

The background of the entire page is a stylized American flag with red and white horizontal stripes and a blue canton on the left. Overlaid on the flag are several strands of black barbed wire. Each strand has a hand, rendered in a dark, almost black color, gripping the wire. The hands are positioned at various points along the wires, creating a sense of being trapped or restricted. The overall mood is somber and restrictive.

Undermining Public Health and Human Rights:

**The United States
HIV travel and
immigration ban**

Update: January 2010

GMHC

FIGHT AIDS. LOVE LIFE.

Credits

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UPDATE: **Lifting the HIV entry ban: What it means on the ground**

By Erin Price

Background

On January 4, 2009, the final repeal of the HIV travel and immigration ban went into effect. For too long the United States denied HIV positive non-citizens access to citizenship, residency and visiting rights based solely on their HIV status. Since 1987, under section 212(a)(1) of the Immigration and Nationality Act (INA), a non-citizen determined to have a “communicable disease of public health significance” has been inadmissible into the United States. Over the past twenty years, the Human Immunodeficiency Virus (HIV) has been considered a “communicable disease of public health significance.” HIV-positive non-citizens have thus been barred from entry into the United States, and HIV-positive non-citizens already in the US have been barred from adjusting their status to that of a legal permanent resident. Although there was a waiver available for HIV-positive non-citizens, it was only available to those with a parent, spouse or child living in the U.S. as a citizen or legal permanent resident. This restriction was put in place in 1987 at the request of the late Senator Jesse Helms (R-NC) during the height of the homophobic political climate of the late 1980s.

Public health experts have long acknowledged that the HIV entry ban does nothing to prevent the spread of HIV across international boundaries and is in fact out of step with the public health and immigration policies of much of the rest of the world. This welcome change is the result of decades of advocacy and education of public officials. The legislative action needed to repeal the ban occurred in July 2008 when President Bush signed into law the reauthorization of the President’s Emergency Plan for AIDS Relief (PEPFAR II). This amended the Immigration and Naturalization Act, striking the provision that renders individuals with HIV inadmissible to the United States. Congresswoman Barbara Lee and Senator John Kerry led the fight in Congress to repeal the entry ban. This repeal of the statutory bar required the Department of Health and Human Services (HHS) to reconsider whether HIV should continue to be listed as a communicable disease “of public health significance” that renders non-citizens inadmissible to the United States. A policy change at HHS was the final barrier to a full repeal. A proposed rule change, started in the final months of the Bush Administration and promulgated by the Obama Administration, proposed the removal of HIV from the list of “communicable disease[s] of public health significance.” During a public comment period in July and August of 2009, HHS received an overwhelming positive response to these proposed changes. While 19,000 comments were made in favor of the change, only 500 were made in opposition.

The publication of the final rule was announced by President Obama on October 30, 2009, to go into effect January 4, 2010.

President Obama noted the historic and significant nature of this policy change: “Twenty-two years ago, in a decision rooted in fear rather than fact, the United States instituted a travel ban on entry into the country for people living with HIV/AIDS. Now, we talk about reducing the stigma of this disease, yet we have treated a visitor living with it as a threat. We lead the world when it comes to helping stem the AIDS pandemic, yet we are one of only a dozen countries that still bar people with HIV from entering our own country. If we want to be the global leader in combating HIV/AIDS, we need to act like it. And that is why, on Monday [Nov. 2], my administration will publish a final rule that eliminates the travel ban, effective just after the new year. ...¹”

What this means for HIV advocacy

Symbolically, the rule will help reduce HIV-related stigma, and bring the United States into compliance with international health policies regarding HIV immigration and travel. The United States’ HIV entry and immigration ban was at odds with current medical knowledge involving the transmission of HIV, and was also in direct opposition to the U.N.’s International Guidelines for HIV/AIDS and Human Rights.² The ban placed the United States alongside only 13 other countries that ban HIV-positive short term visitors: Brunei, Egypt, Iraq, Yemen, Malaysia, Oman, Qatar, Singapore, Sudan, South Korea, Tunisia, Turks & Caicos Islands, and the United Arab Emirates. This put the U.S. in a category with many countries whom the U.S. State Department describes as having either poor or significantly problematic human rights records.³ The new American policy demonstrates the Obama Administration’s commitment to fight HIV-related stigmatization and treat HIV positive non-citizens with an increased standard of dignity.

What this means for HIV positive non-citizens

HIV will be taken off the list of “communicable diseases” that would normally bar entry without a waiver. HIV-positive non-citizens will no longer have to submit to an HIV test when applying for an American visa. Applicants will still need to undergo a visa-related medical examination, but it will not include an HIV test, decreasing the costs of visa-related medical examinations. In addition, HIV-positive non-citizens applying for entry or adjustment will no longer have to file for a waiver of inadmissibility, which costs a hefty \$545. However, applicants will still be denied for any of the other diseases still on the list of “communicable diseases of public health significance”—including active tuberculosis, infectious syphilis, gonorrhea, infectious leprosy, etc.—unless a waiver is obtained.

This change does not provide amnesty for persons with HIV who previously entered without inspection or were previously denied entry due to their health status. While HIV is no longer a bar to applying for permanent residence, all applicants for a green

card must qualify under current immigration law. This means that to get a green card you must have family or employer sponsorship, a current spot in the diversity lottery, asylum, or another recognized means to apply. Many undocumented HIV positive persons who have been living in the United States still will not have access to residency because they have been in the country without lawful status. The new provision simply means that after January 4, 2010, HIV-positive non-citizens going through an already established path to residency will no longer need to apply for an HIV waiver.

People who are at varying points of applying for residency, waivers, visas and asylum are affected differently by this change. Anyone who has filed an HIV waiver as part of his or her green card application should notify the U.S. Citizenship and Immigration Services (USCIS) that the ban has been lifted, and ask that their application be adjudicated.

If you have previously applied for and been denied residency because of your HIV status, you may be able to re-open your case if you are still eligible under current statuses. Anyone applying for asylum on the basis of being HIV-positive should not be affected by this new ruling, because those applications are based upon threat of persecution in country of origin. People previously denied visas because of their HIV status will no longer have that barrier. However, you must still qualify for all other requirements, including a demonstrated intent to return home. While HIV status no longer bars access to immigration, other barriers could affect some people living with HIV. Some people living with HIV whose health poses major barriers may find it difficult to meet USCIS requirements that candidates demonstrate an ability to support themselves, due to the affects of living with HIV. No matter one's relative health, no person is required to bring up their HIV status in the immigration process.⁴

As of the start of 2010 the U.S. no longer bars entry based on HIV status.

The new rule is not retroactive. The final rule obligates the Centers for Disease Control and Prevention and the Department of Health and Human Services to continue working with the State Department and the Department of Homeland Security to ensure that panel physicians and civil surgeons who conduct the medical examinations are aware of the revision to the current rule.⁵

Conclusion:

This is a huge victory for human rights and persons living with HIV. The new rule not only eliminates HIV screenings during medical examinations, but also eliminates the need for an expensive waiver application. It also brings the United States into line with international policies regarding HIV and travel restrictions and removes the institutional stigma placed on persons with HIV and AIDS by the old regulation.

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Notes

- 1 President Barack Obama. “Remarks by the President at the Signing of the Ryan White HIV/AIDS Treatment Extension Act of 2009.” The White House, Office of the Press Secretary. October 30, 2009. <http://www.whitehouse.gov/the-press-office/remarks-president-signing-ryan-white-hiv-aids-treatment-extension-act-2009>. Accessed: December 17, 2009.
- 2 In 2004, the Joint United Nations Programme on HIV/AIDS (UNAIDS) issued a statement concluding that HIV-related travel restrictions have no public health benefit.
- 3 United States State Department. “2007 Country Reports on Human Rights Practices.” <http://www.state.gov/g/drl/rls/hrrpt/2007/index.htm>. Accessed: November 26, 2008.
- 4 ImmigrationEquality. “The HIV Ban: Frequently Asked Questions.” <http://www.immigrationequality.org/template.php?pageid=176>. Accessed: December 17, 2009.
- 5 Department of Health and Human Services: Centers for Disease Control and Prevention. “Medical Examination of Aliens—Removal of Human Immunodeficiency Virus (HIV) Infection From Definition of Communicable Disease of Public Health Significance.” Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS). 42 CFR Part 34. [Docket No. CDC-2009-0003] RIN 0920-AA26. http://www.cdc.gov/ncidod/dq/laws_regs/fed_reg/remove-hiv/full-version-final-rule.html. Accessed: December 17, 2009.

Executive summary

The U.S. HIV travel and immigration ban does great harm to HIV prevention efforts at home and abroad. While its original intent was to protect the public's health, experts agree that the bar has not prevented the AIDS pandemic from spreading to the United States, and actually perpetuates the very problem it seeks to solve. The ban disallows the entry of HIV-positive non-citizens into the U.S., and prohibits HIV-positive non-citizens from becoming permanent legal residents. This serves as a disincentive for immigrants to get tested, diagnosed, and onto treatment, and helps perpetuate the epidemic. Public health experts agree that the ban does more harm than good and have advocated for the lifting of this ban. However, politics has too often disregarded science, and the HIV travel and immigration ban remains.

While a 1987 law banning entry of HIV-positive individuals was repealed by Congress and President Bush in 2008, a 1993 regulation banning entry of HIV-positive individuals remains on the books as of early 2009. This paper provides an analysis of the HIV entry ban and examines public health ramifications and human rights concerns. It critically analyzes economic arguments for the ban, and details recent political successes and remaining challenges.

Introduction to the HIV travel and immigration ban

United States law bars non-citizens infected with the Human Immunodeficiency Virus (HIV) from entering the United States—even for a stopover.¹ Waivers are occasionally granted, particularly for high-level meetings such as the United Nations General Assembly Special Session on AIDS. However, these are often granted in an arbitrary and last minute manner. American law also bars HIV-infected non-citizens *living* in the United States from qualifying for lawful permanent residence,² or, as it is commonly known, a “green card,” save in the most limited circumstances. Individuals denied a green card because of their HIV status confront a dilemma: go “home,” where, as is often the case, they will not have access to effective HIV treatment, or violate American law by remaining in the United States, where HIV treatment is available, and where they can hope to extend their life. Intended to protect the public's health, the United States' HIV travel and immigration bar has in fact not prevented HIV from crossing the American border, promotes discrimination against would-be immigrants living with HIV, and contributes to the spread of HIV in the United States by causing many HIV-positive immigrants to shun HIV testing and treatment.

Support for the HIV bar was fueled...by misconceptions regarding HIV and hostility towards gay men.

History of the policy

Congress has near plenary power over immigration. In order to protect the American populace, Congress has been given the authority to exclude from the United States non-citizens perceived to pose a public health threat to our society. The U.S. has denied entry to individuals for health related reasons since 1881. These health related reasons have been politically determined and/or defined. For example, an implicit bar on homosexual immigrants was originally put in place by the 1917 Act to the Immigration and Nationality Act (INA), also known as the Asiatic Barred Zone Act.³ The Act called for the exclusion of individuals from entering the U.S. if they were “mentally defective” or had a “constitutional psychopathic inferiority.” These terms were interpreted to include homosexuals and ultimately barred all homosexual immigrants who disclosed their sexual minority status.⁴ This was later made explicit with amendments to the INA in 1965 which added “sexual deviation” as a medical ground of denying entry. This anti-gay ban remained in effect until 1990. In 1952 Congress amended the INA to specify thirty-one grounds for excluding non-citizens, including non-citizens infected with “any dangerous contagious disease.”

The HIV entry ban dates back to a 1987 amendment sponsored by U.S. Senator Jesse Helms, the late North Carolina Republican. Senator Jesse Helms directed the Public Health Service (PHS)—the federal agency within the Department of Health and Human Services (HHS) in charge of administering the exclusions list—to add HIV to its list of “dangerous contagious diseases” that preclude people from entering the country.⁵ Then, in 1990, Senator Edward Kennedy introduced and passed a bill, commonly referred to as the Immigration Act of 1990, to amend the Immigration and Nationality Act (INA). This Act authorized HHS to remove the ban.⁶ In 1991, having determined that HIV is “not spread by casual contact” or “through the air,”⁷ HHS proposed to remove HIV as a ground for excluding non-citizens from the United States as the risk “comes not from nationality... but from specific behaviors.”⁸ HHS’s view in favor of dropping HIV from the exclusions list was supported by a cross-section of prominent individuals and health organizations, including the American Public Health Association,⁹ the American Medical Association, the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), the Association of State and Territorial Officials (ASTO),¹⁰ and the 8th International Conference on AIDS.¹¹ Notwithstanding, Congress rejected HHS’s proposal to eliminate HIV as a ground for exclusion of non-citizens and instead elected to further mandate such exclusions through statute. In 1993 Congress wrote the HIV entry ban into law, specifying that excludable conditions “include infection with the etiologic agent for Acquired Immune Deficiency Syndrome (AIDS),” that is, HIV.¹² Congressional records indicate that support for the HIV bar was fueled in part by misconceptions regarding the transmission of HIV and hostility towards certain communities associated in the public mind with HIV (e.g. gay men). Congressional leaders also reasoned that allowing infected non-citizens to enter the U.S. would not only increase the spread of HIV, but would also result in increased demands on public resources by HIV-infected individuals.

Impact of the ban

There are 14 countries around the world—including the United States—that restrict HIV-positive persons from entering the country. Depending on the country, the restrictions target individuals who plan to come to the country as tourists, for business, to visit family, or other short term personal reasons. In some cases, they target HIV-positive people seeking longer stays for educational purposes, employment, as refugees, or those seeking to become citizens of the country. While protecting the public from communicable diseases has traditionally been a rational reason to deny would-be visitors or immigrants' entry to countries, there is no consensus among public health professionals that HIV should be a ground for exclusion. In fact, the consensus is that HIV should not exclude them. Historically, these restrictions were designed to prevent the "introduction" of infectious diseases into a susceptible population, thereby preventing infected visitors or immigrants from placing a country's citizens at risk or becoming a financial burden to the country. However, experts around the world believe that laws and policies that restrict entry to a country based on HIV status, or that require a declaration of HIV status or HIV testing, are ineffective at stopping the spread of HIV and impose undue and arbitrary restrictions on personal liberty.¹³ In the United States, the statutory travel ban on those who are HIV-positive states that:

every applicant for permanent residence over the age of fifteen is required to undergo HIV testing. Applicants for non-immigrant entry are questioned on their HIV status, and if they admit to being positive, can be refused admission. If the government suspects them of HIV infection, it can require an HIV test. People entering the U.S. with HIV medications in their luggage can be questioned or expelled. Non-immigrants who are HIV-positive can request (and can be denied) a waiver for short trips.¹⁴

Since 1993, the International AIDS Society, which convenes the International AIDS Conference, has refused to hold its biennial meetings in the U.S. In July 2007, the IAS Governing Council adopted this additional restriction to its previous policy: "The IAS will not hold its conferences in countries that restrict short term entry of people living with HIV/AIDS and/or require prospective HIV-positive visitors to declare their HIV status on visa application forms or other documentation required for entry into the country." This means that the organization is requiring higher standards from candidate countries willing to hold conferences under IAS auspices in the future.¹⁵ The U.S. also fails to profit from such a large gathering. In addition, other lesbian, gay, bisexual, and transgender (LGBT) and human rights organizations have also boycotted the United States due to the HIV entry ban. The restriction on travel also has a negative effect on numerous international gay gatherings, such as the Gay Games, an event that attracts tens of thousands of athletes and supporters every four years. Travel restrictions limit participation and/or discourage participation, as all HIV-positive competitors are required to undergo scrutiny by the

There is no evidence that entry restrictions have a significant effect on the prevention of HIV transmission.

Department of Homeland Security (DHS), including the need to apply for an HIV waiver.

Current state of the ban

In early 2008, Congressional leaders and advocates decided to include repeal of the HIV entry ban as an amendment to the reauthorization of the President's Emergency Plan For AIDS Relief (PEPFAR). PEPFAR provides funding to countries with the highest HIV prevalence rates such as Africa, the Caribbean, and Southeast Asia. It is popular among politicians on both sides of the aisle, and was viewed as a success of the Bush-Cheney Administration. There was political will to reauthorize the legislation in 2008 despite any controversies. In April 2008, the Senate Foreign Relations Committee passed its version of the PEPFAR reauthorization and included language to repeal the HIV entry ban. Since the PEPFAR reauthorization was signed into law, Public Law No. 110-293. Section 305 of P.L. 110-293 amends section 212(a)(1)(A)(i) of the INA so that HHS is no longer *required* to designate HIV infection as "a communicable disease of public health significance." However, as of March 2009, HHS has not amended the original regulatory action from 1987. This is the second step in full repeal of the HIV entry ban. The signing of PEPFAR repealed the law and returned control of the policy to HHS. Until HHS removes HIV from the list of communicable diseases, the HIV bar will continue to exist, and anyone who is HIV-positive will still be subject to waiver requirements when entering for temporary reasons, or for permanent immigration.

Public health concerns

"Travel restrictions based on HIV status again highlight the exceptionality of AIDS, especially short-term restrictions... No other condition prevents people from entering countries for business, tourism, or to attend meetings. No other condition has people afraid of having their baggage searched for medication at the border, with the result that they are denied entry or, worse, detained and then deported back to their country."¹⁶

—UNAIDS Executive Director Dr. Peter Piot, March 4, 2008

Most experts in infectious disease and public health, including the Joint United Nations Programme on HIV/AIDS (UNAIDS), affirm recommendations from the U.S. Centers for Disease Control and Prevention that "HIV/AIDS should not be considered a condition that poses a threat to public health in relation to travel because, although infectious, the virus cannot be transmitted by the mere presence of a person with HIV in a country or by casual contact."¹⁷ Furthermore, there is no evidence that entry restrictions have a significant effect on the prevention of HIV transmission.¹⁸ The United Nations International Guidelines on HIV/AIDS and Human Rights note that:

There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to current international health regulations, the only disease which requires a certificate for international travel is yellow fever. Therefore, any restrictions on these rights based on suspected or real HIV status alone, including HIV screening of international travelers, are discriminatory and cannot be justified by public health concerns.¹⁹

The HIV ban harms public health efforts

Restrictive measures can in fact run counter to public health interests, since exclusion of HIV-positive non-nationals adds to the climate of stigma and discrimination against people living with HIV, and may thus deter nationals and non-nationals alike from coming forward to get tested and utilize HIV prevention and care services. Moreover, travel restrictions may encourage nationals to consider HIV a “foreign problem” that has been addressed by keeping foreigners outside their borders, so that they feel no need to engage in safe behavior themselves.²⁰

A number of studies now debunk the myth of the HIV infected foreigner spreading HIV in the U.S. In fact, these studies conclude that immigrants, by and large, become HIV infected in the U.S. and not in their home countries, and often bring HIV back to their native lands. For example, research conducted in Los Angeles asserts that most HIV infections among immigrants occur in the U.S.

HIV-positive clients...had immigrated in their late teens or very early 20s and had lived in the U.S. for an average of 12 years. The median time between HIV infection and AIDS diagnosis in untreated cases is 10 to 12 years, and the largest proportion of documented AIDS cases are reported in persons aged 30 through 39 years, generally indicating HIV infection during the clients' 20s. We therefore suggest that most of the HIV-positive STD clients in our study were infected after immigration to the United States.²¹

Research regarding the epidemiology of HIV among Mexican immigrants to California who later return to Mexico, also demonstrates this phenomenon. Many immigrants acquire HIV infection while in the U.S. and later return to rural communities in Mexico that have the highest migration rates to the U.S. According to research findings:

33% of AIDS cases in Mexico have been from those states that export the highest number of immigrants to the United States. This increase... along with the association between AIDS cases and the leading “sending” states provides potential evidence of immigrants acquiring infection while in the U.S.²²

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Immigrants that move to the U.S. from small rural communities are more likely to engage in high-risk sexual practices and alcohol or drug using practices. Feelings of isolation and alienation run high among immigrants, leading many non-citizens to seek comfort in sexual intimacy and/or substance use.²³ Additionally, minimal social control on behavior, coupled with a new environment in which to explore their newfound sexual freedoms, lead many immigrants to adopt new sexual practices, making it difficult for them to navigate safer sex practices.^{24, 25}

Navigation of sexual practices does not take place in a vacuum, but is subject to situational and environmental factors. Individual behavior is one part of an intricate web of interrelated contributors such as environment, relational dynamics, and power differentials.²⁶ Language barriers add to low levels of knowledge about HIV infection and prevention. Many immigrants also find themselves in precarious economic situations that compel them to exchange sex for goods such as food, lodging, and money.²⁷ Marc Lacey of the *New York Times* reports that “more than a third of [male] immigrants at job-pickup sites in Los Angeles had been offered money by men for sex, and about a tenth of that third of immigrants, desperate to earn a living, have agreed.”²⁸

The HIV travel and immigration ban stymies HIV prevention efforts by perpetuating the myth of the HIV-infected immigrant. However, studies based on experiences of people with HIV traveling to the U.S. under current policy have shown that laws restricting entry on the basis of HIV status have not been effective in keeping people with HIV out. Instead they have been counterproductive by pushing the issue underground, as many choose to lie about their status rather than risk being turned away. The fear of getting caught at the border with HIV medication in their luggage may actually lead people with HIV to discontinue use of their medication while traveling. Such interruptions of treatment increase the chances of developing new or further viral mutations, which can lead to drug resistant strains of HIV, with risks of possible treatment failure.²⁹

One other major drawback to these restrictions is that they essentially establish a system that leads to mandatory HIV testing for certain people attempting to obtain legal permanent residence. This is in direct opposition to the UN International Guidelines for HIV/AIDS and Human Rights.³⁰ Furthermore, these tests are often carried out with complete disregard for the immigrants' health. There are often no referral services to care and treatment. Potential immigrants are left with the news that they have HIV and no support system to help. Beyond the lack of health support, these mandatory testing programs miss out on the very real opportunity for HIV prevention education. Very little is done to ensure that those tested are provided with the necessary tools and support to not transmit this virus to others.

The HIV ban and spousal transmission of HIV

Also troubling is the lack of referral services and prevention education that leads to potential spousal transmission of HIV. That is, immigrant workers who test positive for HIV but do not receive appropriate health care interventions may return home in the U.S. and abroad, without education about the risk of transmitting HIV to sexual partners. Marc Lacey of the *New York Times* reports that many women become infected by their husbands who emigrate to the U.S. for economic circumstances. Upon returning back to Mexico, they infect their wives. Lacey reports that “the greatest risk of contracting AIDS that rural Mexican women face is in having sex with their immigrant husbands..., a problem that is compounded by their husbands’ refusal to use condoms.”³¹ Jennifer Hirsch of Columbia University provides further evidence that immigrant men, due to their concerns about social status or reputation in small rural communities, cause “marriage [to be]...the single greatest risk for HIV infection among women in rural Mexico.”³² According to Dr. Hirsch, reputation in rural communities leads to sexual behavior that minimizes a drop in a man’s social status without regard to his and his wife’s risk of HIV infection. That is to say, men’s extramarital affairs with men or women are clandestine in nature and often occur in places far from home, like the U.S.

To add injury to an already damaged system, many testing sites do not understand or honor the code of confidentiality. The result is that for many of the immigrant workers looking to enter the U.S., their privacy is ignored and their HIV test results are often inappropriately discussed by government workers. This can lead to a significant number of immigrant workers returning home with an HIV diagnosis, insufficient information or support for addressing the diagnosis, and the added burden of facing stigma and discrimination because of inappropriate disclosure of their HIV status.³³

HIV incidence among foreign born New Yorkers steadily increased from 2001 to 2006.

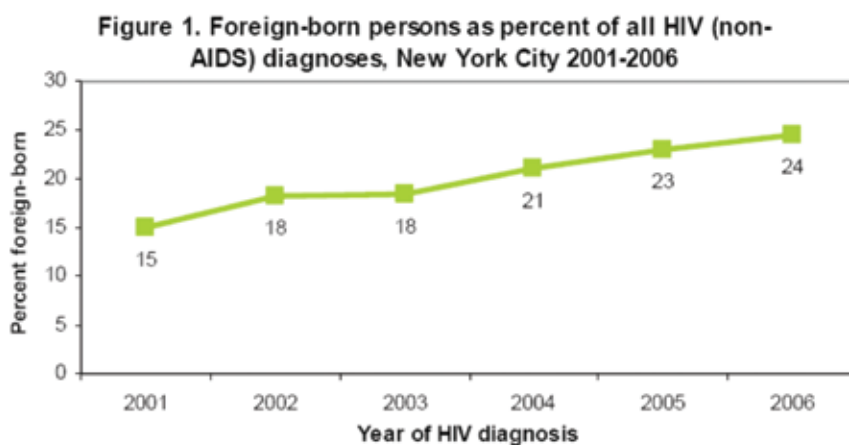
Epidemiology

Researchers from Los Angeles and New York City, the two largest cities and metropolitan areas in the U.S., have conducted a number of epidemiological studies on immigrant populations and HIV infection. Los Angeles has the highest proportion of immigrants in the U.S., followed by New York City, and both cities are home to some of the highest rates of HIV incidence and prevalence.^{34, 35} According to the New York City Department of Health and Mental Health (NYC DOHMH) *HIV Epidemiology & Field Services Semiannual Report*, immigrants from the Caribbean and the West Indies experienced the highest number of new HIV diagnoses, followed by immigrants from Central and South America, and Africa.³⁶ Similarly, a study of HIV prevalence among foreign and U.S.-born clients of public STD clinics in Los Angeles county shows that, among immigrants, individuals from North Africa and the Middle East had the highest

rates of new infections, followed by Caribbean and West Indian clients, and Central American clients.³⁷ These figures are compounded by recent CDC data showing that non-U.S.-born Latinos are not only late testers, but are also diagnosed late in their infection compared to their U.S.-born white counterparts.³⁸ New York City follows this trend closely. According to NYC DOHMH data, foreign-born individuals from nearly every region of the globe are more likely (32%) to be diagnosed with both HIV and AIDS than their native born counterparts (24%), a marker of both late testing and diagnosis.³⁹ This disparity has huge implications for success of HIV treatment and longevity.

Results from the New York City *Community Health Survey* also show significant health disparities between U.S.-born and foreign-born New Yorkers. For example, foreign-born New Yorkers were less likely than U.S.-born New Yorkers to be tested for HIV in 2006 (29% vs. 32%).⁴⁰ Foreign-born New Yorkers are also acquiring HIV infection more frequently than five years ago.

Incidence among foreign-born New Yorkers steadily increased from 2001 to 2006. In 2001, they accounted for 15% of the newly diagnosed versus 24% (1,352 of 5,727 new infections) in 2006.⁴¹ Of the



New York City population, foreign-born New Yorkers make up only 36% of the city's population as of the 2000 Census.⁴² However, they make up 24% of all new HIV infections to the 48% infection rate of U.S.-born New Yorkers.⁴³ The largest number of new infections among immigrants in New York City (which is a plurality not a majority) were from the Dominican Republic (201), followed by Jamaica

(172), and Mexico (163). Given that many of these foreign-born New Yorkers are less likely to afford medical care, have a personal doctor, or have any health insurance, they access public benefits more often than U.S.-born New Yorkers.⁴⁴

While it is true that immigrants represent a large percentage of the poor in the U.S. and thus are more likely to visit free public STD clinics in any given city, the number of immigrants getting tested is still low due to HIV stigma, an increasingly anti-immigrant sentiment in the U.S. and, most notably, fear of deportation and/or the inability to become a permanent resident of the U.S.

Human rights perspectives

The United States was instrumental behind the drafting of the Universal Declaration of Human Rights, which was adopted by the United Nations General Assembly in 1948. As Eleanor Roosevelt, the first Chairwoman of the Commission on Human Rights, said at the time: “[The Universal Declaration of Human Rights is] a global testament of humanity, a standard by which any humble person on Earth can stand in judgment of any government on Earth.” The Declaration provides that “All human beings are born free and equal in dignity and rights.”⁴⁵ The United States’ HIV travel and immigration ban, and compulsory HIV testing for certain lawful permanent residence applicants, is an affront to human dignity, and violates the rights of equal protection, non-discrimination, privacy and freedom of movement—rights which the United States has long defended in the international arena. The United Nations International Guidelines on HIV/AIDS and Human Rights state that:

any restriction on liberty of movement or choice of residence based on suspected or real HIV status alone, including HIV screening of international travelers, is discriminatory. HIV-related travel restrictions raise fundamental issues regarding the human rights of non-discrimination and freedom of movement of people living with HIV in today’s highly mobile world.⁴⁶

People living with HIV/AIDS have the right to full enjoyment of their human rights, including the right to privacy, confidentiality and protection from stigma and discrimination. HIV-related travel restrictions infringe upon these and other human rights in multiple ways. The U.S. Immigration and Naturalization Service currently conducts the largest mandatory HIV-testing program in the world. Every applicant for permanent residence over the age of 15 undergoes HIV testing, and largely without informed consent.⁴⁷ In many instances these mandatory tests are done without appropriate pre- and post-test counseling or safeguards of confidentiality. Any HIV testing should be done voluntarily and on the basis of informed consent.

The personal impact of HIV-related travel restrictions can be devastating for the individual seeking to immigrate, to gain asylum, to visit family, to attend meetings, to study, or to do business. The candidate immigrant, refugee, student or other traveler may simultaneously learn that s/he is infected with HIV, that s/he may not be allowed to travel, and possibly that his/her status has become known to government officials, or to family, community, and employer, exposing the individual to possibly serious discrimination and stigma.⁴⁸ Additionally, HIV travel restrictions add to discriminatory policies experienced by LGBT people. While lifting the HIV bar will help HIV-positive individuals seeking to immigrate to the U.S., same sex partners in bi-national relationships will still be unable to sponsor their foreign-born partners for immigration

Every applicant for permanent residence over the age of 15 undergoes HIV testing, and largely without informed consent.

benefits. The Uniting American Families Act—a bill that if passed will afford bi-national same sex couples equal rights under immigration policy—is currently under debate in Congress.

Furthermore, before January 12, 2009, HIV-positive persons from wealthy countries who have visa waiver relationships with the United States were not subject to review by consular officers or the DHS when traveling to the United States for 90 days or less because they did not need to apply for a visa. However, there was a question on their “landing card” or I-94w which asked, “Do you have a communicable disease?” In contrast, people living with HIV from African, Asian or Latin America/Caribbean countries had to declare their HIV status as part of visa application procedures.⁴⁹ However, beginning January 12, 2009, all nationals and citizens of Visa Waiver Program (VWP) countries are now required by law to obtain a travel authorization prior to initiating travel to the United States under the VWP. This authorization may be obtained online through the Electronic System for Travel Authorization, a free Internet application administered by DHS through a U.S. government Web site. On the electronic website it asks “Do you have a communicable disease?” and now spells out HIV along with:⁵⁰

- Chancroid
- Gonorrhea
- Granuloma inguinale
- Human immunodeficiency virus (HIV) infection
- Leprosy, infectious
- Lymphogranuloma venereum
- Syphilis, infectious stage
- Tuberculosis, active

And others as determined by the Department of Health and Human Services.

Prior to January 12, 2009, it was vague, but people from every non-VWP participating country were subject to an interview and were required to submit an application form for a visa.

Detained and denied life-saving medication

The U.S. has a long history of discrimination towards people with HIV. Although the days of hysteria about HIV are largely over, the bigotry and stigma remain pervasive. In the 1980s, “gay men, intravenous drug users, and immigrants—especially from Haiti—bore the brunt of the fear and antipathy, as preexisting prejudices mixed with loathing of disease to produce a toxic brew of discrimination and stigma.”⁵¹ This unfortunate initial response to HIV lives on in the discriminatory policies passed in the 1980s that

remain in place. People with, or thought to have, HIV were rejected, fired from their jobs, kept out of schools, and in some circumstances, detained. Perhaps the best example of detention is that of HIV-positive Haitian refugees who were housed at Guantanamo Bay until courts intervened and forced the U.S. government to release them.⁵² The HIV travel and immigration ban is a less severe version of the same discriminatory policy. Established during the Reagan administration, the HIV bar continues to deny HIV-positive immigrants' basic human rights, including the right to privacy, confidentiality, and protection against discrimination. HIV travel restrictions infringe upon these and other human rights in multiple ways.

One of the greatest areas of a breach in human rights has to do with immigrants who are detained in U.S. detainee facilities. Reports from these detainee centers show that the U.S. does not provide adequate care, treatment or support to detainees that are HIV-positive. The 2007 Human Rights Watch report, *Chronic indifference: HIV/AIDS services for immigrants detained by the United States*,⁵³ documents the experiences of HIV-positive detainees in immigration custody whose HIV treatment was denied, delayed, or interrupted, resulting in serious risk and often damage to their health. The investigation provided evidence that detention facilities which housed immigrants with HIV infection failed to consistently deliver anti-retroviral medications, conduct necessary laboratory tests, ensure continuity of care, and ensure confidentiality or protection from discrimination.

Contrary to international human rights obligations, constitutional protections, and best practice advisories, DHS detention guidelines for HIV/AIDS care fail to meet both national and international standards for appropriate care. Furthermore, the agency does little to enforce its own minimal standards. Immigrants who end up, for any reason, detained by the U.S. in a detention facility receive dangerously inadequate health care services. This creates a system in the U.S. where we have established a health system for HIV-positive people that is based on an inherent double standard. According to the Human Rights Watch, "with policies and laws seeking to protect [our] own citizens from HIV and from HIV-related discrimination [we are] ignoring the equally valid needs and rights of non-nationals."⁵⁴

Human Rights Watch documented the following deficiencies in the health care of immigrant detainees in U.S. facilities:

1. Failure to consistently deliver anti-retroviral medications.
2. Failure to conduct necessary laboratory tests in a timely manner, including CD4 and viral load testing as well as drug resistance testing.
3. Failure to prevent opportunistic infections.
4. Failure to ensure continuity of care, including access to necessary specialty care.

Of the listed [detainee] deaths, 13% of the 66 individuals died of HIV/AIDS and related conditions.

Human Rights Watch documented substandard medical care and services for immigration detainees with HIV/AIDS. It found that the department responsible for ensuring that detainees receive necessary medical care—the Immigration and Customs Enforcement (ICE) Department within DHS—does not know how many of its detainees have HIV or AIDS, how many need treatment, or how many are receiving care. Further, Human Rights Watch found that DHS policies not only failed to enforce its own minimal standards, but also failed to meet national and international standards of care and treatment of HIV/AIDS. As a result, HIV-positive immigrants in detention risk serious illness, needless suffering, and even death.⁵⁵

Over 30,000 immigrants are detained by ICE while awaiting deportation, or the outcome of their political asylum request on any given day. They are held in county jails, federal detention centers, or privately run prisons. Every year a number of immigrants die while waiting for their immigration status to be resolved. Detainees are not guaranteed free legal representation and only one in ten has an attorney. Furthermore, when lawyers are involved, they often have difficulty finding clients much less obtaining medical information from the DHS bureaucracy.⁵⁶

In May of 2008, through a Freedom of Information Act request, *The New York Times* was able to obtain a list of 66 individuals who died in immigration custody from 2004 through 2007.⁵⁷ Of the listed deaths, nine detainees—that is 13% of the 66 individuals—died of HIV/AIDS and related conditions.

One troubling case exemplifies the extreme conditions that people with HIV/AIDS face while detained. Victoria Arellano died on July 20th, 2007, shackled to a hospital bed after spending eight weeks in deteriorating health because her AIDS treatment had lapsed.

She was a 23-year-old transgender immigrant who came to the United States as a child from Mexico. After being arrested for a traffic charge, she was sent to an immigration detention center in San Pedro, California. She had AIDS when she was arrested but was asymptomatic because of the medicine she took daily. She pleaded with staff members at the detention center for almost two months to see a doctor to get the antibiotics she needed to stay alive, but her requests were routinely ignored and she became extremely ill.⁵⁸ Detainees in her housing unit repeatedly called to guards that she needed medical care, but she was left suffering in her bunk as her condition worsened. Finally taken to the facility clinic, she was taunted and ridiculed by staff. She told her cellmates before she died, “It was a nightmare.”⁵⁹



Victoria Arellano, an HIV-positive detainee who died in a U.S. detention center in 2007 after being denied her HIV medications.

Arellano’s death exemplifies the failure of the federal government to treat immigrants humanely, to provide adequate care, or to respond to emergencies. Immigrant detention centers are not legally mandated to abide by any healthcare standards when it comes to treating sick immigrants.⁶⁰

On May 1, 2008, California Congresswoman Zoe Lofgren introduced the *Detainee Basic Medical Care Act of 2008* in the United States House of Representatives. The bill would require the Secretary of Homeland Security to establish procedures for the timely and effective delivery of medical and mental health care to all immigration detainees in custody, and for other purposes.⁶¹ At present, both houses of Congress have introduced the Act.

Human rights are affected by the travel ban because individuals are forced to get an HIV test, they are not assured of care and treatment, confidentiality is not protected, HIV-positive status may become public, and immigrants are treated differently depending on their country of origin (some wealthy countries are not required to have a visa for entry into the U.S.). In addition, the health rights of immigrants are severely restricted if they are detained in a U.S. detention facility. The United States continues to be one of only 14 countries in the world that exercises an HIV travel and immigration ban. These 14 countries either refuse entry of PLWHA or also require disclosure of HIV infection even for entry for short term stays. The ban places the U.S. alongside some of the worst violators of human rights in the world.

The ban places the U.S. alongside some of the worst violators of human rights in the world.

Countries that ban HIV+ short-term visitors⁶²:

United States of America
Brunei
Egypt
Iraq
Yemen
Malaysia
Oman
Qatar
Singapore
Sudan
South Korea
Tunisia
Turks & Caicos Islands
United Arab Emirates

Examples of countries without HIV bans

Australia
Denmark
Finland
France
Ireland
Italy
Japan
Netherlands
Portugal
Switzerland
United Kingdom

The fact that the U.S. still continues this discriminatory practice places it in the company of some governments that the U.S. State Department describes as having either poor or significantly problematic human rights records. The following observations come from the U.S. State Department's 2007 *Annual Report on Human Rights Practices*.⁶³ A good number of the states that enact a ban on short term visitors do not allow their citizens to select their own governments. Many of these countries

have a history of practicing torture or have security forces that reportedly routinely violate the rights of detainees. Additionally, most countries implementing an HIV entry ban also have dismal records when it comes to women's rights, and active discrimination against women is a common practice.⁶⁴

Some countries have adopted entry and visa restrictions for people with HIV/AIDS. However, the World Health Organization "has taken the position that there is no public health justification for entry restrictions that discriminate solely on the basis of a person's [HIV] status."⁶⁵ And while the U.S. refuses entry to HIV-positive foreign nationals, many other developed countries have no such restrictions. Some other countries, for example Norway and Sweden, do not bar non-citizens solely based on their HIV status; rather, in case of doubt, they may offer or oblige the foreign national to undergo an HIV test, but only to ensure appropriate treatment.

Even China, a country that until recently was on the list of countries that ban HIV-positive visitors, no longer prevents short term HIV-positive visitors from entering the country.⁶⁶ Further, during the 2008 International Conference on AIDS in Mexico City, the *China Daily News* quoted Hao Yang, Deputy Director of the Chinese Ministry of Health's Disease Control and Prevention Bureau, as saying:

Government agencies, including the Ministry of Health and the General Administration of Quality Supervision, Inspection and Quarantine, have reached consensus on the issue... After performing the necessary administrative and legal procedures, the HIV/AIDS restrictions will be lifted in 2009.⁶⁷

This change would mean that China is likely to completely lift its 20 year ban on people with HIV entering its country in the coming months.

Economic perspectives

In addition to an ungrounded public health basis, HIV-related travel restrictions lack an economic justification. People living with HIV can—with the appropriate access to comprehensive resources—now lead long and productive working lives. When the U.S. entry ban was first developed this was not the case. The epidemic has changed, however, and so must the United States' approach. The concern that HIV-positive immigrants will place an undue drain on health resources of the United States has proven untrue through the example of other countries that do not have such travel bans, and Congress must weigh their potential contributions to the U.S. against the small potential drain on the health care system. In fact, the ban on HIV-positive immigrants is over-inclusive, as both wealthy and poor immigrants alike are denied entry.

In 2001, at the first UN General Assembly Special Session on HIV/AIDS, UN member states unanimously adopted a Declaration of Commitment on HIV/AIDS. Five years later, member states agreed to continue expansion of treatment programs towards “universal access” by 2010, and to sustain the fall in the cost of treatment in low- and middle-income countries, helping dispel the myth that the travel of a person living with HIV would drive up the cost of health care systems abroad.⁶⁸ Universal access to treatment programs is an ideal outcome at best, given the current global economic crisis, but one worth pursuing. If said goal is accomplished, however, it will ensure that all individuals around the globe will have access to life sustaining antiretrovirals. Continuing to reduce the cost of treatment will alleviate health care costs often used to argue against lifting HIV travel and immigration bans.

The WHO estimated in 1987 that the costs of setting up screening and testing procedures for all ports of entry (air, sea and land)—including the costs of testing, the cost of personnel and resources required to establish, maintain and monitor the screening activity, and the cost of the necessary infrastructure—amounts to about \$20 per traveler screened.⁶⁹ The U.S. spends about \$10 million a year to exclude approximately 500 HIV-positive non-citizens. This is money that could be used to encourage early testing among immigrants (many of whom did not enter through the traditional ports of entry) and to prevent new infections in immigrant communities. One study finds that the money used for mandated testing could be reallocated to cover the anticipated costs of treating HIV- positive immigrants, even without the public charge provision. This provision protects against granting permanent residence to individuals who would be a drain on the public health care system. The study also found that if the INS were to abolish the testing requirement and require incoming immigrants to place a fraction of what they now pay into a special account, the resulting fund would more than cover the cost of treating HIV-positive immigrants who require government assistance, all without incurring the other expenses of the exclusion.⁷⁰

Ethics aside, on April 11, 2008, the Congressional Budget Office (CBO) issued estimates of what lifting the bar would cost the federal government. Their initial approximation was based on an estimated 900 additional applicants attempting to change their status to lawful permanent resident in the first year of the new policy. CBO estimated that by 2013, an additional 4,300 HIV-positive people would apply for lawful permanent residency, and by 2018, an additional 5,600 would.⁷¹ It is important to note that this report does not address the issue of applicants who are denied their attempt to change status, and assumed that all applicants would be approved.

The April CBO estimate argued that lifting the HIV bar would cost the federal government a total of \$83 million over the next ten years. It primarily arrived at this estimate by calculating potential increased utilization of public healthcare programs. In particular, the report cited a projected increase of \$73 million in Medicaid costs,

The U.S. spends about \$10 million a year to exclude approximately 500 HIV-positive non-citizens.

\$9 million in food and nutrition, and \$4 million in Supplemental Security Income (SSI) increases. SSI provides people with disabilities and seniors with cash to meet basic needs for food, clothing, and shelter. The report claimed that these estimates were calculated with data on immigration trends (i.e. from what parts of the world HIV-positive people entering the U.S. were emigrating) and assumed their projected income level and reliance on public healthcare.

Before final negotiations, a change in revenue calculations altered the cost estimate. These estimates showed that lifting the bar would actually result in a \$21 million surplus over 10 years.⁷² This change in revenue was not a result of changed calculations, but reflective of a proposed increased cost of visa applications that was inserted by Senate PEPFAR negotiators. In 2011, the cost of a visa application would increase from \$131 to \$132, and in 2014 by another dollar to \$133. This applies to all visa applicants, not just HIV-positive people, of which eight million apply annually. This combined additional revenue would total \$103 million over ten years, which more than offset the original projected \$83 million from the original CBO estimates. Accordingly, the new projected \$21 million increase in revenue obviated the threat of a budget point of order, and allowed PEPFAR to pass the Senate. A budget point of order allows Congress to prevent legislation from passing if it violates the terms of a given budget resolution. So important is this process that a single member of the House or the Senate can raise a budget point of order on the floor to block legislation.⁷³

There is no evidence to support arguments that admitting HIV-positive people into a country is costly for the host government. In fact, the evidence from other countries indicates just the opposite. Brazil began providing free universal access to life-saving antiretrovirals in 1996, far earlier than most developing countries. Despite a non-restrictive travel policy based on HIV status, the country did not see an influx of HIV-positive immigrants seeking treatment.⁷⁴ Canada experiences more immigration than Brazil. However, Canadian researchers concluded that, while “the estimated cost of screening [for HIV] would have been \$3.3 to \$3.4 million, the in-hospital cost of treating HIV-infected immigrants in whom AIDS developed...would have been \$5.0 to \$17.1 million.”⁷⁵ Consequently, screening for HIV saves Canada \$1.7 to \$13.7 million over 10 years after one immigrates.⁷⁶ However, Canada acknowledges HIV immigration policy must consider competing risks, the cost of other diseases, and social, legal, and ethical considerations.⁷⁷

While long-term visitors and immigrants who are HIV-positive may indeed require public health care services, and therefore add to the charges on the state’s public health budget, such a financial argument to justify the entry exclusion is discriminatory as there are no entry exclusions for people with other high-cost diseases such as cancer.⁷⁸ According to a study that compares the potential economic burden of HIV to coronary heart disease (CHD), “the impact of CHD, in terms of both the number of people affected and the associated health care costs, would be at least equal to the impact of HIV infection.”⁷⁹

Additionally, the idea of an economic burden associated with one single disease is illogical as diseases do not happen in isolation, but are often a mixture of one's environment, one's behaviors, and one's predispositions or physiology. If one starts to list the aforementioned, it becomes difficult to determine what will cost more over time. And using cost alone to deny entry or permanent legal status to HIV-positive foreign nationals highlights the inherent discrimination of the HIV bar. Smoking and alcohol consumption are two known risk factors for future illness, as is age. Gostin posits the following question in the *New England Journal of Medicine*, "Should we hold persons over 50 years of age medically inadmissible because they are unlikely to contribute significantly to...society in monetary terms, but are likely to need costly health care?"⁸⁰ Immigration policies that are ethical and non-discriminatory are necessary in deciding equitable rules of exclusion. The HIV travel and immigration ban does not meet those criteria.

Advocacy efforts to overturn the ban

GMHC began its efforts to overturn the HIV travel and immigration ban by convening a community advocacy board on immigration issues with other concerned advocates in 1987. Three years later (1990), AIDS activists organized a boycott of the 6th Biennial International AIDS Conference (IAC) scheduled for San Francisco. Conference organizers sent waiver instructions to potential delegates and organized legal panels to prevent problems at the border to no avail, as it was estimated that thousands of people stayed away while thousands of others demonstrated at the San Francisco meeting. The U.S. has never hosted another IAC since. The most recent IAC attracted 25,000 people.⁸¹

In 1995, GMHC effectively argued the first successful case affording an individual with HIV asylum in the United States on the basis of his or her membership in a particular social group; that is, individuals infected with HIV. This case set an important precedent for thousands of future asylum seekers seeking refuge in the U.S. because of their HIV-positive health status. The next year, DHS legal offices advised immigration officers and judges to grant, where legally appropriate, some forms of immigration relief (such as asylum) to qualified applicants with HIV. Moreover, the Surgeon General directed DHS to modify its practice to make it easier for HIV-positive refugees abroad to gain a waiver in 1999. The following year, the INA was amended to offer more generous waivers to people with HIV in select groups, such as certain applicants from Vietnam, Cambodia, and Laos; non-citizens involved in national lawsuits challenging implementation of a 1980s amnesty program; domestic violence survivors; victims of human trafficking and other crimes.

Asylum applies to "refugees" escaping persecution based on a number of different reasons and affords individuals a more permanent stay.⁸² HIV infection and being LGBT are qualifying reasons. The HIV waiver allows some HIV-positive people to enter the United

Immigration policies that are ethical and non-discriminatory are necessary in deciding equitable rules of exclusion. The HIV ban does not meet those criteria.

States on short-term visas. The waiver does not create a new regulatory scheme that would permit HIV-positive persons to enter the United States temporarily nor does it change the law for HIV-positive immigrants already in the U.S. HIV-positive immigrants are still subject to the 212(g) waiver requirements, including the need for a qualifying family member, private health insurance, etc. HIV-positive travelers seeking a waiver are limited to admission on a B-1 (entering for a short business related reason) or B-2 visa (visitors for pleasure) for visits of 30 days or less. However, under the new rule, they are able to apply for a waiver to allow them admission into the United States without prior approval by the Secretary of Homeland Security. In other words, the determination on their application is made at the consular officer level in their home countries rather than by DHS. The “visa stamp” is valid for 12 months or less; and the traveler is allowed into the U.S. for 2 “visits” not to exceed 30 days. Waiver applicants are still allowed to apply under the current system.

Over the years, GMHC has launched highly effective advocacy campaigns to educate government officials on the legal barriers faced by undocumented LGBT and HIV-positive immigrants. At IAS meetings, GMHC was in the forefront in bringing together an international movement to repeal the entry ban, consisting of various non-governmental organizations (NGOs). GMHC issued a working document entitled, *HIV/AIDS and Lawful Permanent Residency: An Analysis of the HIV Bar, Waivers, and Prospects for Change*. This document was first published in 1999, and updated in 2008, for use as an educational and advocacy tool to gain support from legislators and other organizations. GMHC legal staff also provided the concept, outline, and language for the Immigrant Health and Safety Act of 2000. This federal legislation would have granted permanent residence to HIV-positive immigrants facing extreme medical hardship in their countries of origin.

In 2001, 2006, and 2008, the GMHC legal team worked closely with the Joint United Nations Programme on HIV/AIDS (UNAIDS) during the biennial United Nations High Level Meeting on HIV/AIDS held in New York, offering technical guidance to delegates with HIV/AIDS who had to obtain special waivers to attend the meeting(s) held in New York City. GMHC also worked closely with UNAIDS to facilitate an international effort to apply pressure on the U.S. government to address the discriminatory HIV travel and immigration bar. GMHC also served as advisors for the Gay Games in Chicago in 2006, and served as advisors for participants who were stopping in the U.S. on their way to the 2006 IAC in Toronto, Canada. Additionally, GMHC policy and legal staff convened a roundtable in May 2006 of advocates, activists, scholars, human rights workers, lawyers, and policy workers from around the world to strategize about lifting the HIV bar. The momentum generated by this event enabled GMHC to spearhead *Lift the Bar*—an ongoing, working coalition dedicated to overturning this policy.

Founding members of Lift the Bar include: Immigration Equality, the International Gay and Lesbian Human Rights Commission, African Services Committee, Queers for Economic Justice, the New York Immigration Coalition (representing more than

200 groups in New York State that work with immigrants and refugees), the Global Network of People Living with HIV/AIDS-North America, and GMHC. Individuals from various legal advocacy, LGBT, and human rights organizations are members as well. With GMHC's leadership, working groups were formed to tackle story collection, produce research briefs on the economic, human rights, and public health costs of the ban, organize community forums, and draft statements for national sign-on. The coalition has led efforts to educate federal policymakers on the counterproductive public health impact of the HIV entry ban.

Recent changes and successes

In late 2007, legislation to repeal the HIV entry ban from the INA was introduced by Congresswoman Barbara Lee and Senators John Kerry and Gordon Smith. While this constituted significant progress, passing any bill requires garnering political will and time. In early 2008, Congressional leaders and advocates considered a new vehicle for removal of HIV from the INA. It was decided to include repeal of the HIV entry ban as an amendment to the reauthorization of the President's Emergency Plan For AIDS Relief (PEPFAR) for a second five-year period. PEPFAR provides funding to countries with grave HIV prevalence rates, is widely popular among politicians on both sides of the aisle, and was a success of the Bush Administration. There was political will to reauthorize the legislation in 2008 despite any controversies.

In April 2008, the Senate Foreign Relations Committee passed its version of the PEPFAR reauthorization and included language to repeal the HIV entry ban. As a result, some Senators requested that the Congressional Budget Office analyze the financial impact of lifting the ban. That report indicated that lifting the ban would cost over \$80 billion over the next five years. GMHC led a response to the CBO estimate clarifying what lifting the ban would actually mean. The response was later adapted into a Dear Colleague letter sent to Congressional offices via Senators John Kerry and Gordon Smith.

Up until the final minutes of the Senate vote on PEPFAR, it was anticipated that conservative Republicans would introduce amendments to remove the immigration repeal language. Because of persistent lobbying efforts by advocates, Congressional leaders, and the White House, hostile amendments were not offered. The House of Representatives adopted the Senate version of the bill, and PEPFAR was signed into law by President Bush on July 30, 2008. In authorizing PEPFAR for the next five years, Congress and the President effectively removed the HIV entry ban from the INA.

However, HHS has yet to remove the HIV from the list of communicable diseases. HHS must amend 42 CFR 34.2(b) to remove HIV infection from the list of diseases

There is no public health or economic rationale for such a measure that arbitrarily limits the individual rights of HIV-positive people.

that qualify as a “communicable disease of public health significance.” This has been the advocacy target since PEPFAR was signed into law in July 2008. In Fall 2008, HHS indicated they were taking regulatory action and intended to remove HIV from the list of communicable diseases. GMHC and coalition partners circulated a sign-on letter to HHS Secretary Michael Leavitt urging swift regulatory action on the HIV entry ban. In a response letter dated September 30, 2008, Secretary Leavitt indicated HHS was taking action. Dr. Julie Gerberding, then Director of the Centers for Disease Control and Prevention, reiterated HHS’s intent to remove HIV from the list. In a letter to the *Washington Post*, Gerberding wrote, “Again, this administration is committed to removing HIV infection as soon as possible from the list of communicable diseases that prohibit entry to the United States—a fact demonstrated by this interim step and the process underway at HHS.”⁸³ However, as of March 2009 this process had still not been completed. A draft rule change has yet to be published in the *Federal Register*.

Conclusion

The HIV travel and immigration ban undermines public health and human rights. There is no public health or economic rationale for such a measure that arbitrarily limits the individual rights of HIV-positive people; whether one is a tourist or seeking permanent legal residence status. If this restriction on travel were actually effective in identifying and limiting access to the U.S. by HIV positive immigrants, it would not stop U.S. citizens from becoming infected. Furthermore, since the virus is not spread casually, individuals with HIV do not pose a threat to the general public. The ban has resulted in double standards of care and education. Whereas U.S. citizens can, in most areas, elect to undergo an HIV test and potentially access treatment, immigrants are often forced into testing. Immigrants already here may not seek testing out of fear of being deported. Clearly the HIV entry bar has done more harm than good to public health. It should be repealed immediately.

“I can glimpse the life I want—it is all around me— but I can’t live it.”

Dear Friends:

I was born in Buenaventura, Colombia, and am the oldest of several children. As many of you know, Colombia is a country with a long history of violence and corruption—violence and corruption born of oppression and desperation and insecurity and greed.

Systemic violence and corruption mean unstable and unreliable government, and distortion and stress in the way people manage their life, raise their children, feed themselves, plan for the future, negotiate their way through the day, and even take care of their health.

Inevitably, violence and corruption lead to hunger and poverty, and that of course is what it meant for my family.

My family was poor and my parents were unable to adequately feed themselves or their children. When this happens in a family—and it happens every day all around the world—children are forced from the expectations of childhood—from school, from games, even from mischief—towards other expectations, the expectations of grown-ups.

As the oldest child, I was asked at a very early age to help my parents meet their obligations to the family. I say “ask” but no one really asks—poor children everywhere do what they must for the family.

In time, like so many other people in this part of the world, I turned my attention northward, to the United States. In 1984, in an effort to help my family in Colombia lead a better and more stable life, I moved to New York. Like millions of others who make the trip north, I engaged in odd jobs paying small wages. Naturally, I spent as little money as possible, sending the rest to my family in Colombia.

One lucky day I found a job as a cook in a Spanish restaurant. Having washed what seemed to me to be every dirty dish in New York City during the previous two years, it never occurred to me that I would like cooking or that I might have a talent for it.

As it turned out, my employer was thrilled with my newly-discovered skills, with the result that he decided to sponsor me for a green card. I, too, was thrilled, since a green card would mean lawful residence in the United States, and lawful residence meant



Photo Credit: African Services Committee

freedom, the freedom to work, especially, the freedom to show my face, and, at some point in the future, the freedom to bring my family to the United States.

It took about two years, but, finally, the immigration authorities scheduled a green card interview for me. The interview was to take place not in New York but at the American Embassy in Bogota, Colombia, as then required by American law. It would be my first flight home, and, unlike most trips home by undocumented immigrants, it would be a flight free of the fear of apprehension or deportation. If I was nervous, it was because I was so excited about getting a green card.

I made the necessary arrangements and waited for the appointed day.

And then the unexpected happened: just a few weeks before my flight to Bogota, I fell ill. The illness was serious and required hospitalization. Unable to determine the cause of the illness, my doctors recommended that I get tested for HIV, which I did. The results were positive. I was devastated.

Despite my illness, I was released from the hospital in time to make the flight to Colombia. HIV or no HIV I wanted my green card.

But my doctors' bad news about my health was made all the worse by bad news from my immigration lawyer. It turned out that my newly-diagnosed HIV status meant that I would not be able to travel to Colombia for my green card interview. This is because HIV-positive individuals are barred from entering the United States.

If I were to keep my appointment in Colombia, I'd be unable to return to the United States, to my hoped-for new life, to what I supposed would be a new future. Flying to Colombia would mean having to remain in Colombia, which was unthinkable—not only because of the stigma that attaches to HIV in Colombia—but because I'd lose access to HIV medications. I had no choice but to cancel the green card interview.

Unable to keep my green card appointment, I naturally lost my job. Soon I was back to doing odd jobs, and like millions of other undocumented individuals, I went back to living a quiet and unnoticed life on the margins, hoping, the way all the undocumented do, for a change in the law.

Sometime later rumors began to fly—as they always do in the undocumented community—about pending changes in the law that would allow an undocumented immigrant to file for a green card. Surprisingly, the rumors turned out to be true, and soon the laws were changed to permit undocumented immigrants to adjust status and file for a green card.

But there were two obstacles: first, the new law required a sponsor, either an employer or an immediate relative living in the United States—I had neither; and, second, the new law required HIV-positive individuals—even those with sponsors—to get a special waiver before obtaining a green card. As it turned out, I did not meet the requirements for the special waiver.

Once again, my dream of getting a green card was thwarted by my HIV status.

It is now 24 years since I moved to New York. I live in a state of anxiety and frustration. I can glimpse the life I want—in fact, it is all around me—but I can't live it.

My frustration is deepened by the fact that I live in fear of being apprehended—perhaps as a result of some chance encounter on the street, or because of a traffic accident, or as the result of a raid on my workplace.

If apprehended, I will of course be deported.

In recent months, I have become progressively sicker. I survive only because of the HIV medications that are available to even undocumented immigrants in New York City.

In Colombia, of course, these drugs are either unavailable or unaffordable.

Between the unavailability of HIV medications and rampant stigma—not to mention the threat of violence—life in Colombia is still not an option for people like me.

It has been a long time since I visited Colombia. Naturally, I miss my family; but I am not free to visit them. Any trip through customs would likely result in detention and deportation. And even if I had a visa, I'd be afraid of having my luggage searched, since travelers carrying HIV medications can be detained and turned away by American customs officials.

Still, I remain in the United States because it is the only sure way to stay alive. I know that if I were not HIV-positive I would likely have gotten a green card a long, long time ago. In fact, I probably would have been an American citizen by now, and I would surely have brought my family out of poverty.

It is, of course, good news that the United States may soon do away with the HIV bar. Unfortunately, the repeal of the bar, should it happen, will not help those of us who are what they call “out of status”—that is, those of us who have overstayed our welcome. This is because individuals who are out of status will likely have to return to their native country for a minimum of ten years before they qualify for so-called legalization. Ten years is a long time to be without medication—for some of us it will be too long.

Sincerely,

Anonymous

“I survive only because of the HIV medications that are available to even undocumented immigrants in New York City.”

Notes

- 1 Section 212(a)(1)(A) of the Immigration and Nationality Act (INA), 8 U.S.C. § 1182(a)(1)
- 2 INA § 232(b), 8 U.S.C. § 1252(b),
- 3 Jane Guskin and David L. Wilson. "The Politics of Immigration." *Monthly Review Press*. 2007.
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About Gay Men's Health Crisis

Our Mission: GMHC fights to end the AIDS epidemic and uplift the lives of all affected.

Our Clients, Our Services: Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. GMHC serves one in every six persons diagnosed with AIDS in New York City. As the world's oldest AIDS service provider, GMHC helps over 15,000 men, women and children and their families each year. GMHC offers a wide range of comprehensive client services, including hot meals, benefits/entitlements advocacy, healthcare advocacy, case management, legal assistance, HIV counseling and testing, individual and group counseling services, prevention education, home-based support, and mental health services.

GMHC has been on the frontlines of the AIDS epidemic since it began, focused on the communities most threatened by HIV and expanding our service provision as the epidemic shifts and grows. The number of GMHC clients has increased by over 50% just since 2000. Our clients reflect the diversity of the HIV epidemic:

- 67% are people of color;
- 65% are gay, lesbian, bisexual;
- 23% are women; and
- Over 50% reside outside of Manhattan.

Additionally, approximately 27% of our clients are 50 years of age or older, while 19% of all new prevention clients are under 30. Of our total clients served we continue to see a larger proportion living in poverty – approximately 78% are living on an annual income of less than \$10,000, while 8% are either homeless or living in transitional housing. Over 70% of GMHC clients rely on Medicaid, while 15% rely on the AIDS Drug Assistance Program (ADAP) for their medical care and life-saving prescription drugs.

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