigration policy. With a broad spectrum of medical professionals, including the United Nation's World Health Organization, calling for an end to all HIV travel and immigration restrictions and affirming that these restrictions have no grounds in clinical or epidemiological research, it is impossible to pretend that these restrictions are anything but another example of exclusion based on irrational hatred, not public health concern.

Destroying Lives

The destructive impact of these restrictions simply cannot be exaggerated. Immigrants who have lived and paid taxes in the United States for years and became infected there live in fear of deportation, unable to access much needed services, uncertain of their ability to maintain essential support networks. Individuals at risk, or possibly already infected, are driven underground rather than learning of their HIV status and facing the punitive consequences. Refugees fleeing political persecution have been repatriated to their certain deaths based on their HIV status alone. These are not merely unfortunate policies that might be changed in a more enlightened future, they are murderous policies that must be overturned at once.

Compassion not Discrimination

In facing this pandemic, the global community must insure that the human rights and dignity of those suffering its devastating effects are preserved. This is the only way to effectively care for people with AIDS and it is the only way to create an environment that prevents its further spread. Immigration restrictions deny people with HIV the internationally recognized right to freedom of movement. These restrictions stigmatize and ostracize people with AIDS and create the erroneous illusion that AIDS can be prevented by shutting a nation's door and purging its populace. This illusion is bitterly ironic in the case of the United States which has the highest AIDS caseload and yet hides behind these restrictions to abdicate its responsibility to the rest of the world. These restrictions are parochial in a time when we must be global. They are discriminatory in a time that pleads for compassion. They are motivated by hate during a crisis that must be faced with medical understanding.

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The Association of Schools of Public Health (ASPH), the only National Association that represents the 24 U.S. Schools of Public Health, joins in opposing current travel and immigration restrictions imposed by the United States against person testing positive to the Human Immunodeficiency Virus antibody test. Such restrictions contradict the recommendations of every major domestic and international public health body. Travel and immigration restrictions are an unwarranted infringement on the human rights of persons living with HIV. Useless for curtailing spread of the virus, these restrictions only serve to lay blame for the epidemic at the feet of those who have suffered most from its devastating effects.

We are especially concerned that the travel and immigration restrictions are interfering with the fight to end the AIDS epidemic rather than aiding it. The moving of the VIII International Conference on AIDS from Boston to Amsterdam is a chilling demonstration of how government policies can create barriers to the free flow of scientific information. Less well known is how travel and immigration restrictions impede access to treatments, interfere with the ability to visit social support networks, and undermine the prevention and treatment campaigns aimed at communities with significant immigrant populations.

In accordance with the recommendations of the Centers for Disease Control and with the initial position taken by Secretary Sullivan, we call on the Bush Administration to lift all travel and immigration restrictions against people with HIV. AIDS policies must be aimed at stemming the spread of the disease, not at discriminating against those infected or at spreading misinformation about it.

A Triumph for the Politics of Homophobia

By Jerome E. Groopman



At first blush, the Bush administration's recent decision to renege on altering the immigration law that bars HIV-infected foreigners from entering this country without a special waiver might seem to make some sense.

Unfortunately the decision owes more to the politics of homophobia and xenophobia than to the ethics of public health.

In our zeal to protect ourselves from infected foreigners, it is easy to forget that Americans have been the main exporters of AIDS to the world. Although the prevalence of HIV infection is highest among populations in Central Africa, they're not mobile.

The World Health Organization recently presented reasonable, conservative estimates of the prevalence of HIV infection among adults between the ages of 19 and 45 in the United States. The data are striking: about 1 in 75 men and 1 in 400 women in this age group carry the virus. Worldwide, there will be 40 million people infected with AIDS by the end of this decade.

The United States now joins such enlightened governments as the Soviet Union and the People's Republic of China in threatening deportation of foreigners carrying the human immunodeficiency virus. France, England, Germany and Italy – to name a few Western countries – have not even raised the idea of such an immigration law.

HIV is a virus transmissible by sexual intercourse, transfusion, intravenous drug use and from mother to child during the birth process. HIV infection leads to AIDS, a disorder of the immune system with development of severe infections, neurological dysfunction and certain cancers.

The general physical condition of people with clinical AIDS is often that of debilitation, and the libido declines at a rate faster than their immune function. Moreover, the vast majority of traveling HIV-infected people, specifically homosexual men, hemophiliacs or women infected through heterosexual intercourse, are generally well educated with respect to both the danger of transmitting the virus to others through unsafe sex as well as their own self-interest in not contracting venereal diseases.

There are no data to suggest that allowing HIV-infected people to enter the United States will contribute to the spread of the virus. The major current vector of the spread of HIV is currently through intravenous drug abuse in the West, and few hard-core addicts have frequent-flier miles to vacation on our shores.

The administration's decision does a great disservice to people with HIV infection and to those involved in the medical struggle against AIDS. It also damages the reputation of our country abroad.

During last year's debate on this question, the organizers of the International AIDS Conference decided the conference would not occur in a nation that discriminates against people with HIV. Harvard University took the appropriate position that it would only serve as the host of the conference planned for 1992 if the law were repealed.

Considerable effort and seed money have already been expended to organize the infrastructure of the 1992 Boston AIDS meeting. All that is now likely to be annulled. The United States has become a virtual pariah nation among scientists and physicians for its stance on HIV.

Despite the rationality of laws against genuine threats to public health from immigrants, the application of the principle to HIV makes no sense. It is a measure essentially directed against homosexuals. That is the resonant chord struck among the right wing, a cheap shot that can be easily exploited in congressional election campaigns. Curiously, there is no effort to extend the regulation to other less stigmatized conditions.

President Bush's child died of leukemia, the nightmare of every parent, and a loss from which one never recovers. He must certainly understand the importance of caring for people with life-threatening diseases.

It stretches the imagination to think he would consciously humiliate patients carrying a leukemia virus for the sake of political expediency by forcing them to obtain a waiver to enter the United States. Would the right wing of the Republican Party score votes in a tight congressional election by boasting that dying leukemia patients were required to obtain waivers to be treated in our cancer centers?

The immigration law snuffs out the thousand points of light formed by the laboratory researchers, clinical care givers, social workers and philanthropists who have committed themselves to battle an epidemic that could lead to the deaths of tens of millions. HIV foreigners will not seek haven in the United States; one need not fear that we will become the hospice of the world for AIDS.

The poor and infected from developing countries are hardly in a position to move en masse to this country. Temporary visitors from other Western countries, if they become sick while in the United States, are covered by their own socialized medical insurance in their country of origin. Those settling here for longer periods of time are not granted visas in the first place without proof that they have the ability to support themselves.

In any case, America is the symbol of freedom, tolerance, rationality and medical excellence, all attributes that provide hope and will to those people with AIDS fighting to survive. We do a disservice not only to ourselves as a caring nation but, more important, to the ill who look to us for medical support and progress that could change their condition from one of great suffering and ultimate death to a more chronic and controlled illness.

Societies have an obligation to protect themselves from importing diseases, but that protection comes from a sober assessment of the real risks posed and the methods needed to reduce such risks. Societies such as ours that are blessed with the highest levels of medical research and technology have the opportunity and responsibility to share such knowledge, not only with scientific peers but also with the patients whose lives depend upon the progress of such research.

The epidemic will not be contained by blocking entry of infected people from abroad who wish to visit, or to get access to an experimental drug, or to receive a second opinion from an expert physician, or attend a conference to both learn and teach.

I am hardly an activist who leaps to the barricades. I am a scientist who believes that real change is effected not by rhetoric but by hard work in the laboratory and in the clinic. But in this case, the chanting of AIDS activists in the streets is echoed in the laboratories and hospitals: "Shame, shame on America."

Jerome E. Groopman is the director of the divisions of blood diseases, cancer and AIDS at Deaconess Hospital-Harvard Medical School. This article first appeared in The New Republic.

This AIDS Ban Invites Ridicule

The American policy to block visits or permanent immigration by foreigners infected with the AIDS virus came under justifiable criticism at the international AIDS conference in Italy this week. The policy has very little public health value. Its chief effect is to make the United States a laughingstock in world medical circles. The policy should be abandoned, quickly.

The U.S. currently bans entry to foreigners infected with several diseases, including syphilis, gonorrhea, leprosy, tuberculosis — and the virus that causes AIDS. But the Department of Health and Human Services has proposed to eliminate all but infectious tuberculosis from the list.

The wisdom behind that proposal seems plain. Neither AIDS nor any of the other diseases to be struck is spread through air, food or water to casual bystanders. Virtually the only way for an adult to get AIDS in this country is through unprotected sexual intercourse with an infected person or by sharing contaminated drug needles.

But the Justice Department, responding to an avalanche of complaints, blocked the new H.H.S. policy, leaving the old rules in place pending further debate. The two chief arguments for the ban are superficially plausible. One is that some of the infected foreigners will surely spread the virus to Americans. The other is that infected immigrants will eventually require costly care.

But the danger is slight. And if cost is the issue, then the U.S. would ban all foreigners with kidney disease, cancer or other costly ailments. It enforces no such mean-spirited policy in those cases, nor should it for AIDS.

The ban is particularly silly for short-term visitors. Trying even to identify such individuals brings widespread condemnation. The World Health Organization and European health ministers plan to boycott the international AIDS conference in Boston next year unless the U.S. changes its policy.

How to handle foreigners seeking permanent residency is a tougher issue because the longer they stay the greater the chance some might spread the virus or require care. But by one government estimate, only about 600 AIDS-infected individuals would be admitted as permanent residents each year — compared with a million Americans already infected. And finding them among the 600,000 admitted each year would require costly testing. If the goal is to fight AIDS, this is not where to spend the money. The rate of infection is far less among the foreigners than among Americans.

What a travesty that the United States, with one of the largest AIDS-infected populations in the world, has taken a stance that implies the danger comes from abroad. The Bush Administration should reverse this ban, whose chief effect is to give the U.S. an international black eye.

Richard Cohen

AIDS and Immigration

The word for the day is "counterintuitive." It means that something that seems to make sense actually does not. Take, for example, the question of whether persons with AIDS should be admitted to this country. The Department of Health and Human Services says "yes," but the Justice Department, which has the last word, says "no." Common sense says Justice is right. That, folks, is what we mean by counterintuitive.

Since AIDS was first identified 10 years ago, AIDS activists have been looking for two things: a cure for the disease and a way of uncoupling it from hostility to gays. So far, so bad. No cure has been found, and the dispute between HHS and Justice is just additional evidence that anti-gay bias infects the debate about AIDS. If gays got the sniffles, anti-gay crusaders like Sen. Jesse Helms (R-N.C.) would find a reason to bar them from this country.

Yes, I hear you mutter, but AIDS is not the sniffles. Not only is it communicable, but it's always fatal as well. True enough. But some facts need to be considered. The first is that you and I need not be at risk. AIDS, as opposed to infectious tuberculosis (another proscribed disease), is not casually communicated. To get AIDS, a person has to engage in certain kinds of (unprotected) sex or use an infected needle. That's not the same thing as being downwind from someone with TB.

Second, we are not talking about introducing AIDS into this country, but adding only incrementally to the legion of victims already here. They number over 1 million, with more than 100,000 deaths already recorded. So when HHS Secretary Louis Sullivan says that "allowing HIV-infected aliens into the country will not impose a significant additional risk" he is simply stating the obvious. Since certain other communicable diseases (some of them transmitted sexually) were dropped from the list, Sullivan treated AIDS no differently.

That's where he miscalculated. Justice, which runs the Immigration and Naturalization Service, used its veto. In doing so, however, it did not question Sullivan's medical judgment but pointed instead to the more than 30,000 letters it had received protesting the proposed new policy. That's a lot of letters—some of them, I am told, from physicians and other health practitioners and none bearing the tell-tale signs of an organized campaign. Nonetheless, medical issues should not be decided by a show of hands.

Was Justice basing its decision on public health and economic concerns (the expense of long-term care), or was it pandering to a conservative constituency? It's hard to say, but some hints exist. In the first place, Attorney General Dick Thornburgh has shown the Bushian penchant to find his political principles in public opinion polls. And, second, it's Thornburgh, not HHS Secretary Sullivan, who announced for a U.S. Senate seat from Pennsylvania. That might explain why only in Washington is a second medical opinion sought from a lawyer.

Trouble is, both sides are adept at playing politics. For their part, homosexual advocates would have more credibility if they ceased being so defensive and, at times, so casual with the truth. They fight attempts to have AIDS-infected physicians or dentists identified. They are averse to contact tracing, although people with other sexually transmitted diseases are routinely asked what they did and whom they did it with. They fight patient screening in hospitals—as if physicians and nurses needn't know when alertness is required. And they have sometimes distorted the government's immigration policy. For many gays, personal privacy, not public health, is the main concern.

AIDS activists have legitimate concerns. In the public mind, procedures that identify AIDS victims identify homosexuals as well. Moreover, it's always open season on gays. For instance, when Helms attacked affirmative action in his reelection campaign, he was roundly condemned for race-baiting. But when he said homosexuals were "buying" the election for his opponent, a deafening silence was heard in the land. The awful truth is that when it comes to standing up to homophobia, most politicians are just plain sissies.

But when it comes to the deadlock between HHS and Justice (due to be settled in July), AIDS activists have the better arguments. If all of the terminally ill are to be excluded, fine. If all communicable diseases are to be proscribed, again fine. But when Justice makes its stand on the one disease associated with an unconventional life style, gays and others are entitled to suspect that politics, not medical science, is the reason. That's not counterintuitive but as plain as the nose on your face.

THE WASHINGTON POST June 14, 1991

THE WASHINGTON POST August 2, 1991

U.S. Won't Lift HIV Immigration Ban

Cost of Treating Those Who Develop AIDS Called Unacceptable

By Malcolm Gladwell
Washington Post Staff Writer

Federal health officials have decided, after seven months of review, not to lift the controversial, four-year ban on immigrants infected with the AIDS virus.

The decision, which sources said will be announced officially within a few days, reflects the conviction of many inside and outside the Bush administration that the cost of treating immigrants who eventually develop AIDS poses an unacceptable burden to the U.S. health care system.

The organizers of next year's international AIDS conference, which had been scheduled for Boston, have said that unless the U.S. restrictions were lifted, they would cancel the event.

The move appears to end a bitter debate in the administration, in which the Justice Department fought the Health and Human Services Department's recommendation to drop the restriction. But the way the decision was reached has left AIDS activists and public health groups angry and frustrated.

Chief among their complaints is that the Bush administration has declared the costs of treating immigrants unacceptable, without providing any estimate of what those costs really might be. Various interest groups have come up with their own widely differing estimates, painting what many call a confusing picture of the true implications of excluding immigrants infected with the virus.

"We wish there could have been an open debate that could have dealt forthrightly with the issues of access to health care and cost," said W. Shepherd Smith Jr., president of Americans for a Sound AIDS Policy.

"We are making policy in a vacuum," said Jeff Levi, director of government relations for the AIDS Action Council.

See AIDS, A6, Col. 4

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AIDS, From A1

HIV immigration restrictions were enacted by Congress four years ago. At the request of Sen. Jesse Helms (R-N.C.), HIV was added to the list of infectious diseases—which includes tuberculosis, syphilis and hepatitis—for which all would-be immigrants must be tested and which are deemed sufficient, on public health grounds, to deny the immigrant a visa. Congress subsequently passed a law transferring to the president the power to alter the list.

Since then the health justification has been attacked by many public health experts, from the World Health Organization to senior health officials in the Bush administration, who said that because HIV could not be transmitted casually, HIV-infected immigrants did not pose a health threat to others. At the beginning of this year the administration proposed that the ban be dropped.

By May, however, proponents of the ban countered with a new argument, namely that HIV-infected immigrants should be turned away because they might pose an economic burden.

"I for one don't want to come out 100 percent against discriminating against HIV and against gays," said Stanford University bioethicist Peter Carpenter. "But the question is not the disease. The question is that when we know or could easily know that someone is going to cost a great of deal of money and is not going to be able to pay for their care, should that be a factor in the admissions process? I'd say we'd be crazy not to use it."

But while the economic argument has gained popularity, it is not clear what that economic burden would be.

For example, a Canadian study estimates that the percentage of infected immigrants to Canada is between 0.2 and 0.4 percent of all newcomers. Two weeks ago, Rep. William E. Dannemeyer (R-Calif.) extrapolated from these figures to project that between 3,000 and 6,000 HIV-infected people would come into the United States each year. Dannemeyer sent his estimate to the White House, where it is said to have played a key role in convincing the administration to continue backing the HIV restriction.

Dannemeyer's numbers are controversial. First of all, the Canadian percentages were based not on immigrants but on the prevalence of HIV infection in countries from which Canadian immigrants come. Some AIDS experts note that HIV infection in these countries is concentrated among prostitutes and drug abusers, not the groups seeking to emigrate.

Further, in making his estimate, Dannemeyer used the total number of immigrants for 1990, nearly two-thirds of whom were illegal aliens granted citizenship under a special amnesty law. That law allows them to apply for a waiver if they test positive and get in anyway.

The people truly affected by the HIV ban, immigration experts say, are the 600,000 granted traditional visas every year. Even using the disputed 0.2 to 0.4 percent infection rate, that gives a lower estimate of from 1,200 to 2,400 HIV-infected immigrants yearly.

An entirely different set of figures comes from the State Department's HIV testing data, which show that adult immigrants tested by the government from 1988 to 1990 had an average HIV infection rate of approximately 0.1 percent. This amounts to just under 500 people a year.

AIDS experts say, however, that if the ban were lifted, many who now do not bother to apply would probably do so. Factoring in these extra people, some administration health officials have estimated there would be between 600 and 800 HIV-infected immigrants annually.

Depending on which estimate is used, the projected cost of caring for immigrants with AIDS varies widely. Dannemeyer estimates that the cost of caring for infected immigrants—and for those whom the immigrants infect—could come to as much $720 million a year.

Using the State Department numbers as a base, however, and a more modest estimate of how many additional infections would result, gives an estimated annual cost of just over $60 million, assuming not one of them has private health insurance.

AIDS groups also say that the cost of HIV in immigrants is less than the cost of other diseases routinely allowed into the country. The same Canadian study estimated that 1.6 percent of all immigrants would suffer from coronary heart disease within 10 years of arrival, at an average cost of $17,618 each. Extrapolated to the United States, these calculations mean that each year's immigrants could be expected to run up $170 million in heart disease-related expenses.

"If the policy is that the country should not admit those who are likely to become public burdens, then that should be applied across the board to persons regardless of illness or circumstance," said Tom Stoddart of the Lambda Legal Defense Fund in New York.

San Francisco Examiner

May 29, 1991

The right decision loses

Aliens with the AIDS virus are not a threat to public health and should be allowed into the U.S.

POLITICS AND public health don't mix.

Dr. Louis Sullivan, the secretary of Health and Human Services, concluded last January that infection with HIV, the virus that causes AIDS, should not be grounds for barring an alien from the United States. AIDS is not spread by casual contact, he said, so "allowing HIV-infected aliens into this country will not impose a significant additional risk of HIV infection to the U.S. population." This was the correct public health decision and the correct social policy.

But the Justice Department could not leave well enough alone. The department was swamped by letters from people who want to keep out HIV-infected aliens. So it has intervened and reversed Sullivan's decision. Not for medical reasons, but for political reasons, pure and simple. With only ideology behind it, the Justice Department has decided that Sullivan failed to justify his conclusion that HIV infection is not "a communicable disease of public health significance."

When Congress passed the new immigration law last fall, it empowered Sullivan to make this judgment. The controversial, automatic exclusion of aliens with the AIDS virus was removed from the law, and it was left to the secretary of Health and Human Services to determine the appropriate policy. The new law, which takes effect this Saturday, requires that aliens be excluded if they have "a communicable disease with public health significance." The secretary was to make the determination "based on current epidemiological principals and medical standards."

AIDS is not easily communicable. If you could catch it from sneezing, high-risk groups would not exist, and the incidence of the epidemic would be much, much greater than it already is. Sullivan concluded that the disease "is transmitted among adults in this country almost exclusively by two routes: sexual intercourse with an infected person and sharing of contaminated" needles. He removed HIV infection from the list. The Justice Department, which oversees the Immigration and Naturalization Service, now says that people who are HIV positive might become public charges and should therefore be excluded under a different section of the immigration law.

The intention of Congress was to let the secretary of Health and Human Services make this decision as a medical judgment. Sullivan has done that. His decision was based on reason and public health, not politics and fear. Congress should write Sullivan's decision into law.

ACT UP | IMMIGRATION WORKING GROUP

BAY AREA REPORTER AUGUST 6, 1992

Community News

Travel and Immigration Restrictions Foster Spread of HIV in U.S.

Tomas Fabregas is a Spanish citizen and permanent resident of the United States. Diagnosed with AIDS in 1989, Fabregas announced at the International Conference on AIDS that he would return to San Francisco in violation of federal law excluding people with HIV from entering the country. Fabregas arrived at San Francisco International Airport July 25 and reentered the country without incident.

by Tomas Fabregas



Tomas Fabregas and his lover Jeff Brooks (Photo: Rick Gerharter)

Imagine the federal government targeting large segments of the city of San Francisco and taking steps to impede its access to AIDS education and prevention programs. Imagine the government repeating that process in cities all across the country. The threat to the people directly affected and to the public health is obvious. Nevertheless, that is one of the practical results of the Bush administrations's ban on HIV-positive immigrants and travelers.

Commentary

1990 census figures show that since 1981, nearly 600,000 foreign-born persons have settled in the San Francisco Bay Area, making up about 20 percent of the current population. There are now 17 million foreign-born persons living in the United States of America. I am one of them. We need the information that can help us protect ourselves from HIV infection. Those of us who become infected must be reached with the emotional and practical support required to ensure that the virus is not passed on to others. But we do not find the threat of deportation appealing, and so we hide. And when millions of people are not reached with the help we know they need, the transmission of the virus continues unabated, and every person in the country is placed at greater risk.

For years, the activist community has warned that these restrictions foment prejudice and violence against people living with HIV. For some very unlucky Haitians this has certainly proven to be true. Earlier this year, the United States National Commission on AIDS filed a friend of the court brief supporting a request for an injunction against the Bush administration and its preferred method for handling HIV-positive Haitians, even those who had established that a return to Haiti would jeopardize their lives. The National Commission documented reports of the United States Army beating and starving asylum seekers until they would consent to HIV testing. When some of the refugees refused, they were held to the ground by American soldiers and blood was drawn forcibly from their arms. And, of course, those testing positive for HIV antibodies immediately had their refugee status "reviewed," and they were returned to Haiti.

In a field fraught with controversy, on this point there is consensus within the medical, scientific, public health and activist communities. There is no public health interest served by prohibiting HIV-positive people from entering the United States. In fact, the fear and intimidation these restrictions create drive significant populations underground and away from AIDS education and prevention services. These restrictions foster the spread of HIV.

In the absence of any public health need for these restrictions, it is important to us all that they be dropped. HIV infection is not a just basis for censure. In 1987, the immigrant community was sacrificed to the radical right and its punitive views on HIV. Last year, health-care providers came under attack. Who will it be next year? You?

Last month, at the AIDS Conference in Amsterdam, I challenged George Bush to prevent me from returning to my home in the Bay Area. If my presence was any threat to the citizens of the United States, it would have been incumbent upon him to keep me out. Instead of being kept out, I was ushered in. A special immigration desk was opened at San Francisco International Airport to expedite my reentry. My thanks go to the immigration working group of ACT UP/Golden Gate and ACT UP/San Francisco, the San Francisco AIDS Foundation, and to everyone who has publicly opposed these dangerous restrictions. ▼

ACT UP | IMMIGRATION WORKING GROUP

Spanish Man Who Has AIDS Defies U.S. Ban

THE WALL STREET JOURNAL.

MONDAY, JULY 27, 1992

By MARILYN CHASE
Staff Reporter of THE WALL STREET JOURNAL

SAN FRANCISCO – The U.S. Immigration and Naturalization Service allowed a Spanish citizen with AIDS to return to his adopted home here in what supporters called a symbolic victory in their fight against the Bush administration's controversial five-year-old ban on immigrants with the AIDS virus.

Tomas Fabregas Boudin, flew to the U.S from the international AIDS conference Saturday after publicly annoucing his condition and daring the INS to expel him. But local INS officers declined to invoke the law, whisking him through a special immigration booth.

"Mr. Bush, I am home," he said in a speech before a crowd of supporters at San Francisco International Airport. Mr. Fabregas has lived and worked in the U.S. since 1979, and holds a "green card" as a legal resident alien.

In Washington, an INS spokesman said enforcing the ban against Mr. Fabregas was never in question due to his status as a legal alien. The agency added that Mr. Fabregas didn't declare that he had acquired immune deficiency syndrome upon landing Saturday. However, Mr. Fabregas had televised his challenge and wore a T-shirt with the slogan "No Borders."

While medical experts have vehemently opposed the ban, conservative politicians support it largely out of a fear that foreign AIDS patients will flock to the U.S. for health care. The AIDS conference was moved to Amsterdam from Boston because of the immigration ban.

The 34-year-old Mr. Fabregas was diagnosed with AIDS in 1989 when he was studying for a business degree at the University of California at Berkeley. "In the 3½ years since my diagnosis, the fear of my deportation has been constant," he said, adding he wants to help the 4.5 million people a year who now must submit to testing for the human immunodeficiency virus in order to apply for U.S. residency.

Despite the INS denial that it sets any precedent, Mr. Fabregas' companion Jeffrey Brooks insisted the case symbolically removes "a piece of the wall."

"If he'd represented any kind of public health threat, INS would have been compelled to keep Tomas out," said Mr. Brooks. "The fact that they didn't do so means there is no threat."

DER TAGESSPIEGEL

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Gesucht: Eine Strategie gegen Aids

Von Hartmut Wewetzer

„Eigentlich sollte ich mich um meine Krankheit kümmern"

Beim Internationalen Aids-Kongreß in Amsterdam gelang der schwierige Dialog zwischen Betroffenen und Wissenschaftlern / Von Justin Westhoff

AMSTERDAM, 23. Juli Grauer Flanell und Krawatte, ernste, aber emotionslose Mienen, wissenschaftliches Kauderwelsch und abgehobene Vorträge – so stellt man sich Fachkonferenzen vor, und so laufen sie ja auch fast immer ab. Bei einer der größten wissenschaftlichen Veranstaltungen überhaupt, dem jährlich stattfindenden Kongreß über das erworbene Immundefekt-Syndrom, war es dieses Jahr in Amsterdam ganz anders – innerhalb und außerhalb des Kongreßzentrums. Die ganze Stadt mit ihren fast 800 000 Einwohnern schien sich darauf eingestellt zu haben, und schon vor Beginn des offiziellen Teils war es mit der Beschaulichkeit der Grachten vorbei. Demonstranten trugen Särge durch die Straßen, und sie trafen auf einhellige Zustimmung. „Aids kennt keine Grenzen" hieß das in jedem Sinne des Wortes zutreffende Motto. Der Protest richtete sich gegen die Einwanderungspolitik zahlreicher Staaten, gegen die auch seuchenpolitisch sinnlose Diskriminierung von Menschen mit HIV und Aids. Der Demonstrationszug hielt vor mehreren Botschaften an, und er wurde schließlich – dies war das erstaunlichste – zum festen Bestandteil des 8. Welt-Aids-Kongresses.

Hier wurde nicht mehr über „Betroffene" geredet, sondern mit ihnen. Sie hatten im vor dem Kongreß erheblichen Einfluß auf die Gestaltung des wissenschaftlichen Programms nehmen können. Offenbar mußten die Experten bei dieser neuen Pandemie, bei dieser weltweiten Seuche, schneller als bei jeder anderen Krankheit lernen, wem ihr Wissen und Streben zu dienen hat; sie haben vor allem rasch gelernt, daß das erworbene Immundefekt-Syndrom mehr ist als ein Virus. Aids ist eine tödliche Krankheit, aber Aids ist auch Ausdruck der sozialen Benachteiligung vieler Menschen. Und es ist eine ökonomische Bedrohung, die nur noch von Einsichtslosen im satten Norden geleugnet wird. „Es gibt immer noch Mediziner und Politiker, die glauben, daß sie alles im Griff haben oder daß Aids in ihrem Land beherrschbar bleibt", schüttelte ein Referent den Kopf. „Wir sollten sie in einen Jumbo stecken und beispielsweise nach Zentralafrika fliegen – sie würden mit einer völlig veränderten Einstellung zurückkommen."

In Amsterdam aber trafen sich Fachleute: jene, die durchs Rasterelektronenmikroskop schauen, und jene, die in ihrer Umgebung, bei Betreuten und Freunden, täglich mit Leid und Tod zu tun haben. Der alles überragende Eindruck: Sie haben längst begonnen, voneinander zu lernen. Wenn es um die medizinische Behandlung ging, dann konnten Laienhelfer darüber berichten, woran es mangelt. Und die Eröffnungsfeierlichkeiten – sie waren kein Defilee selbstgefälliger Nobelpreisanwärter, sondern typisch für diese Art der Integration von Sozial- und Naturwissenschaft, Medizin und Politik.

Sicherlich, der Minister, der Bürgermeister und noch ein paar Honoratioren verlasen ihre Grußworte. Doch schon als die ersten Wissenschaftler, weltbekannt auf ihrem Teilgebiet, das Wort ergriffen, wurde deutlich, daß es mit der Geduld vorbei ist. Egal, ob Immunologe oder Psychologe, egal, ob Aids-Kranker oder Sozialarbeiter: Ein Redner nach dem anderen attackierte mangelnde Menschlichkeit und Einsicht der Verantwortlichen – und stellvertretend für alle: George Bush. Die amerikanische Regierung läßt Menschen, die mit dem Humanen Immundefekt-Virus (dem HIV) infiziert wurden, nicht einreisen, obwohl jeder Drittklä[ß]ler heute weiß oder wissen sollte, daß vom alltäglichen Umgang mit ihnen keinerlei Gefahr ausgeht. Dies war der Grund dafür, daß die internationale Aids-Fachgesellschaft den Weltkongreß vom ursprünglich geplanten Tagungsort Boston abzog und nach Holland verlegte. Doch die Empörung hat sich immer noch nicht gelegt: Selbst als dem oberste Mediziner der USA das Wort „Arschloch" nachgerufen wurde, waren nur wenige pikiert.

Liz Taylor, auch in Amsterdam Anziehungspunkt für Kameraleute und Fotografen, veranstaltete ihre Pressekonferenz einen Tag später, in ihrer ganz anderen Rolle als Vorsitzende der Amerikanischen Stiftung für Aids-Forschung (AmFAR). Befragt, inwieweit Forschungsförderung helfe, wenn das soziale und politische Klima zur Bekämpfung von Aids (und nicht der Aids-Kranken) nicht stimme, sagte sie nur: „Ich glaube auch, daß Herr Bush nicht einmal weiß, wie man Aids buchstabiert."

Anders als beim Hollywoodstar sprach über Thomas Fabregas niemand, bis zum 19. Juli 1992, dem Tag der Eröffnungsveranstaltung des Weltkongresses. Der gebürtige Spanier lebte seit einem guten Jahrzehnt in San Francisco, wo er sich mit HIV infizierte. Nach einer Reise befürchtet er, nicht mehr „nach Hause" gelassen zu werden. Auftritt in Amsterdam, ganz im offiziellen Rahmen: Thomas verkündet Flugnummer und genaue Ankunftszeit in „Frisco" und ruft aus: „George Bush soll doch persönlich kommen und versuchen, mich vor den Augen der Presse an der Einreise zu hindern." Und darauf hin geschieht, was die Stimmung wohl am besten kennzeichnet: Nicht nur Aids-Aktivisten jubeln ihm zu. Alle im riesigen Saal stehen auf und spenden Beifall, auch hochseriöse Forscher im feinen Tuch.

Seither ist Thomas Fabregas ein Medienereignis. Um ihn herum scharen sich im Pressezentrum beinahe genauso viele Reporter wie um den französischen „Aids-Star" Professor Luc Montagnier; und vor den laufenden Kameras von CNN darf Fabregas sagen: „Es ist eine Schande, daß ich nun Politik machen muß, daß ich diesem Streß ausgesetzt bin, weil die Politiker in meinem Land versagen. Eigentlich sollte ich mich um meine Krankheit und meinen Immunstatus kümmern."

Dieses „shame on you" wurde gleich ein weiteres mal proklamiert, auch diesmal einhellig beklatscht. „Schande über die Pharmafirma", die ein Medikament zur Behandlung von HIV-Folgekrankheiten so teuer verkauft, daß eine Therapie alleine damit jährlich an die 25 000 Dollar kostet. Es sieht so aus, als ob sehr viele Ärzte dem Boykottaufruf der amerikanischen Aids-Aktivisten-Gruppe „Act Up" gegen dieses Unternehmen folgen werden.

„Act Up" und andere Aids-Aktivisten-Gruppen haben viel erreicht. Die Vorgänger des von gut tausend Journalisten aus aller Welt beobachteten Amsterdamer Ereignisse, die Kongresse in Florenz, San Francisco und Montreal, waren von ihnen massiv gestört worden und drohten teilweise zu platzen. Der diesjährige Kongreßpräsident, Jonathan Mann, hat dafür gesorgt, daß sie nun zu den mehr als zehntausend Teilnehmern der einwöchigen Konferenz gehören. Eine Puertorikanerin aus einem Armenviertel New Yorks berichtet über ihre Leiden unter HIV; sie wird warmherzig empfangen. Eine Gruppe von Frauen aller Hautfarben stellt sich und ihr Programm vor und macht nachvollziehbar, wie sehr die zusätzlichen Bürden von HIV-positiven und aidskranken Frauen bisher vernachlässigt worden sind, obwohl – international gesehen – die Hälfte aller Infizierten Frauen sind.

Wohl bei keinem Welt-Aids-Kongreß zuvor waren auch so viele Vertreter jener Länder, die in einem ganz anderen Ausmaß unter der Pandemie leiden als die reichen Industriestaaten. Die massive Präsenz der „Dritten Welt" allerdings ist wohl kaum ein Verdienst der Aids-Aktivisten, die denn doch zu sehr auf ihre Klientel aus der nördlichen Erdhälfte schauen. Jonathan Mann, in Unfrieden als Direktor des Aids-Programms der Weltgesundheitsorganisation (WHO) geschieden, hat hier wohl korrigierend eingegriffen. Er rief in Amsterdam zu einer „neuen Aids-Initiative" auf. Für ihn sind zwei Voraussetzungen zu erfüllen, wenn der „Kampf" einigermaßen erfolgreich sein soll. Es bedürfe eines viel massiveren Einsatzes der Politik und eines verständigen Klimas. Und gefordert sei die Einsicht, daß Krankheiten solchen Ausmaßes nur besiegt werden können, wenn die enormen sozialen und ökonomischen Unterschiede in der Welt verringert werden. „Wir müssen endlich das Menschenrecht auf Gesundheit durchsetzen", sagte der von manchen Naturwissenschaftlern eher skeptisch beäugte Aids-Experte. Vielleicht nannte Mann dieses Treffen deshalb einen „Kongreß der Hoffnung", obwohl er und andere ein düsteres Bild von der epidemiologischen Entwicklung zeichneten und obwohl „wir mit unseren Bemühungen immer mehr hinter der Katastrophe herlaufen". Die Hoffnung bedeutet, daß von Amsterdam jene Menschenrechtsinitiative ausgehe.

Horizonterweiterung

eid Von höchster Warte wird am östlichen Firmament „Bewegung in der Sache" geortet. Ein „Entscheidungshorizont" ist in Sicht! Endlich, endlich nähert sich die unendliche Geschichte um den Republikflüchtling Honecker dem Ende, mag man meinen. In der Tat, es war der Kanzler höchstpersönlich, der – in fürsorglicher Aufschüttung des in seiner Abwesenheit stets drohenden Sommerlochs – der gespannten Öffentlichkeit des Ferienrätsels Lösung schenkte: Honecker am Horizont! Da muß was dran sein. Wir hätten ihn ja fast schon vergessen, den Scheinasylanten. „Totale Spinnerei", erhebt da der trotzige Berliner Anwalt Honeckers Einspruch und hält so, im trefflichen Zusammenspiel mit Kohl, die Sache tatsächlich auf Touren. Wir sind dankbar, aber: Halten zu Gnaden, Herr Advokat! Das Argument, Mann, habe Ihnen glaubhaft andere Reisepläne versichert, hilft nicht weiter. Sie wird keineswegs zu Rate gezogen werden, wenn die Beratungen zwischen Bonn, Moskau und Santiago jetzt in den dann sicherlich freiwilligen Entschluß der Chilenen munden, das Paar doch besser vor die Botschaft in Moskau zu setzen. Es gibt wahrlich nichts mehr zu deuteln: Die Einheitsbetten in Moabit sind gemacht, die grauen Wolldecken ausgerollt. Schon wieder.

de Volkskrant VAN VRIJDAG 24 JULI 1992

Nee, laten we het vandaag maar niet over Liz hebben

Van onze verslaggever
ERIC VAN DEN BERG

AMSTERDAM — Wat zullen we vandaag schrijven over Liz Taylor? Ze is per slot van rekening beschermvrouwe van de achtste internationale aids-conferentie, in Amsterdam, en ze heeft gisteren de wereldpers uitgenodigd voor enkele *remarks*.

Zullen we schrijven dat de persconferentie in de RAI — voor acht tv-camera's, dertig fotografen, honderd journalisten en evenveel sympathisanten en fans van Liz — geen nieuws bevatte? Want we wisten al dat de zestigjarige actrice hier niet had moeten zijn, omdat de conferentie in Boston gehouden had moeten worden. 'Niemand had hier vandaag moeten zijn. Maar de droevige en vreselijke waarheid is dat de regering van de Verenigde Staten te dom, te arrogant en te laf is om mensen met een HIV-infectie niet vrij te laten reizen en immigreren in Amerika.'

Nee, dat zou dus idioot zijn, ook al geeft de helft van de zaal Liz een staande ovatie en schreeuwen velen '*Alright. Yes. Alright Liz.*' We weten al dat Taylor, voorzitter en fondstrekker van de *American Foundation for Aids Research* (Amfar), tegen elke reis- en verblijfbeperking voor aids-patiënten en seropositieven is. En dat ze George Bush voor het oog van de wereld wederom oproept de restricties op te heffen, als voorbeeld voor de 46 andere landen die ook beperkingen opleggen aan HIV-geïnfecteerden.

'Laten we beginnen met Amerika', zo staat in de tekst die Taylor foutloos uit haar hoofd voordraagt met veel klemtonen en trillingen, 'President Bush, maak dat we tróts zijn op de Verenigde Staten. Laten we de mensen binnen laten, die komen om te worden behandeld of komen om wat tijd, wat kostbare tijd door te brengen met familie en vrienden.'



Liz Taylor krijgt naar haar speech applaus van aids-patiënt Tomas Fabregas (links) en voorzitter Murphy van de Wereld Federatie voor Hemofilie. Foto Ard Nuis

Bush of Clinton, het maakt Taylor niet zo veel uit, al laat Bill Clinton, presidentskandidaat voor de Democraten, in een brief aan de voorzitter van de aids-conferentie weten dat er onder zijn presidentschap een einde komt aan de discriminatie van aids-patiënten en seropositieven bij de grens. 'We kunnen het ons niet veroorloven om nog eens vier jaar niets te doen, en achterover leunend onze mensen dood te zien gaan', aldus Clinton. De inhoudelijke reactie van Taylor: 'We steunen iedereen die ons steunt.' Applaus. *Yeah.*

Zullen we dan maar schrijven dat de diva wellicht binnenkort wéér een persconferentie geeft? 'Als Tomas dat wil, *sure*', zegt ze tegen Tomas Fabregas, een seropositieve man uit Amerika, die op de persconferentie zijn verhaal mag doen. Hij heeft zijn moeder bezocht in Spanje en de conferentie in Amsterdam en keert zaterdag terug naar San Francisco. 'Vergeet het niet. Zaterdag 25 juli, *United Airlines* vlucht 931, London Heathrow naar San Francisco, aankomst 4.50 uur 's middags. Meneer Bush, ik ga naar huis.' Als Tomas het land niet in mag, verschijnt — ze heeft het beloofd — Liz weer op het toneel.

We zouden ook kunnen opschrijven wie er — o ja — ook nog iets hebben gezegd op de persconferentie. Liz is met ieder afzonderlijk op de foto gegaan, met de directeur van de Wereld Federatie voor Hemofilie, met de vertegenwoordiger van de Wereld Gezondheidsorganisatie, met Tomas. De voorzitter van de Nederlandse HIV-vereniging staat alleen op de groepsfoto's. De fotografen moeten bukken, want CNN wil het plaatje ook schieten. Op de foto staat ook de achtste echtgenoot van Taylor, Larry Fortensky. Die was er ook. We kunnen opschrijven dat het nieuws is dat ze nog steeds bij elkaar zijn, maar daar zijn andere bladen voor.

Hollywood dan maar? Hoe gaat Hollywood om met aids en seropositieven — de link met Liz is gevonden. Er is een serieuze vraag over gesteld. Is het waar dat de sterren heel terughoudend of zelfs afwijzend reageren op besmette acteurs? Er is nog veel onwetendheid en angst, dat is waar, zegt Taylor, wier vriend Rock Hudson aan aids is overleden, maar ze zijn '*really trying*'. 'LA is wakker aan het worden.'

Aids en toch een beetje showbiz. Zo moet het dan maar duidelijk worden. Tomas ('Ik zou graag willen dat mijn geliefde nu ook naar voren komt') krijgt een zoen van de ster, en nog eentje voor de foto. *You should be running up for president, miss Taylor!*, schreeuwen omstanders. *Liz for president! Yeah.*

Nee, we schrijven vandaag maar niets over Elizabeth Taylor.

ACT UP
IMMIGRATION WORKING GROUP

Buenos Aires, viernes 24 de julio de 1992 ★ CLARIN

EN EE.UU. PROHIBEN EL INGRESO DE PERSONAS ENFERMAS

Liz Taylor atacó a Bush por su política sobre el SIDA

AMSTERDAM (ANSA y EFE). — **"George Bush** está equivocado. Ningún presidente, primer ministro ni rey tiene el derecho de impedir el ingreso a un país de gente inofensiva e inocente". Con estas palabras, la actriz **Liz Taylor** le recriminó al presidente Bush su política de inmigración que prohíbe el ingreso a los **Estados Unidos** de los enfermos de **SIDA**.

Convertida en una activa defensora de los derechos de los enfermos de SIDA, Liz Taylor dijo que "el horror y la vergüenza que provoca esta desgraciada política son compartidos por millones de norteamericanos, que luchan contra las directivas discriminatorias de **Washington**".

El gobierno de los Estados Unidos exige un visado especial a todos los enfermos de SIDA que estén por viajar a ese país. Estas disposiciones impidieron la realización de la **VIII Conferencia Internacional sobre el SIDA**, en **Boston**, como estaba previsto. La sede de la reunión se trasladó a **Amsterdam**, donde se realiza actualmente.

Liz Taylor, titular de la **Fundación Norteamericana para la Investigación sobre el SIDA**, participó ayer en una reunión de prensa donde se trató el tema de la **discriminación contra los enfermos de SIDA**. Al comparar la actitud del gobierno de Bush con la de las autoridades holandesas dijo: "Qué ejemplo para los de Washington, que crearon y reforzaron una reglamentación tan odiosa y arbitraria".

La actriz mostró ante los periodistas su pasaporte del **Reino Unido** y agregó: "Si tuviera SIDA y fuera a los Estados Unidos este documento me obligaría a regresar".

El lunes, Liz Taylor había considerado que "la **Argentina** es un país **al borde del precipicio** en cuanto a la incidencia del SIDA" porque "se está produciendo un explosivo crecimiento de la enfermedad" (ver aparte).

Estas declaraciones provocaron una dura polémica entre las autoridades y especialistas argentinos. El ministro de **Salud y Acción Social, Julio César Aráoz**, dijo que "no estamos tan mal" y que quizá "la actriz haya manejado mala información". Pero las organizaciones no gubernamentales de la Argentina que hacen campañas contra el SIDA apoyaron la opinión de la actriz.



Lyz Taylor besa a Tomas Fabregas, ciudadano americano de origen hispano, que contrajo el SIDA hace 3 años. Vive en California y teme que no lo dejen volver por su enfermedad.

Ayer, Liz Taylor manifestó su apoyo a **Tomás Fábregas**, un español enfermo de SIDA que vive en **Oakland**, Estados Unidos, desde hace 14 años. Fábregas dijo que temía que le fuera impedido su regreso a los Estados Unidos. "Espero no tener problemas. Pero si los tengo, no serán mis problemas sino del presidente Bush", dijo Fábregas, quien integra la **Fundación SIDA de San Francisco**.

Declan Murphy, presidente de la **Federación Mundial de Hemofílicos**, dijo que las autoridades consulares norteamericanas le negaron la visa a un niño español portador del virus HIV, que deseaba visitar **Disney World**. "La respuesta de los funcionarios fue que el niño debía presentar un certificado de un médico norteamericano que asegurara que iba a examinarlo", agregó Murphy.

En medio de las críticas a la política de Bush respecto del SIDA, los organizadores de la conferencia leyeron un telegrama de **Bill Clinton**, candidato del Partido Demócrata para las próximas elecciones norteamericanas. Clinton prometió aplicar una política distinta en caso de llegar a la **Casa Blanca**.

"Aplicaré una política de inmigración honesta y justa para terminar con esta discriminación. Esta es la única manera de que los Estados Unidos puedan estar a la cabeza de la lucha mundial contra el SIDA y permitan conferencias como la de Amsterdam", dice el mensaje de Clinton.

ACT UP | IMMIGRATION WORKING GROUP

EL PAIS, MADRID, ESPAÑA
CONTRAPORTADA, LUNES 27 DE JULIO DE 1992

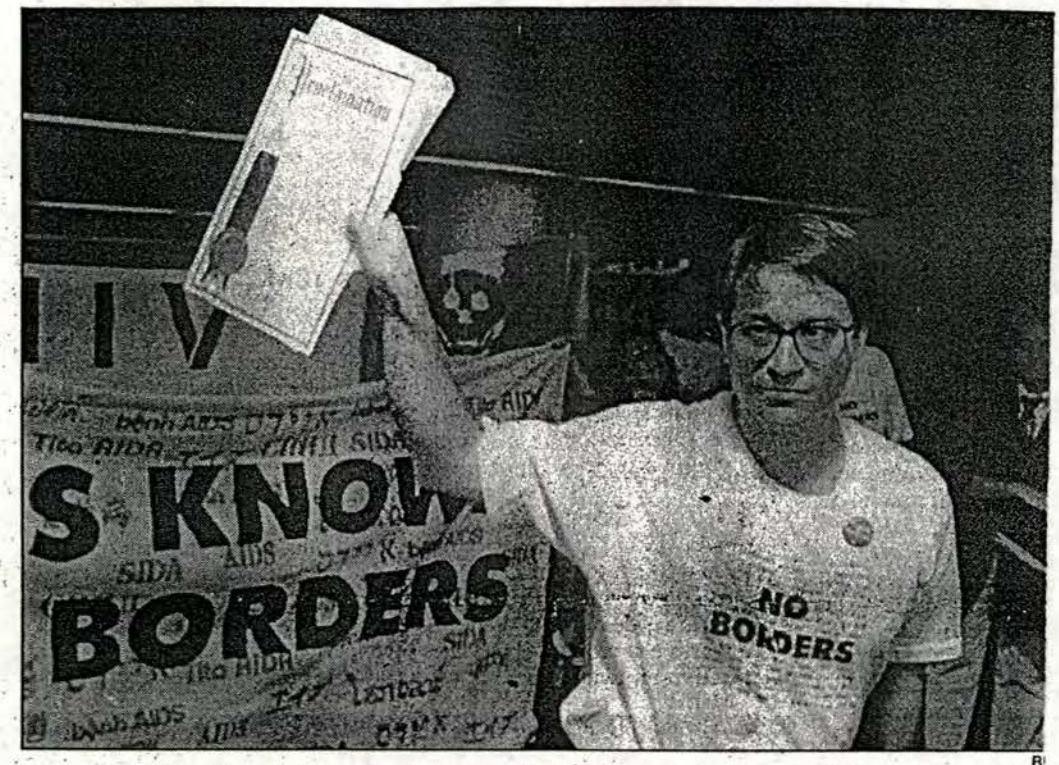
El gran día de Tomás Fábregas

Un activista antisida español desafía con éxito las leyes de inmigración de EE UU

ALFONSO ARMADA
San Francisco

Tomás Fábregas no las tenía todas consigo en el avión que le trasladaba desde Amsterdam a San Francisco. Este coruñés de 34 años, con más de 12 de residencia legal en Estados Unidos, había desafiado al presidente George Bush a que aplicara contra él la legislación que impide entrar en EE UU a los ciudadanos de otros países que sufran el síndrome de inmunodeficiencia adquirida (SIDA). Pero Fábregas pudo ayer dormir en su casa del barrio de Oakland gracias a la repercusión pública del reto que hizo en la conferencia sobre el sida clausurada el viernes en la capital holandesa. Frank M. Jordan, alcalde demócrata de San Francisco, sensible a los estragos que la enfermedad ha causado en la ciudad, bendijo su vuelta a casa con un bando en el que proclamaba el 25 de julio de 1992 "Día de Tomás Fábregas en San Francisco", en "reconocimiento a su histórico y valiente esfuerzo" en contra de las "incoherentes y discriminatorias regulaciones de inmigración".

"Francamente no tenía claro que me fueran a dejar entrar en el país", declaró Fábregas en su casa a EL PAÍS. En el aeropuerto se habían congregado un nutrido grupo de amigos, activistas antisida y cámaras de televisión para ver si las autoridades de inmigración aplicaban la ley sin contemplaciones. David Ilchert, director de la Oficina de Inmigración de San Francisco, había echado leña al fuego cuando afirmó la víspera: "Todo lo que yo sé es que un tipo está dando la murga en Europa diciendo que quiere volver a casa con su amante. Nosotros responderemos a la pregunta [de si puede entrar o no en EE UU] cuando llegue aquí y podamos determinar su situación de inmigrante".



Fábregas muestra el bando del alcalde de San Francisco a su llegada al aeropuerto de la ciudad.

"Hubiera sido una vergüenza que no me dejaran entrar", aseguró Fábregas. "Llevo casi 13 años viviendo en EE UU, me he infectado con el sida en EE UU y me parece inconcebible que EE UU tenga la desfachatez de considerar el no dejarme volver a mi casa. Mi vida está aquí, mi médico está aquí, mi compañero está aquí, soy residente legal permanente en el país..., pero todos mis derechos quedan en suspenso por tener sida". Fábregas es licenciado en Informática, ha trabajado como editor para las Naciones Unidas y en la actualidad lucha activamente contra el sida desde la organización independiente Act Up. También forma parte del equipo de dirección de la Fundación contra el Sida de la Ciudad de San Francisco.

Para Fábregas, las leyes que prohíben la entrada en EE UU de personas seropositivas contribuyen a la expansión del sida, puesto que dan una falsa sc ción de seguridad. La ame de la deportación hace qu emigrantes que hayan contr la enfermedad se escondan pongan fuera del alcance de tema médico.

Fábregas cree que su ent en el país, pese a su notoria dición de seropositivo, reve hipocresía de la política de I "Si yo fuera una amenaza pa salud pública del país, el Go no me tendría que haber im do la entrada. La aplicació lectiva de la ley revela las f premisas en las que se basa

To reach the ACT UP Immigration Working Group after the Conference:



The New York Times

MONDAY, JULY 27, 1992

Man With H.I.V. Challenges U.S. Entry Ban

SAN FRANCISCO, July 26 (AP) — A citizen of Spain who has the virus that causes AIDS challenged the ban by the United States on admitting noncitizens infected with the virus by entering the country through the San Francisco International Airport on Saturday.

The Spaniard, Tomás Fábregas, 34 years old, is a legal resident of the United States who lives in Oakland, Calif. Mr. Fábregas attended the International AIDS Conference in Amsterdam last week, where he had announced he would challenge the ban on admitting into the country people infected with the virus or who have AIDS.

Mr. Fábregas, who was found to have the human immunodeficiency virus in 1987, was greeted at the airport as he returned from Amsterdam by about 40 supporters.

Oakland Tribune

SATURDAY, JULY 25, 1992

Battling AIDS' borders

Oakland man tests U.S. immigrant ban

By Susan Stern
Tribune staff writer

An Oakland resident with AIDS will grab international attention today by attempting to challenge the U.S. ban on admitting non-citizens infected with the human immunodeficiency virus.

Tomas Fabregas, a citizen of Spain who has been a legal U.S. resident for 12 years, will fly into San Francisco International Airport at about 5 p.m. today after attending the International Conference on AIDS in Amsterdam.

Fabregas, 34, an AIDS activist with a UC-Berkeley business degree, announced at the AIDS conference this week that he would challenge the U.S. ban on HIV-infected immigrants.

"I defy George Bush to prevent me from returning to my home," Fabregas said. "I am vulnerable, but I am not weak."

See OAKLAND, Page A-9



The Associated Press

AIDS conference participant Tomas Fabregas of Oakland kisses actress Elizabeth Taylor.

Oakland man protests HIV ban

Continued from Page A-1

The conference was moved from Boston to Amsterdam because of the ban, which is opposed by the World Health Organization. AIDS activists say the United States is one of only seven countries that strictly limit AIDS-infected immigrants.

Beset by media phone calls, David Ilchert, director of the San Francisco district immigration office, said he'll decide what to do with Fabregas when he arrives.

"All I know is that there's some guy ranting and raving there on the west coast of Europe, saying he wants to come home with his lover. We'll question him when he gets here to determine his immigration status."

Ilchert noted that all non-U.S. citizens, from tourists to longtime legal residents, are subject to examination anytime they reenter the United States after a "legal departure."

Foreigners have long been barred for a variety of infectious diseases. Last year, however, Secretary of Health Louis Sullivan recommended removing all but active tuberculosis cases from the exclusion list.

Sullivan's decision was praised by AIDS authorities, who have opposed the ban on HIV-infected people. They argue that it is unnecessary because AIDS is not contagious through casual contact.

But conservatives flooded the Bush administration with more than 40,000 protest letters, and HIV was put back on the exclusion list.

"This is very encouraging," Rep. William Dannemeyer, R-Fullerton, said at the time. "It is simply not in the interests of this nation to allow into this country as permanent immigrants people who have a non-curable disease."

But Ilchert noted that Fabregas may be allowed to re-enter the country because of a number of exceptions to the law.

His short trip may be deemed only a "casual departure," a type of trip after which a legal resident cannot be barred. Or Fabregas may be allowed to return to his Oakland home under a waiver of the law.

But Fabregas could be detained by the INS and face proceedings to revoke his residency, said Fabregas' attorney, Ignatius Bau. In that case, he could be forced to spend the weekend — or longer — in jail, a possibility Fabregas' friends fear.

Whatever happens, it will be a victory for people with AIDS, Bau said.

"If he is successful in coming in, he makes the point that he's not a public health threat," Bau said. "And if he's not a threat, how can they say that the immigrant with AIDS behind him in line is a public health threat?"

If Fabregas is detained, Bau said, it will trigger a legal battle over the exclusion of HIV-infected immigrants. That battle could end up in the Supreme Court, as did the case of Leona Benten, the Berkeley women who unsuccessfully challenged the U.S. ban on RU486 by trying to bring the abortion pill into the country this month.

> *'I defy George Bush to prevent me from returning to my home. I am vulnerable, but I am not weak.'*
>
> **— Tomas Fabregas of Oakland, challenging HIV immigration restrictions**

Bau said he would argue that the exclusion of HIV-infected foreigners is strictly political, because Sullivan recommended HIV be removed from the list.

Joe Fera, a spokesman for the San Francisco AIDS Foundation, said Sullivan also recommended taking venereal diseases off the exclusion list, but unlike AIDS, they were not put back on after conservative pressure.

The San Francisco AIDS Foundation, of which Fabregas is a board member, is organizing a welcome-home celebration for him at the airport today. Fera said San Francisco Mayor Frank Jordan will attend, as will San Francisco ACT UP, the organization Fabregas represented at the International AIDS conference.

Friends described Fabregas as a "determined, angry and committed" AIDS activist who has in the past year turned his attention to the U.S. anti-AIDS immigration policy.

They said Fabregas went to the Amsterdam AIDS conference planning to make his attention-grabbing public challenge, even though the pressure could harm his already fragile health.

Friends said Fabregas, who holds a master's degree in business from UC-Berkeley, was a San Francisco bank executive until his health failed. He was diagnosed with AIDS in 1989.

"Tomas is a workaholic," said a Brazilian ACT UP activist, who asked to remain anonymous because of his own pending immigration application.

"The word 'hero' gets passed around too easily in this culture. But Tomas is a man who can count his T-cells on one hand, yet he's been tireless in this fight. I see in him the essence of the American spirit. That whole idea that if you think something isn't right, you fight to change it."

Before receiving a master's degree in business from UC-Berkeley last year, Fabregas studied computer science at Hunter College in New York. He had previously worked for Merrill Lynch & Co. in New York.

Fabregas has lived in Oakland for several years with his partner, Jeff Brooks, a U.S. citizen, who will be returning with him to San Francisco today.

"I applaud what he's doing," said Jerry DeJong, executive director of Oakland's Center for AIDS Services and a colleague of Farbegras.

"It's not easy to make yourself a martyr. As far as his own life is concerned, he'd be better off just coming into this country quietly as he had done many times before. But, at some point, someone has to stand up against stupidity."

San Francisco Examiner
METRO

WEATHER B-2
DATELINES B-2
DEATHS B-7



Tomas Fabregas of Oakland challenges the United States on its policy of not allowing non-citizens with HIV to enter the country. [B-8]

Sunday, July 26, 1992

Oakland man dares U.S. on HIV entry ban

Spanish citizen returns from AIDS conference without incident, is honored by The City

By Wylie Wong
OF THE EXAMINER STAFF

During the Bush administration to block his return from the AIDS conference in Amsterdam, Tomas Fabregas, an Oakland resident with HIV, arrived at San Francisco International Airport unchallenged by immigration officials Saturday night.

"George Bush, I am home," the 41-year-old Fabregas said as he was greeted by a cheering crowd of about 50 supporters and friends.

Fabregas, a Spanish citizen who has been a U.S. resident for 14 years, was diagnosed with HIV 3½ years ago.

He announced at the conference last Sunday that he would challenge the 4-year-old ban on foreigners infected with HIV from entering the United States.

The U.S. policy on HIV prompted AIDS conference organizers to move the meeting site from Boston to Amsterdam, where there are no such travel and immigration restrictions.

Karen Philis, port director of the Immigration and Naturalization Service, said Fabregas passed immigration without delay because he did not bring up the subject of having HIV. "Him having AIDS was not an issue," she said.

Philis would not say whether the INS will take future action.

Earlier last week, David Ilchert, INS district director at San Francisco, said if Fabregas announced to an INS agent that he was infected, he would be given a "parole" entry into the United States while the INS determined whether he had HIV. Even so, Ilchert said, Fabregas would still be able to receive a waiver because of his 14-year residency in the United States.



EXAMINER/CRAIG LEE

Tomas Fabregas *arrives at SFO Saturday night, where he was greeted by crowd of cheering supporters.*

Upon arrival Saturday night, Fabregas — who traveled with his partner Jeff Brooks — carried a sign reading, "AIDS Knows No Borders."

"I challenge the Bush administration and the U.S. Immigration and Naturalization Service to act on their morally repugnant HIV exclusion law," Fabregas said. "The only intent of this exclusion is to discriminate, harass and punish people living with HIV."

Jean Harris, an aide to Mayor Jordan, welcomed Fabregas with a proclamation from the mayor's office stating that the day was named for him.

Supporters from ACT UP and the San Francisco AIDS Foundation called Fabregas' challenge of the HIV policy "courageous."

"He believes a change must happen. He's devoted the past year and a half of his life fighting this," said Ney Fonseca, a friend of Fabregas for two years. "Thousands of people in this country who are hiding right now are thanking him for that."

Rene Durazzo, San Francisco AIDS Foundation's director of public policy, had similar sentiments.

"This is more than symbolic. It says a lot on what people with HIV must live with. They are told they are criminals, a threat to the general population," he said. "He put his personal life on the line to show how serious this policy of discrimination is to the country."

SUNDAY Oakland Tribune

SUNDAY, JULY 26, 1992

AIDS activist reenters U.S., challenges ban

By Yasmin Anwar
Tribune staff writer

SAN FRANCISCO — Tomas Fabregas, a Spanish-born Oakland resident with the AIDS virus, sailed smoothly through U.S. immigration yesterday after returning from an Amsterdam AIDS conference, announcing "Yes, George Bush, I'm home."

Not only was the 34-year-old AIDS activist greeted by a raucous, banner-carrying welcoming party at San Francisco International Airport, he also got a day named after him by San Francisco Mayor Frank Jordan.

"We want to make it clear to the INS that we stand behind Fabregas," said Jean Harris, an aide representing Jordan.

Sporting a T-shirt emblazoned with "No Border" and flanked by his lover, Jeff Brooks, Fabregas accepted a certificate from Harris proclaiming July 25 "Tomas Fabregas day."

"I did not truly know if they would let me in," he said. "And I did not expect San Francisco would have a Tomas Fabregas day."

Fabregas, a legal U.S. resident for 12 years who was diagnosed with the AIDS virus in 1989, made news at an international conference on AIDS last week when he declared that he would challenge a U.S ban on admitting non-citizens who have the AIDS virus.

Congress passed restrictions in 1988 to forbid people with the human immunodeficiency virus from entering the United States and which the Bush administra-

See AIDS, Page A-6

AIDS

Continued from Page A-1

tion proposed and then declined to remove.

"It's a silly policy and it's tragic that someone like Tomas has to put their freedom on the line to fight it," said San Francisco supervisor and gay activist Harry Britt, who was part of the welcoming party.

Immigration and Naturalization Service port director Karen Philis said airport immigration did not question Fabregas about his HIV status and allowed him though because "he did not make an issue of having AIDS."

"How could you know if someone has AIDs or not, a lot of them don't even know," said Philis.

Fabregas said he felt his action was necessary to fight not only the ban but also discrimination against people with HIV.

"The only intent of this politically inspired exclusion is to discriminate, harass and punish people living with HIV," Fabregas said.

After a tense plane journey, Fabregas said he was relieved to be home. "Magic Johnson has been welcomed into my country (for the Olympics) and I'm glad I've been welcomed into his."



By Amy Douglas/Oakland Tribune

Jeffrey Brooks, left, reassures Tomas Fabregas.

Bill Clinton
FOR PRESIDENT COMMITTEE

To Jonathan Mann, Chair of the VIII International Conference on AIDS:

I would like to congratulate you and all the participants of the VIII International Conference on AIDS for your continued commitment to the fight against AIDS and your very successful meeting. This is a crisis of epidemic proportions, and it is vital to move forward to fight the battle against AIDS.

We have seen a lot of tough talk out of Washington, but no leadership in declaring war on AIDS. President Bush refuses even to implement the recommendations from his own Commission on AIDS. We cannot afford another four years of inaction while we sit idly by and watch our people die.

A Clinton Administration will pledge its utmost support to the recommendations of commissions like the President's Commission on AIDS, and conferences like this one. And we will have a fair immigration policy to end discrimination against people with AIDS, so that the U.S. would be able to be a world leader in the fight against AIDS, welcoming conferences such as yours here in America.

I would be grateful if you could make this statement available publicly at the conference.

Best Wishes,

Bill Clinton

National Campaign Headquarters • P.O. Box 615 • Little Rock, Arkansas 72203 • Telephone (501) 372-1992 • FAX (501) 372-2282

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BILL CLINTON ON AIDS

Fighting the AIDS epidemic will be a top priority of a Clinton Administration. If we fail to commit our hearts and resources now to fighting AIDS, we will pay a far greater price in the future, both in deaths and in dollars. We need a President who will focus national attention on AIDS, to encourage compassion and understanding, to promote education and to speak out against intolerance.

We can't afford another four years without a plan to declare war on AIDS. We can't afford to have yet another President who remains silent about AIDS or who puts the issue on the back burner. You may not agree with everything in Bill Clinton's plan. But you have a right to know what he'll do and where he stands.

THE CLINTON PLAN TO FIGHT AIDS

- Increase funding for desperately needed new initiatives in research, prevention and treatment.
- Appoint an AIDS policy director to head a "Manhattan Project" that coordinates federal AIDS policies, cuts through bureaucratic red tape and implements recommendations made by the National Commission on AIDS.
- Speed up the drug approval process and commit increased government resources to research and development of AIDS-related treatments and vaccines, and ensure that women and people of color are included in research and drug trials.
- Fully fund the Ryan White CARE Act. Work closely with individuals and communities that are affected by HIV to create a partnership between the federal government and those with knowledge and experience in fighting HIV.
- Promote a national AIDS education and prevention initiative that disseminates frank and accurate information to reduce the spread of the disease, and educates our children about the nature and threat of AIDS.
- Provide quality health coverage to all Americans with HIV as part of a broader national health care program; work vigorously to improve access to promising experimental therapies for people with life-threatening illnesses; and improve preventive and long-term care.
- Combat AIDS-related discrimination and oppose needless mandatory HIV testing in federal organizations such as the Peace Corps, Job Corps and the Foreign Service; stop the cynical politicization of immigration policies by directing the Justice Department to follow the Department of Health and Human Services' recommendation that HIV be removed from the immigration restrictions list; promote legislation based upon sound scientific and public health principles — not on panic, politics or prejudice.

participation of under-represented populations.
• Reorganize the NIH infrastructure to streamline AIDS research efforts and improve planning, efficiency and communication.
• Promote a more rapid review by the NIH of research grant applications and a speedier distribution of funding for approved studies.
• Facilitate greater access to drugs and work to speed up the drug approval process. Ensure that the FDA has the resources to assist in the efficient design of AIDS-related drug trials and to review their results rapidly. The FDA will also make possible greater access to promising experimental therapies without compromising patient safety.

Discrimination

• Fight all AIDS-related discrimination as well as discrimination based on race, gender and sexual orientation.
• Fully implement the Americans with Disabilities Act and resist any efforts to weaken its provisions. The Department of Justice and the U.S. Commission on Civil Rights must make it a high priority to monitor the occurrence of AIDS-related discrimination and the enforcement of the ADA with respect to HIV-related complaints.
• Forbid health insurance companies from denying coverage to HIV-positive applicants. Prohibit all health plans from adopting discriminatory caps or exclusions that provide lower coverage for AIDS than for any other life-threatening illnesses. No American will be denied health coverage because he or she loses a job or has a pre-existing condition.
• Oppose mandatory testing in federal organizations such as the Peace Corps, Job Corps and the Foreign Service.
• Lift the current ban on travel and immigration to the U.S. by foreign nationals with HIV.

The Clinton Record in Arkansas

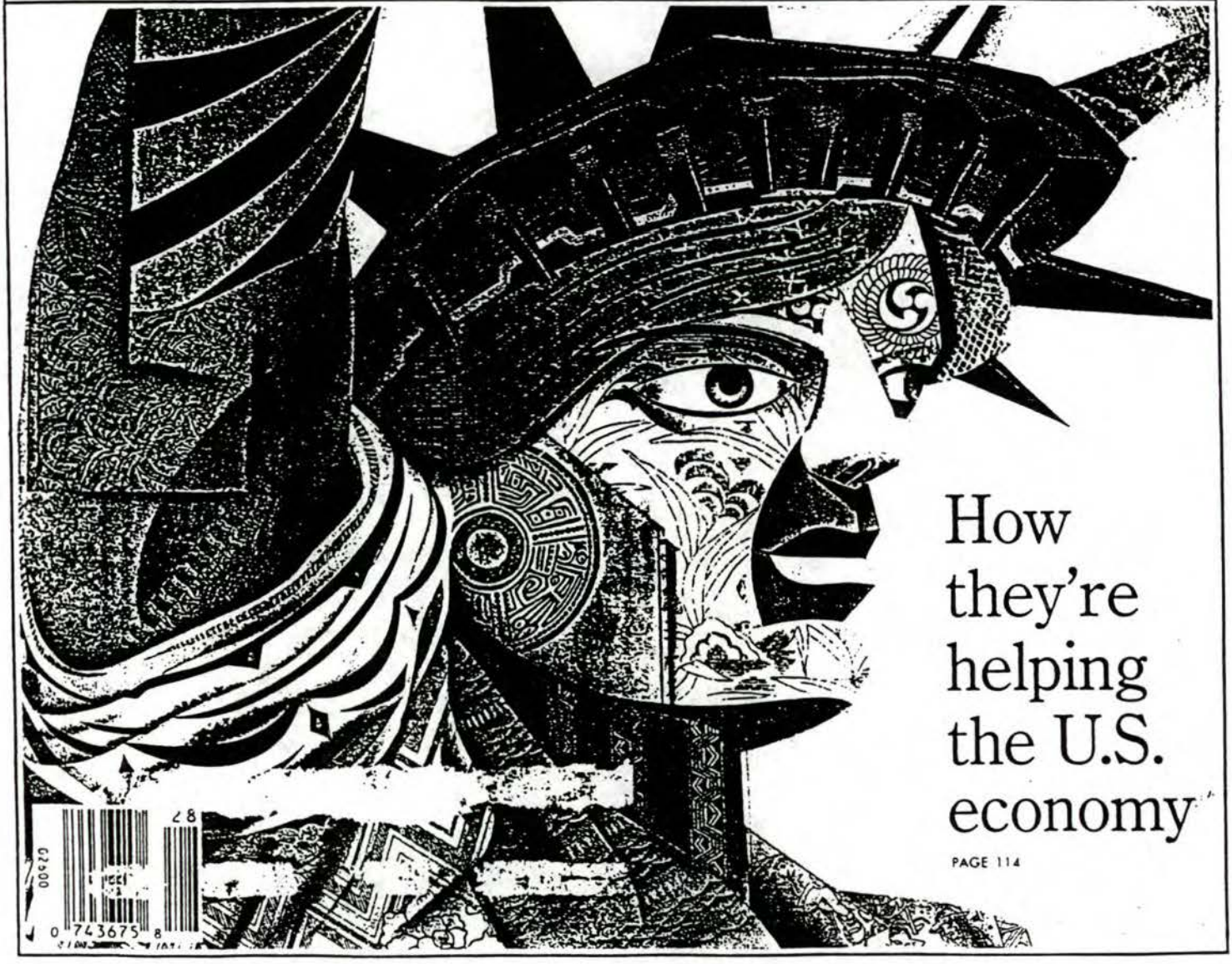
• As chairman of the National Governors' Association, formed the first working group of governors to develop an AIDS policy. Clinton was a moving force in the creation of an AIDS action plan adopted by the Governors' Association, which called for education and prevention efforts at the local, state and federal levels.
• The Arkansas Board of Education adopted a resolution calling for the "development of AIDS education skills...to be integrated into the Health Education Course Content Guide."
• In 1989 and 1990, Governor Clinton supported teacher training for AIDS education and a detailed study of the availability of HIV education at the local level.
• Since 1990, AIDS education has been required in all Arkansas schools, and there has been a 40% increase in HIV counseling and voluntary testing in Arkansas.
• The AIDS Advisory Committee was established in 1987. This committee makes recommendations on HIV policy and program services. HIV services in the state currently include anonymous testing at two centers and confidential testing and counseling at public health clinics located in all 75 Arkansas counties.

GLOBAL 1000 THE WORLD'S MOST VALUABLE COMPANIES **IRAQGATE** THE ROLE OF BUSINESS **THE PRU** STRATEGY BATTLE

BusinessWeek

JULY 13, 1992 A McGRAW-HILL PUBLICATION $2.75

THE IMMIGRANTS



How they're helping the U.S. economy

PAGE 114

THE IMMIGRANTS

HOW THEY'RE HELPING TO REVITALIZE THE U.S. ECONOMY

Give me your tired, your poor,
Your huddled masses yearning to breathe free. . . .

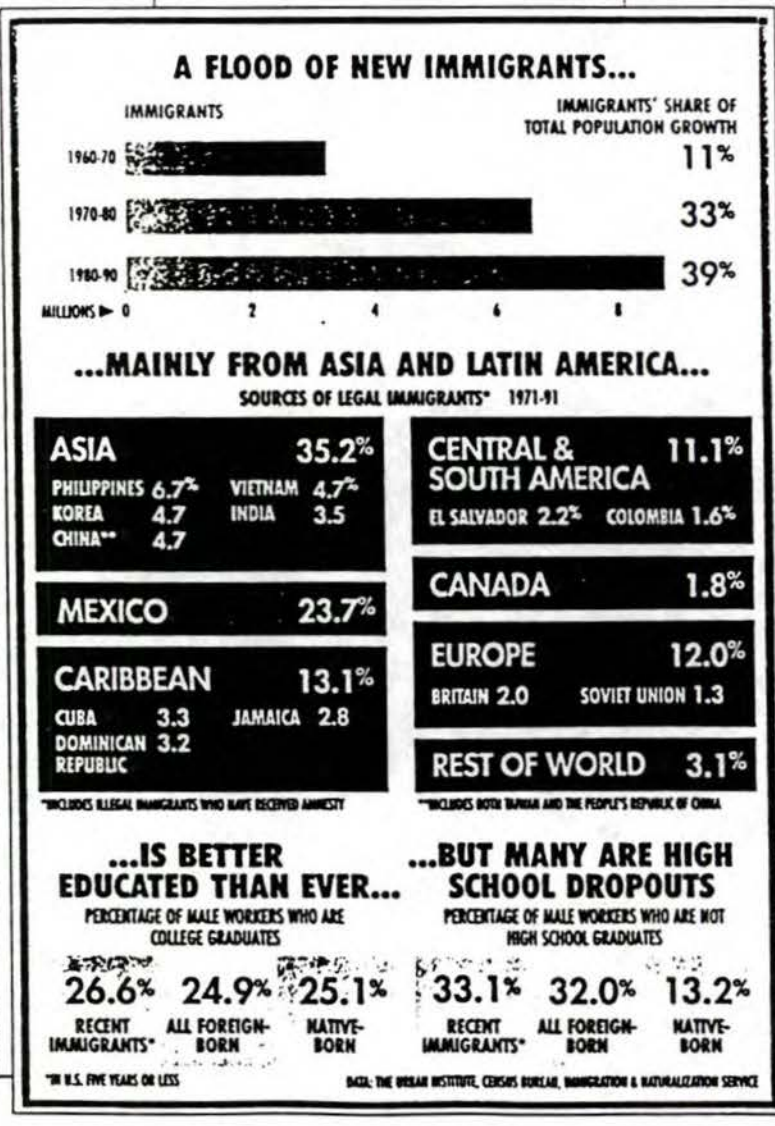
These words carved into the base of the Statue of Liberty speak to America's vision of itself. We were, and still are, a nation of immigrants. In the 1980s alone, a stunning 8.7 million people poured into the U. S., matching the great immigration decade of 1900-10. But with the country facing difficult economic and social problems, is it time to put aside our romantic past and kick away the immigrant welcome mat?

A lot of Americans feel the answer is "yes." In a BUSINESS WEEK/Harris poll, 68% of respondents said today's immigration is bad for the country, even though most thought it was good in the past. President Bush has found it politically expedient to refuse refugees from Haiti. And in areas like recession-weary Southern California, immigrants are being blamed for everything from rising unemployment to a rocketing state budget deficit. "I understand, in the past, 'give me your tired, your poor.' Today, the U. S. has to look at our own huddled masses first," says former Colorado Governor Richard D. Lamm, who is running for the U. S. Senate.

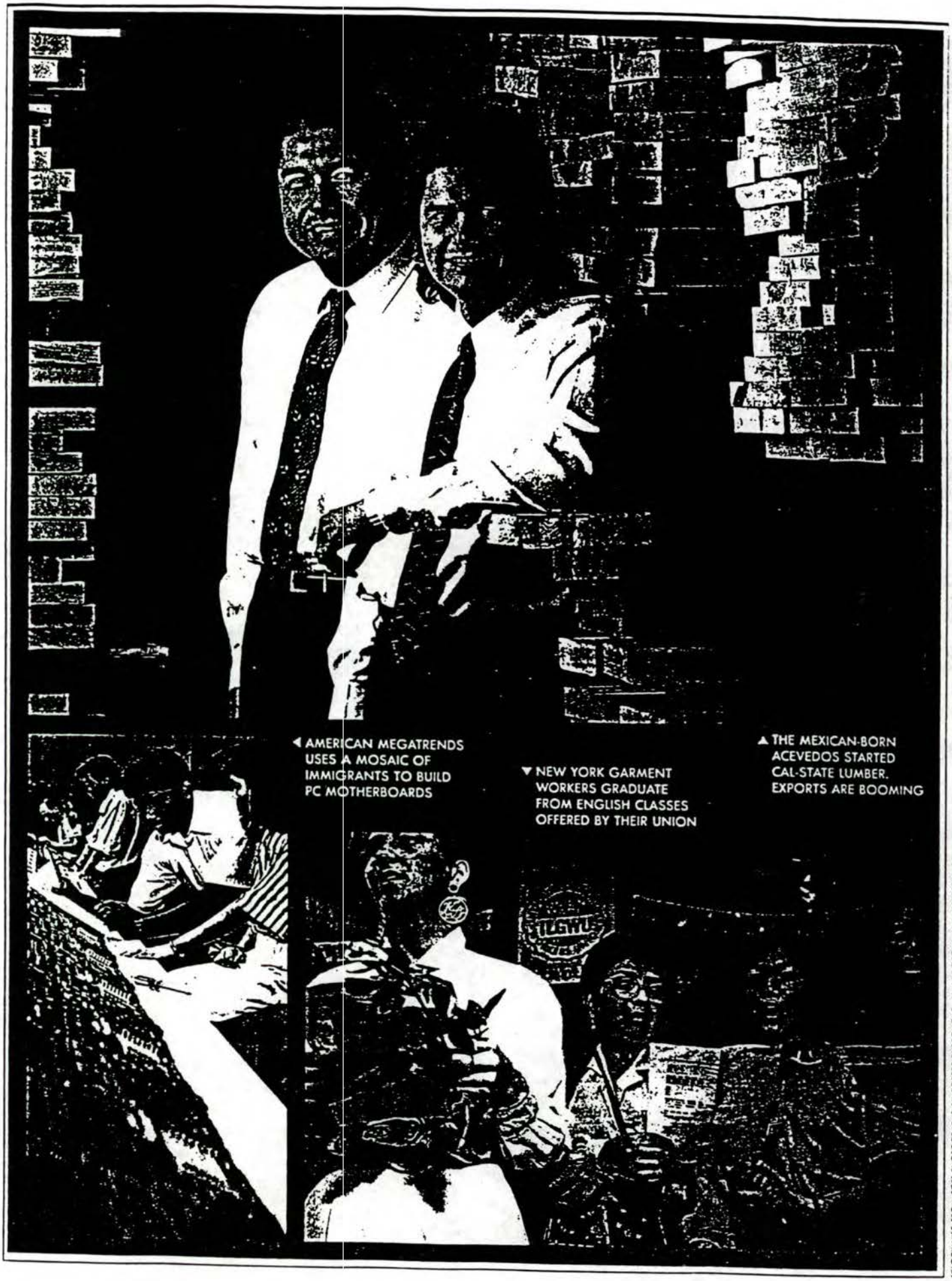
This rising resentment against immigrants is no surprise. The million or so immigrants—including 200,000 illegals—that will arrive in the U. S this year are coming at a time when unemployment is high and social services strained. Unlike past waves of immigration, the new immigrants are mainly from Asia and Latin America. And just like the American work force, these immigrants are split between the highly skilled and well-educated and those with minimal skills and little education. Hungry for work, the newcomers compete for jobs with Americans, particularly with the less skilled. The large number of untrained immigrants, especially those from Mexico, are finding it harder to move up the employment ladder than did past generations of newcomers. And in the cities, the new immigrants seem to inflame racial and ethnic conflicts.

But on balance, the economic benefits of being an open-door society far outweigh the costs. For one thing, the U. S. is reaping a bonanza of highly educated foreigners. In the 1980s alone, an unprecedented 1.5 million college-educated immigrants joined the U. S. work force. More and more, America's high-tech industries, from semiconductors to biotechnology, are depending on immigrant scientists, engineers, and entrepreneurs to remain competitive. And the immigrants' links to their old countries are boosting U. S. exports to such fast-growing regions as Asia and Latin America.

Even immigrants with less education are contributing to the economy as workers, consumers, business owners, and taxpayers. Some 11 million immigrants are working, and they earn at least $240 billion a year, paying more than $90 billion in taxes. That's a lot more than the estimated $5 billion immigrants receive in welfare. Immigrant entrepreneurs, from the corner grocer to the local builder, are creating jobs—and not only for other immigrants. Vibrant immigrant communities are revitalizing cities and older suburbs that would otherwise be suffering from a shrinking tax base. Says John D. Kasarda, a



LAUREL DAUPHIN/BW



◀ AMERICAN MEGATRENDS USES A MOSAIC OF IMMIGRANTS TO BUILD PC MOTHERBOARDS

▼ NEW YORK GARMENT WORKERS GRADUATE FROM ENGLISH CLASSES OFFERED BY THEIR UNION

▲ THE MEXICAN-BORN ACEVEDOS STARTED CAL-STATE LUMBER. EXPORTS ARE BOOMING

[CLOCKWISE FROM TOP] PHOTOGRAPHS BY ROBERT BURROUGHS; ALAN DOROW; ANN STATES/SABA



sociologist at the University of North Carolina at Chapel Hill: "There is substantial evidence that immigrants are a powerful benefit to the economy, and very little evidence that they are negative."

In 1965, when Congress overhauled the immigration laws, nobody expected this great tide of new immigrants. But that law made it easier to bring close relatives into the country and, influenced by the civil-rights movement, eliminated racially based barriers to immigration. Prior to that, it was difficult for anyone who was not European or Canadian to settle here. The result: a surge of immigrants from Asia and Latin America, especially from countries like South Korea and the Philippines that had close economic and military ties to the U.S. And once a group got a foothold in the U.S., it would continue to expand by bringing over more family members.

NEW WAVE. The aftermath of the Vietnam War provided the second powerful source of immigrants. Over the last 10 years, the U.S. granted permanent-resident status to about 1 million refugees, mostly from Vietnam, Cambodia, and Laos. And now the end of the cold war is tapping another immigrant stream: Over the last three years, the fastest-growing group of new settlers has been refugees from Eastern Europe and the former Soviet Union.

Throughout the 1970s and 1980s, a total of some 5 million illegal immigrants from Mexico and other countries settled in the U.S., drawn by opportunity here and fleeing economic troubles at home. Many settled in Southern California and Texas. In 1986, Congress passed the Immigration Reform & Control Act (IRCA), which imposed penalties on employers who hired illegal immigrants but also gave amnesty to many illegal immigrants. About 2.5 million people have become permanent residents under the amnesty program. And the pending North American Free Trade Agreement, by strengthening economic ties between Mexico and the U.S., might very well increase illegal immigration in the short run rather than diminish it.

Opening the gates to Asians and Latin Americans dramatically altered the face of immigration. In the 1950s, 68% of legal immigrants came from Europe or Canada. In the 1980s, that percentage fell to only 13%. Conversely, the proportion of legal immigrants coming from Latin America and Asia rose from 31% to 84%, including illegal aliens granted amnesty under the 1986 law.

As the ethnic mix of the new immigrants changed, so did their levels of skill. At the low end, the plethora of low-wage service-sector jobs drew in a large number of unskilled, illiterate newcomers. About one-third of immigrant workers are high school dropouts, and one-third of those entered the U.S. illegally.

But the number of skilled immigrants has been increasing as well. "The level of education of recent immigrants has definitely increased over the last 10 years," says Elaine Sorensen, an immigration expert at the Urban Institute. About one-quarter of immigrant workers are college graduates, slightly higher than for native-born Americans. Some groups, such as Indians, are on average much better educated than today's Americans. Observes Steven Newman, an executive at the New York Association for New Americans, which will resettle about 20,000 immigrants from the former Soviet Union this year, including many engineers, computer programmers, and other skilled workers: "The only thing they lack is English skills."

TALENT BASE. Even immigrants who were doing well in their home countries are being drawn to the U.S. Take Subramonian Shankar, the 43-year-old president of American Megatrends Inc., a maker of personal-computer motherboards and software based in Norcross, Ga. He was director of personal-computer R&D at one of India's largest conglomerates. Then in 1980, he came to the U.S. In 1985, he and a partner founded AMI, which last year had sales of $70 million and employed 130 workers, both immigrants and native-born Americans. "I couldn't have done this in India," says Shankar. "That's one good thing about America. If you're determined to succeed, there are ways to get it done."

And U.S. industry has been eager to take advantage of the influx. About 40% of the 200 researchers in the Communications Sciences Research wing at AT&T

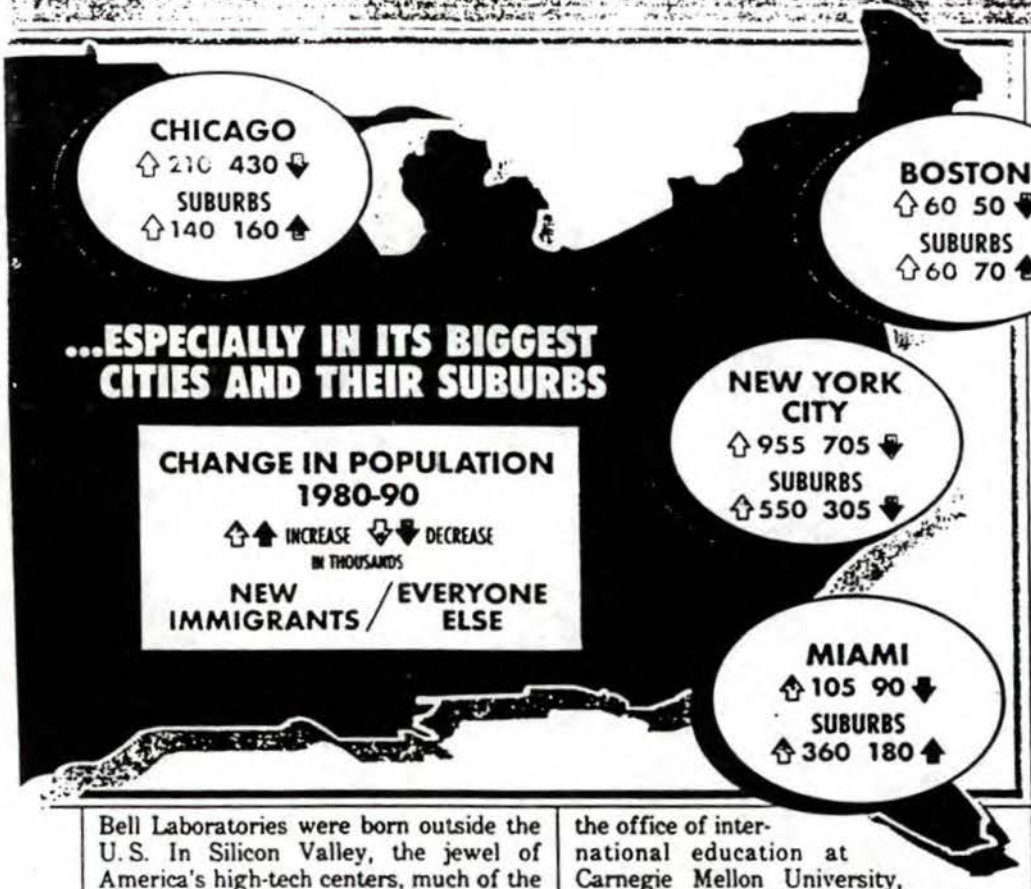
IMMIGRATION'S NEW LOOK

The 1990 Immigration Act took effect this year. The new law boosts legal immigration by 40%. It still favors family members of U.S. citizens and permanent residents, but it more than doubles the slots available for skilled workers. Political refugees come under a different oct. Here's the likely pattern of immigration in 1992:

■ Close relatives of U.S. citizens, and spouses and children of permanent residents	520,000
■ Skilled workers and their families	140,000
■ Citizens of countries with relatively few immigrants in recent years, such as Argentina and Ireland	40,000
■ Political refugees, including those from the former Soviet Union	141,000
■ Illegal immigrants	200,000*
TOTAL	1,041,000

*Estimate

DATA: IMMIGRATION & NATURALIZATION SERVICE, BW



Bell Laboratories were born outside the U.S. In Silicon Valley, the jewel of America's high-tech centers, much of the technical work force is foreign-born (page 120). At Du Pont Merck Pharmaceutical Co., an $800 million-a-year joint venture based in Wilmington, Del., losartan, an antihypertensive drug now in clinical trials, was invented by a team that included two immigrants from Hong Kong and a scientist whose parents migrated from Lithuania. People from different backgrounds bring a richness of outlook, says Joseph A. Mollica, chief executive of Du Pont Merck, "which lets you look at both problems and opportunities from a slightly different point of view."

The next generation of scientists and engineers at U.S. high-tech companies will be dominated by immigrants. While about the same number of Americans are getting science PhDs, the number of foreign-born students receiving science doctorates more than doubled between 1981 and 1991, to 87% of the total. In biology, the hot field of the 1990s, the number of non-U.S. citizens getting doctorates tripled over the last 10 years. And about 51% of computer-science doctorates in 1991 went to foreign-born students. "We are getting really good students—very, very smart people," says Victor L. Thacker, director of the office of international education at Carnegie Mellon University, which has doubled its foreign enrollment since 1985.

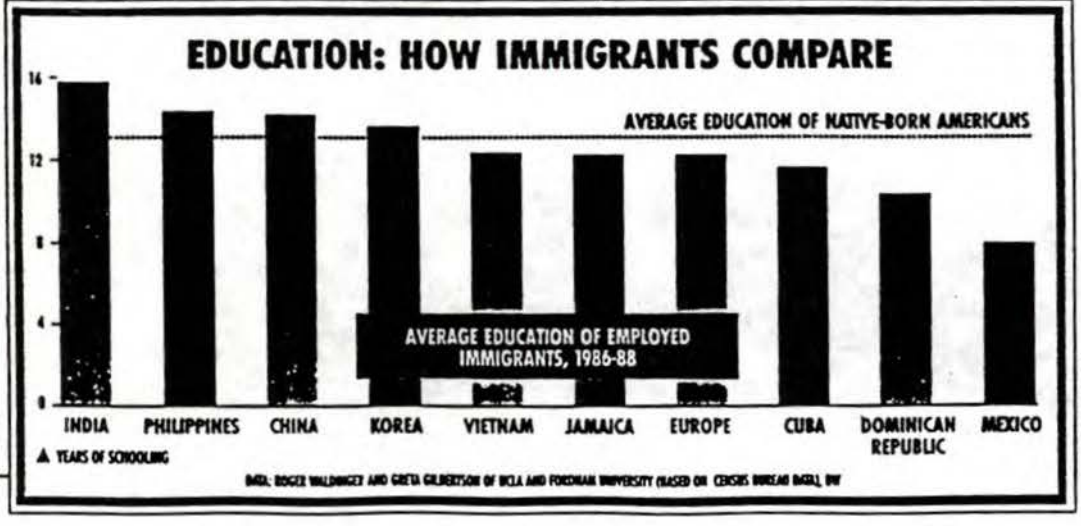
UP THE LADDER. Attracted by the research opportunities and the chance to use what they know, about half of them stay in the U.S. after graduation, estimates Angel G. Jordan, a professor and former provost at Carnegie Mellon, who himself emigrated from Spain in 1956. And the 1990 changes to the immigration law, by increasing the number of visas for skilled immigrants, will increase the number of foreign graduates who remain in the U.S.

Besides boosting the nation's science and engineering know-how, the latest wave of immigrants is loaded with entrepreneurs. Korean greengrocers and other immigrant merchants are familiar sights in many cities, but the entrepreneurial spirit goes far beyond any one ethnic group or single line of business. Almost by definition, anyone who moves to a new country has a lot of initiative and desire to do well. Says Dan Danilov, an immigration lawyer based in Seattle: "They're willing to put in more hours and more hard work."

And do they work. Paul Yuan, for example, left Taiwan with his wife in 1975, seven days after their marriage, eventually settling in Seattle with several thousand dollars in life savings and no work visas. For two years Yuan, a college graduate, worked in Chinese restaurants. Then, in 1978, he became a legal resident and opened his own travel agency while working nights as a hotel dishwasher. Today, at age 43, Yuan owns a thriving Seattle travel business, and he and his family live in a $4 million house. In 1965, 21-year-old Humberto Galvez left Mexico City for Los Angeles. He started pumping gas and busing tables, working his way up the ladder, with a lot of bumps along the way. After starting, then selling, the chain of 19 "El Pollo Loco" charbroiled chicken restaurants in the Los Angeles area, he now owns six Pescado Mojado (wet fish) seafood diners, employing 100 workers.

Immigrant entrepreneurs have also made big contributions to the U.S. export boom. Businesses run by immigrants from Asia, for example, have ready-made connections overseas. Immigrants bring a global perspective and international contacts to insular American businesses. And it is not just Asians. From Poles to Mexicans, "the utility of the immigrant groups is that they bring their fearless spirit of competing globally," observes Michael Goldberg, dean of the University of British Columbia's business school.

That's certainly true for Benjamin and



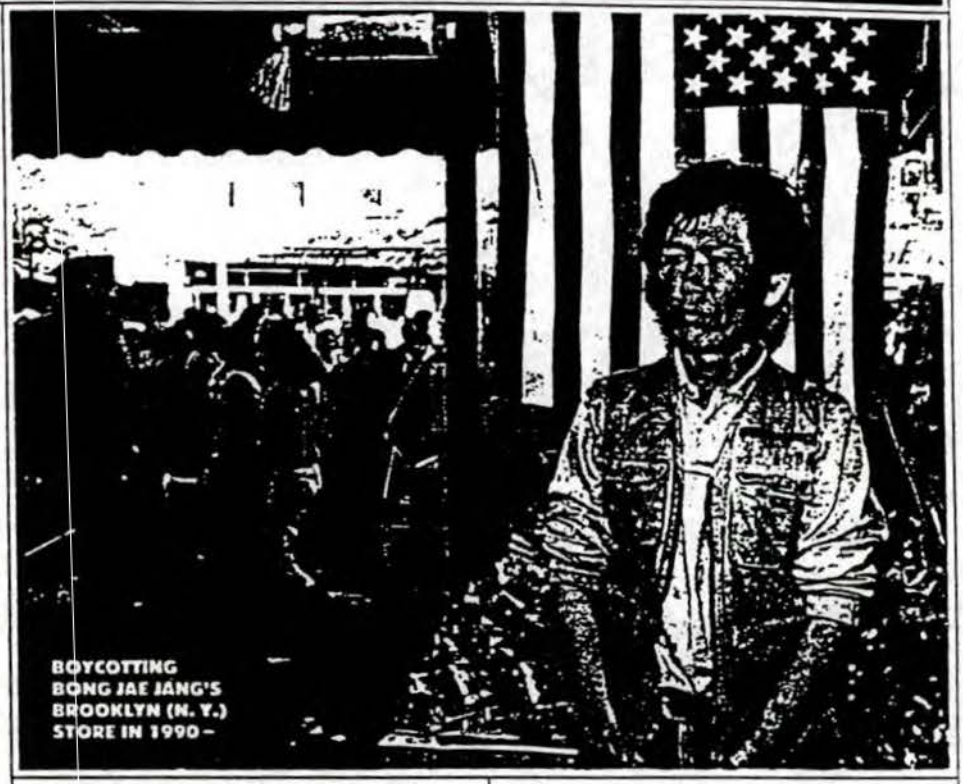
LAUREL DALPHIS/BW

Victor Acevedo, two brothers whose family moved from Tijuana, Mexico, to California in 1960, when they were 3 and 8. In 1984, the Acevedos started up a wood-products company in the south San Diego community of San Ysidro, just across the U. S.-Mexico border. Cal-State Lumber Sales Inc. now commands 10% of the architectural molding market in the U. S. and had 110 employees and $147 million in sales last year. And as long-term trade barriers with Mexico crumbled over the past few years, the Acevedos have been able to take advantage of their bicultural heritage. "My brother and I started shipping all over Mexico, and our export business boomed," says Ben Acevedo.

URBAN BOOSTERS. Perhaps the least-appreciated economic benefit from the new immigrants is the contribution they are making to American cities. Immigrants have been drawn to the major metropolitan areas. They are invigorating the cities and older suburbs by setting up businesses, buying homes, paying taxes, and shopping at the corner grocery. In the past decade, population in the nation's 10 largest cities grew by 4.7%, but without new immigrants it would have shrunk by 6.8%, according to calculations done by BUSINESS WEEK based on the 1990 census. Almost a million immigrants came to New York City in the 1980s, more than offsetting the 750,000 decline in the rest of the city's population. Indeed, about a third of adults in New York, 44% of adults in Los Angeles, and 70% of adults in Miami are now foreign-born, according to the 1990 census.

Immigrants have turned around many a decaying neighborhood. Ten years ago, Jefferson Boulevard in south Dallas was a dying inner-city business district filled with vacant storefronts. Today, there are almost 800 businesses there and on neighboring streets, and about three-quarters of them are owned by Hispanics, many of them first- and second-generation immigrants. "They were hungry enough to start their own businesses," says Leonel Ramos, president of the Jefferson Area Assn. And sociologist Kasarda adds: "There is a whole multiplier effect throughout the community."

Moreover, immigrants provide a hardworking labor force to fill the low-paid jobs that make a modern service economy run. In many cities, industries such as hotels, restaurants, and child care would be hard-pressed without immigrant labor. At the Seattle Sheraton, 28% of the hotel's staff of 650 is foreign-born, and most work in housekeeping, dish-washing, and other low-paying jobs. "We don't have American-born people apply for those positions," says Carla Murray, hotel manager for the Seattle Sheraton.



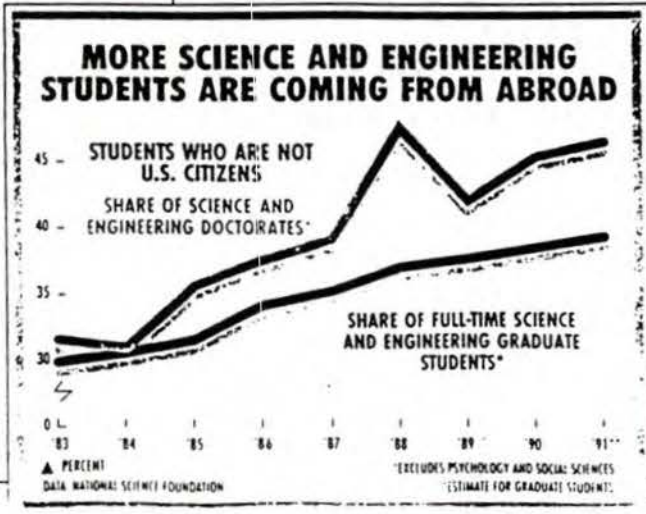
BOYCOTTING BONG JAE JANG'S BROOKLYN (N. Y.) STORE IN 1990 –

MARGIN DWELLERS. But all the economic vitality immigrants add comes at a price. While economists and employers may celebrate industrious immigrants, many barely survive on the economy's margins. "They don't go to the doctor, don't buy insurance, don't buy glasses, don't buy anything you or I are used to," says Hannah Hsiao, head of the Employment Program at the Chinese Information & Service Center in Seattle. A firing, unpaid wages, a deportation, or some other calamity is always threatening. And racial discrimination makes their lot even harder, especially those who don't speak English. Some, like economist George J. Borjas of the University of California at San Diego, worry that these poor and unskilled immigrants are condemned to years of poverty.

In many cities, newcomers and longtime residents struggle over jobs and access to scarce government resources. Immigrants are straining health and education services in some cities and suburbs. And many African-Americans believe the apparent success of immigrants is coming at their expense. In New York City, blacks picketed a number of Korean greengrocers. According to the BUSINESS WEEK/Harris poll, 73% of blacks said businesses would rather hire immigrants than black Americans.

The people hurt worst by immigrants are native-born high school dropouts, who already face a tough time. They compete for jobs against a large number of unskilled immigrants, including illegals from Mexico and the Caribbean who are poorly educated, unable to start their own businesses, and willing to work harder for lower wages than most longtime residents.

For Americans who have at least a high school education, however, the influx of immigrants hasn't had much negative impact. High school graduates, for example, saw their real wages decline by 10% in the 1980s. But almost all of that drop came from import competition and rising skill requirements of many jobs, and only a fraction from immigrant com-



PHOTOGRAPH BY MICHAEL HEISCH GAMMA LIAISON

AMERICA'S WELCOME MAT IS WEARING THIN

Most Americans are uneasy about immigrants. While a majority think immigration was once a good thing, they now believe it's harming the country. The public worries that new arrivals take away jobs, drive down wages, and use too many government services. But forget the conventional wisdom about black resentment of immigrants: Even though 73% of blacks believe businesses would rather hire immigrants, blacks in general feel more positively toward immigrants than do nonblacks.



FEELING THE INFLUX

■ Compared to other times in our history, would you say there are more immigrants coming to the U.S. now, fewer immigrants, or about the same number as before?

	All respondents
More	64%
Fewer	11%
Same	21%
Not sure	4%

PAST BENEFITS

■ Overall, over our history, do you think immigration has been good or bad for this country?

	All respondents
Good	59%
Bad	35%
Neither	3%
Not sure	3%

PRESENT DANGERS

■ Right now, do you think immigration is good or bad for this country?

	Nonblacks	Blacks
Good	26%	40%
Bad	69%	53%
Neither	2%	6%
Not sure	3%	1%

LESSEN THE FLOW

■ In the 1990s, would you like to see this country admit more, fewer, or about the same number of immigrants as were admitted in the 1980s?

	Nonblacks	Blacks
More	3%	12%
Fewer	62%	47%
Same	31%	34%
Not sure	4%	7%

BOON OR BURDEN?

■ Now I'd like to read you a series of statements about immigration in this country. For each statement, please tell me if you agree or disagree.

	Nonblacks			Blacks		
	Agree	Disagree	Not sure	Agree	Disagree	Not sure
New immigrants take jobs away from American workers	62%	37%	1%	63%	34%	3%
A lot of immigrants bring needed skills to this country	49%	49%	2%	60%	34%	6%
New immigrants joining the labor force drive down wages	66%	32%	2%	61%	36%	3%
Many new immigrants are very hard-working	83%	15%	2%	87%	10%	3%
Immigrants use more than their fair share of government services, such as welfare, medical care, and food stamps	62%	32%	6%	59%	34%	7%
A lot of immigrants start new businesses, which helps the U.S. economy grow	55%	40%	5%	67%	29%	4%
Immigration makes race relations in our cities worse	61%	35%	4%	43%	52%	5%

ON THE HIRING LINE

■ Which do you think businesses prefer to hire—immigrants or black Americans?

	Nonblacks	Blacks
Immigrants	49%	73%
Black Americans	30%	15%
Makes no difference	6%	5%
Not sure	15%	7%

BILINGUAL DILEMMA

■ In areas where there are a lot of non-English-speaking immigrants, do you think public schools should or should not offer education in their language?

	Nonblacks	Blacks
Should offer	43%	77%
Should not offer	56%	20%
Not sure	1%	3%

PRICE OF ADMISSION

■ Should immigrants who have education and skills be favored for admission to this country over those immigrants with less education and skills or not?

	Nonblacks	Blacks
Immigrants with education and skills should be favored for admission	47%	36%
Not favored	48%	59%
Not sure	5%	5%

THE DREAM LIVES ON

■ Is the American dream of middle-class prosperity still a realistic goal for new immigrants or not?

	All respondents
American dream still realistic	56%
Not realistic	39%
Not sure	5%

Edited by Christopher Power

Survey of 1,418 adults, including 246 blacks, conducted June 10-14, 1992, for BUSINESS WEEK by Louis Harris & Associates Inc. Results should be accurate to within 3 percentage points, except that results for the smaller sample of blacks should be accurate to within 7 percentage points.

LAUREL DALRYMPLE/BW

HIGH TECH'S HUDDLED MASSES: MAKING A MARK IN SILICON VALLEY

In 1979, Solectron Corp., a circuit-board assembler based in Silicon Valley, was about to go under. Enter Winston H. Chen, a Taiwanese immigrant. Tapping into savings accumulated during an eight-year stint as an IBM manager, he bought half the company for $100,000 and engineered a quick turnaround. Sales have grown on average by more than 50% a year for the past 14 years, to $181 million, and the company is now a symbol of American competitiveness in a field dominated by East Asian companies. Last year, Solectron won a coveted prize in American business: the Malcolm Baldrige National Quality Award.

Immigrants play a big role in Silicon Valley—from assembling chips and computers to developing the next generation of high-tech products. Asians, for example, make up about a third of the Valley's engineering work force. And the design of Intel Corp.'s latest microprocessor, which will run a new generation of personal computers, was managed by an East Indian native and a Taiwan-born vice-president.

Some of the valley's best-known entrepreneurs were born in other countries. Chief Executive Officer Andrew S. Grove escaped from Hungary in 1956 and built Intel into the largest U.S. chipmaker. In 1983, Frenchman Philippe Kahn founded Borland International Inc., one of the world's biggest software companies. Now, a new generation of immigrants is working its way up the high-tech hierarchy. Says Taiwan-born David N. K. Wang, vice-president of Applied Materials Inc.: "Silicon Valley is one of the most international business centers in the world."

IDIOM WATCH. Still, it's not all that easy for immigrants to get into management. A 1990 study by Pacific Studies Center, a public interest information center in Mountain View, Calif., showed that despite the large Asian presence in the Valley's high-tech work force, they account for less than 10% of management.

Some new arrivals have language problems, of course. And it takes time to move them up the management ladder. But China-born David K. Lam, founder of Lam Research Corp., a large manufacturer of chipmaking equipment, believes that many white executives think Asians can't be good managers. "Underlying prejudice is still there," he says.

Several Valley companies are trying, however, to open up their managerial ranks. In many companies, managers routinely take courses on "managing diversity." Some companies offer immigrants classes on American idioms and business culture. In the highly competitive electronics business, more and more companies are finding that it pays to tap the cultural backgrounds, financial contacts, and entrepreneurial drive of the new immigrants.

By Robert D. Hof in San Jose, Calif.



SOLECTRON'S CHEN: MILLIONS IN SALES AND A BALDRIGE AWARD

JAMIE TANAKA

petition, according to a study by Borjas of UC San Diego, and Richard Freeman and Lawrence Katz of Harvard University. "It is extremely convenient to point a finger at immigrants," says Muzaffar Chishti, director of the Immigration Project for the International Ladies' Garment Workers' Union in New York. "But the problems of black employment are outside the immigrant domain."

Moreover, for all their struggles, most immigrants are hardly wards of the state. Illegals are not eligible for welfare, and even many legal immigrants shun it, fearing that it will make it harder to become a citizen in the future. A study by Borjas shows that in 1980—the latest national data available—only 8.8% of immigrant households received welfare, compared to 7.9% of all native-born Americans. And with the education and skill levels of immigrants rising in the 1980s, the expectations are that the spread between the two hasn't worsened, and may have even narrowed. In Los Angeles County, for example, immigrants amount to 16% of the 722,000 people on Aid to Families with Dependent Children, the government's main welfare program. Yet immigrants are more than 30% of the county's population. "Immigrants benefit natives through the public coffers by using less than their share of services and paying more than their share of taxes," says Julian L. Simon, a University of Maryland economist.

SCHOOL DAZE. One real concern is whether urban school systems can handle the surge of immigrant children. "The public school is the vehicle through which the child of immigrants becomes Americanized," says Jeffrey S. Passel, a demographer for the Washington-based Urban Institute. But in many cities, the task of educating immigrant students has become an enormous burden. In Los Angeles, 39% of the city's students don't speak English well, and in Seattle, 21% come from homes where English is not the family's first language. In the nation's capital, the school system is nearly overwhelmed by a huge number of Vietnamese, Haitians, and Salvadorean children. "If the school system is inadequate, then it's much more difficult to help immigrants move up the economic ladder," says Robert D. Hormats, vice-chairman of Goldman, Sachs International and head of the Trilateral Commission's working group on immigration.

City schools, despite the constraint of tight resources, are finding innovative ways to reach immigrant children. In Seattle, about half the immigrant students speak such limited English that they qualify for a program where they are taught subjects in simplified English. The Los Angeles schools offer dual lan-

guage classes in Spanish, Korean, Armenian, Cantonese, Filipino, Farsi, and Japanese. Other organizations, such as unions, are also teaching immigrants English. In New York, the Garment Workers Union, often called the immigrant union, offers English classes to its members and their families.

In the coming decade, it won't be easy to assimilate the new immigrants, whether they come from Laos or Russia. But the positives far outweigh any short-term negatives. In today's white-hot international competition, the U.S. profits from the ideas and innovations of immigrants. And by any economic calculus, their hard work adds far more to the nation's wealth than the resources they drain. It is still those "huddled masses yearning to breathe free" who will keep the American dream burning bright for most of us.

By Michael J. Mandel and Christopher Farrell, with Dori Jones Yang in Seattle, Gloria Lau in Los Angeles, Christina Del Valle in Washington, S. Lynne Walker in San Diego, and bureau reports

ARMAGEDDON—OR SHINING CITY OF THE FUTURE?

Drive west along Miami's N.W. 62nd Street, and it's easy to see the impact of immigration. Gracing the shores of Biscayne Bay are apartments, condos, and houses inhabited by affluent whites. West of U.S. 1 is Little Haiti, home to most of the city's estimated 75,000 Haitians. Continue past I-95 to Liberty City, one of Miami's black American centers, where signs of economic life are returning after riots 12 years ago. Farther west in Hialeah, Dade County's second-largest municipality, store signs switch to Spanish in a city of 188,000 that is 87% Hispanic.

No other area in America has been so transformed by immigrants as Miami. A sleepy tourist area 30 years ago, this metropolis with a Latin beat now has more foreign-born residents than any other major U.S. city. Indeed, Hispanics constitute 49% of Dade County's 1.9 million population. "We're the new Ellis Island," says Marvin Dunn, professor of psychology at Florida International University.



CAROLE DEVILLERS/SYGMA

PAST TENSE. But in the aftermath of these changes, Miami has become a troubled city. Uncomfortable in the newly ethnic milieu, thousands of whites moved north to neighboring counties in the 1980s. Miami has exploded in a fury of riots three times over the past 12 years. The shooting of a black motorcyclist by a Hispanic police officer sparked the last riot, in 1989. And the ethnic frictions haven't subsided. Between black Americans and Haitian immigrants there is tension over jobs, language, and culture. But in front of the Winn-Dixie supermarket in Liberty City, J. A. Alex says the real conflict is between blacks and Cuban immigrants. "Nobody's backing up. Blacks aren't going back to the 1950s, and Cubans are not going to go back to Havana."

Miami's immigrant transformation began with the waves of Cuban refugees in the 1960s and 1970s and culminated with the 1980 influx that brought about 125,000 Cubans and Haitians to Miami within just two months. Nicaraguans, Peruvians, and scores of other Hispanics fleeing war and economic upheaval at home soon followed. And more Haitians keep trying to get into the U.S., despite the Bush Administration's goal of sending Haitian refugees back home.

The first waves of Cuban immigrants were mostly middle-class. Some had squirreled away capital to start up businesses. And as their numbers grew, Cubans drew on a ready market connected by language and culture for the businesses they established. Economic gains were matched by political triumphs: Miami's mayor is Cuban, the city commission is controlled by Cubans, and one-third of the county's state representatives are Cuban.

A large part of the tension between Miami's black and Hispanic community stems from the perception among many blacks that the Cubans' gain came at their expense. Indeed, a 1990 study on immigration's impact by anthropologist Alex Stepick of Florida International University notes that it was Cuban immigrants, not blacks, who won the lion's share of public and private money available for minority economic development after the 1960s civil rights movement.

BOYCOTTS AND BRIDGES. Miami's racial tensions are exacerbated at times by the role of geopolitics in local affairs. Black leaders have waged a two-year boycott of Miami as a convention site after the city snubbed African National Congress leader Nelson Mandela in 1990 for thanking Cuban leader Fidel Castro for support during his imprisonment. The boycott has cost the city 28 canceled conventions. And attorney H. T. Smith, who has led the boycott effort, says he has had hundreds of requests by blacks to start a Cuban business boycott, an effort he hasn't supported. Now that Cubans are the new power elite, they "have the opportunity to rule over the model city of the 21st century or Armageddon," he says. "It's that serious."

There have been attempts at building bridges between blacks and Hispanics. Hotel and tourist companies are making a determined effort to hire more blacks in management positions and sales jobs, and black businesses are getting more floral, catering, and other contracts. A Greater Miami Chamber of Commerce committee is working to promote Hispanic-black coventures. Says Nicaraguan banker Roberto Arguello, a co-chairman of the committee: "The tension is there, but leaders are working to decrease it." But with all Miami's problems, that's going to take a long time.

By Gail DeGeorge in Miami

IMMIGRANTS HAVE WORLDS TO OFFER

Immigration fatigue is weighing upon many Americans, following the arrival of a near-record 10 million immigrants since 1980. Fly from Portland, Ore., to Los Angeles, where 44% of the adults are foreign-born, or drive from Coral Springs, Fla., to Miami, where 70% of adults are born abroad, and the sense of entering a different country is very real.

Too real for 68% of this nation's population, who now think immigration is "bad" for the country, according to a BUSINESS WEEK/Harris poll (page 119). Are they right? From the standpoint of the overall economy, the answer is a resounding "no." Immigration has proved to be a powerful, pervasive economic stimulant. Yet it would be unwise to simply deny the pain of immigration that our society is experiencing. It would be even more unwise to leave it to know-nothing bigots to give voice to what two-thirds of the people are feeling.

The heated public debates over multiculturalism and bilingual education in public schools reflect a deep social anxiety. The fear is that recent immigrants by virtue of their sheer numbers and, in some cases, through their own choice are resisting the assimilation of core, shared American values, especially the desire to speak English. People also are concerned that in an era of high social need and low financial resources, the extra burden placed on social services, especially the schools, by the large number of immigrants who speak limited English may be too great.

FAST ASSIMILATION. To judge by the newcomers' remarkably successful record in the globally competitive top half of the U.S. economy—such industries as high technology, industrial design, biotechnology, and advertising—there isn't much of a problem. The new immigrants' attitudes toward education and work represent values that are as American as you can get. A quarter of all immigrants have college degrees, slightly higher than the average for native-born Americans. Engineers, scientists, and entrepreneurs from overseas have been critical to the great success of hundreds of computer, biotech, and software companies. To take just one example, Andrew S. Grove, founder of Intel Corp., is from Hungary, and his company is staffed with people born in India, Taiwan, and elsewhere. With their bilingual skills, family ties, and knowledge of how things get done overseas, immigrants are making important contributions in exporting Made-in-the-USA goods and services, especially to the fast-growing Latin American and Asian markets. Immigrants also are bringing new energy to our aging cities by setting up businesses and buying real estate. Without them, the nation's 10 largest cities would have shrunk by 6.8% in the past decade, instead of growing by 4.7%. Immigrants pay an estimated $90 billion in taxes, compared with the $5 billion in welfare benefits they receive. So if building new companies and generating jobs, profits, and taxes to pay for social services are American, these immigrants are probably assimilating as fast, or perhaps even faster, than our grandparents did.

The picture is less clear at the bottom half of the economy, which is under severe pressure as the competitive forces of globalization sweep across America, drying up unskilled jobs and putting downward pressure on wages. While about one-quarter of the past decade's new immigrant workers had college degrees, about one-third actually dropped out before graduating from high school. Many only finished the fifth or sixth grade. These immigrants tend to be non-English-speaking, sometimes barely literate in their own native languages, less able and less willing to adapt to American culture, and more of a burden on social services. Of course it is true that an advanced degree is not a prerequisite for becoming an entrepreneur. Many of these immigrants have proved extremely adept at using their extended families to pool resources and start their own small businesses on city streets. Yet many others are joining tens of millions of poorly educated and low-skilled Americans at the bottom of the ladder, competing for a shrinking number of poorly paid jobs. Some 73% of African-Americans believe that immigrants are taking jobs away from them, according to the BW/Harris poll.

NEPOTISM? So, does America have an immigration "problem"? By and large, no. This nation of immigrants is benefiting nicely from its infusion of new peoples. But there are changes in public policy that can improve the situation. Right now, 62% of all legal immigrants, including political refugees, are granted visas solely on the basis of their family ties to people already living in the U.S., while only 17% get admitted on the basis of job-related skills. While that appears to be fair to those with family already in the U.S., the policy resembles nepotism to the millions of other would-be immigrants around the world who are now locked out of America. The law already restricts the definition of "family" to immediate relatives. Cutting back the quota based solely on family would open up immigration slots for others by boosting the number of people allowed to immigrate on the basis of skills. That would make the immigration standard more merit-based.

By doubling the percentage of skills-based immigration, the U.S. would also permit a greater number of Eastern Europeans into the country. That would help many people caught up in the turmoil of the end of communism, just as the 1965 immigration law helped millions of Asians and Latin Americans caught up in the conflicts of their own countries during the '70s and '80s. Finally, the school systems of gateway cities that bear the brunt of immigration should receive special federal assistance for bilingual programs that help children make the transition to classes conducted in English. There can be no denying the pain of immigration, both for the immigrants who must discard some of their cherished traditions in their new world and for mainstream Americans who must adjust to the newcomers. But for an immigrant society such as ours, the pain is more than worth it. Immigration is revitalizing America.