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HIV Exclusion of Immigrants under the Immigration Reform & Control Act of 1986

Bettina M. Fernandez

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HIV Exclusion of Immigrants Under the Immigration Reform & Control Act of 1986

Bettina M. Fernandez†

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Mr. Rodriguez,\(^1\) an amnesty applicant has resided in the Bay Area for almost ten years. By all accounts he is a model citizen. He is very involved in his community and works for a very well known and prestigious non-profit organization which provides food for persons afflicted with Acquired Immune Deficiency Syndrome (AIDS). Mr. Rodriguez has always paid his personal income taxes, has a degree in real estate, speaks two languages fluently, and has always held a steady job. He is beloved by colleagues, friends, and family. Not too long ago, he was required by law to take a mandatory Human Immunodeficiency Virus medical exam. He tested positive for the virus. As a result, Mr. Rodriguez must now comply with stringent regulations to justify why a person infected with a "dangerous contagious disease"\(^2\) should be allowed to remain in the United States.

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1. Mr. Rodriguez is a pseudonym. The facts, however, are true.
2. This was the United State's classification of the HIV virus as of May 31, 1991. The Immigration Act of 1990 changed the definition to "communicable disease of public health significance." Immigrant advocates hoped that this change would result in the deletion of HIV as an excludable medical condition. To date, however, HIV remains on the list. See infra notes 21-22 and accompanying text.
The scenario just described might not happen to you. But it could have if you were an immigrant applying for "amnesty," the popular name for certain provisions of the Immigration Reform and Control Act of 1986 (hereinafter IRCA). In part, IRCA was designed by Congress to allow legalization for immigrants who have resided in the United States since January 1, 1982. Due to a 1987 enactment of an amendment requiring mandatory testing for the HIV virus, amnesty applicants found themselves facing another hurdle to legalization.

In 1987, President Reagan approved a spending bill that, among numerous unrelated provisions, authorized the addition of the human immunodeficiency virus (hereinafter HIV), the precursor to acquired immune deficiency syndrome (hereinafter AIDS), to the list of "dangerous
contagious diseases” that could potentially bar legalization. Pursuant to the bill, the Department of Health and Human Services amended its regulation regarding medical examinations of aliens to include HIV. After December 1, 1987, all immigrants wishing to legalize their status under IRCA were required to submit to a mandatory HIV test performed by designated civil surgeons. Immigrants testing positive for the virus were considered “inadmissible” to the United States.

Inadmissibility was not considered a total bar to legalization since applicants were allowed to submit an application requesting a waiver of the ground of excludability. However, as of July 1990, the Immigration and Naturalization Service (hereinafter INS) has denied thirty-seven out of fifty-nine waiver applications. Because the legalization decisions are confidential, the INS cannot use information in the application as a means of deportation. These denials, however, may tend to act as constructive deportations since the applicants can no longer obtain legal authorization to work in the United States.

The scope of this article only concerns legalization applicants (immigrants applying for an adjustment of their unlawful status to that of a person admitted for lawful residence), one of the major categories of immigrants provided for under IRCA. While the exclusion applies to virtu-

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9. PHS Medical Examination of Aliens, 42 C.F.R. § 34.2(b)(4) (1989).
10. It should be noted here that all immigrants, those outside the country as well as those within, are subject to the HIV test with two exceptions. See infra note 17. The subject of this paper confines itself to the plight of those IRCA applicants who have been residing in this country since January 1, 1982 because of the special problems posed by the implementation of the HIV amendment and subsequent regulations. However, most of the points addressed in this paper lend themselves to an analysis of the situation of those aliens wishing to enter the country from outside its borders, for whom waivers are unavailable. See infra note 13.
11. HS Medical Examination of Aliens, 42 C.F.R. § 34.2(e) (1989).
13. This waiver is not available to all immigrants. For example, immigrants who apply for permanent residence through normal immigration channels (non-amnesty applicants) cannot obtain a waiver of this excludable condition under current law.
14. See Appendix I for an informal statistical study of the pattern of denials, approvals, and remands across the country. (The data were compiled under the auspices of the Bar Association of San Francisco’s Volunteer Legal Services Program-Legalization Project).
15. INA § 245A, 8 U.S.C.§ 1255a(c)(5) (§ 245A was added by IRCA, Pub. L. 99-603).
16. I use constructive deportation in a non-legal sense. The INS regulations do not authorize deportation based on a positive HIV test. Neither does IRCA authorize deportation based on a denial of legalization. So, the end result is the “constructive deportation” of illegal aliens to an HIV subclass who continue to reside in the United States without work authorization. Arguably, such individuals are also left without access to health care since fear of INS detection would probably deter them from seeking treatment.
ally all aliens.\textsuperscript{17} I have narrowed the research to legalization applicants because their waiver and adjustment applications are decided by immigration offices specially created due to the enormous number of applicants that the INS expected under the IRCA provisions. These specially created offices do not compile their decisions in a conventional immigration reporter; thus, creating a need for careful monitoring by outside parties. IRCA legalization applicants also demand a more careful study because, unlike most classes of immigrants, they are already residing in the United States and have been doing so for a significant number of years. By developing financial, social, and familial equity, due to their long term illegal residency, their expulsion would be more problematic than would be the case for someone applying for permanent residence from abroad.

This article asserts that the HIV amendment acts as a punishment for undocumented aliens infected with the virus, rather than a viable national health and safety measure. The disruption of their long-term residence in the United States, through constructive deportation, must be justified on compelling and persuasive grounds because it contravenes the legislative intent in creating the amnesty component of IRCA. Waivers of exclusion were supposed to be administered generously.\textsuperscript{18} Nevertheless, the INS has rejected nearly two-thirds of the applications for a waiver of excludability based on a positive HIV test despite the lack of conclusive evidence that these immigrants imported the disease when they entered this country illegally prior to January 1, 1982.

Rather than rely on health education and early treatment as prophylactic measures to combat AIDS, the amendment targeted individuals who do not have the resources to challenge their exclusion. Moreover, the amendment was based on an ill-founded notion that depicts HIV positive immigrants as dangerous to the public health of the United States. In fact, the proffered justification that immigrants with HIV are dangerous to the United States public health was a smoke screen for the true purpose behind the HIV amendment: its conservative proponents hoped

\textsuperscript{17} There are two classes of aliens who do not have to submit to mandatory HIV testing: aliens under IRCA who have resided in the United States since January 1, 1972 ("registry" aliens) and aliens who go through "suspension of deportation" proceedings. Registry is discretionary relief that can be applied for at any time. 8 U.S.C.A. § 1259 (Law. Co-op 1990) (as amended by IRCA in 1986, Pub. L. 99-603, § 203(a),(b), 100 Stat. 3405). Suspension of deportation is a type of discretionary relief that can only be applied for in deportation proceedings and requires, among other factors, a showing of extreme hardship to the alien or her family should deportation occur. If a suspension of deportation is granted, it results in adjustment of status to permanent residence. 8 U.S.C.A. § 1254(a) (West 1990). I could find nothing indicating a legislative rationale which accounted for these two exceptions. Non-immigrants (persons entering the country for short periods of time, usually holiday or school) also do not have to submit to mandatory testing, even though theoretically the exclusion applies to them as well since they, too, are capable of transmitting the disease.

\textsuperscript{18} See infra note 90 and accompanying text.
to establish a precedent for instituting mandatory testing in the United States. Prior attempts at domestic mandatory testing having failed, immigrants provided a politically impotent group amenable to mandatory testing.

In this article, I argue that mandatory HIV testing of marginalized subsets of the population is contrary to existing AIDS health policy. I begin with a brief discussion of the HIV amendment’s relevancy as a microcosm of the political and social dissension that exists regarding AIDS generally and specifically its impact on immigrants. I then trace the historical treatment of immigrants and persons with AIDS as a backdrop for the subsequent discussion and analysis of IRCA, the HIV amendment, and the Immigration Act of 1990. A careful analysis of the HIV amendment reveals that it created the plethora of problems usually associated with carelessly passed legislation. Not only did the HIV amendment flout the medical consensus regarding AIDS, but it also proved unworkable, in part because Congress gave little direction to the INS in promulgating attendant regulations. I then compare competing normative claims concerning AIDS in general. Finally, after examining weaknesses of those claims that disregard scientific and medical evidence, this paper proffers reform proposals that will ensure that AIDS policy in and outside the immigration field will focus on research, education, and treatment. The problems generated by a pandemic such as AIDS will have to be addressed, but not with mandatory testing of perceived “high risk” groups such as immigrants.

II.
RELEVANCY

The Immigration Act of 1990 changed “dangerous contagious disease” to “communicable disease of public health significance” and left it to the Secretary of Health and Human Services to decide which diseases would continue to be bases of exclusion. Subsequently, the Secretary proposed the deletion of all but one disease, active tuberculosis, from the list of excludable medical conditions. If the rule had been finalized, an HIV positive result would no longer have been a basis for exclusion. To

19. See infra note 45.

20. Public health experts have consistently argued that the better alternative to mandatory testing is public education and voluntary testing with strict confidentiality requirements. These types of preventive measures are already in place all over the country. As to “high risk” groups, the problem with that term lies in its all encompassing nature. The focus of preventive measures should be on high risk behavior, rather than high risk groups. See infra notes 129-133 and accompanying text.


date, however, the rule has not been finalized. The federal government's treatment of HIV positive immigrants seeking legalization thus bears discussion for four reasons.

First, the HIV amendment is a prime example of the deleterious effects engendered by legislation which has as its impetus the political goal of sanctioning mandatory testing for HIV as the correct way to address the AIDS epidemic. Rather than continue to propose domestic mandatory testing legislation without success, Congress, heavily influenced by the ideological right, focused on a defenseless group. This resulted in unfortunate consequences. For example, amnesty applicants who tested positive may have gone underground rather than confront the multitude of issues involved in applying for a waiver of their condition. Hence, the HIV amendment effectively closed the door on counselling, education, and treatment of what may have been a significant number of potential amnesty applicants. Furthermore, since applicants denied a waiver of excludability cannot be deported based on information in their application, they have probably remained in this country without work authorization, and therefore without the opportunity to seek or pay for treatment. In retrospect, the amendment seemed to target individuals without thorough research on the impact that administration of the law would have on them and the population of the United States as a whole.23

Second, as will be discussed in greater detail in a later section, the INS instituted HIV waiver guidelines mandating eligibility criteria, which were laudable yet hardly typical of the average American citizen let alone an amnesty applicant.24 Instead, Congress and administrative agencies created a catch-22 situation, whereby immigrants infected with HIV were singled out for discriminatory treatment by being held to higher standards of proof in their quest to legalize their status than the average American citizen could satisfy. The criteria reinforced American immigration policy which has always held immigrants to a higher civic standard than United States-born citizens.25 These higher standards were strictly applied, even though the legalization program was

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23. It has never been established that immigrants, as a class, are more likely to be infected with HIV than other persons. Moreover, only 59 HIV waivers have been adjudicated as of June, 1990. See Appendix I. The 59 cases do not account for a significant number of applicants as a whole and thus the inference that immigrants pose a serious health threat to the United States population is further belied.

24. See infra note 93 and accompanying text.

25. For example, legalization applicants are required to demonstrate basic citizenship skills. INA § 245A, 8 U.S.C. § 1255a. Applicants can expect to be asked questions such as: when is Thanksgiving Day, when was the Declaration of Independence signed, and who can declare war. Immigration and Naturalization Service, U.S. Department of Justice, STUDY GUIDE: IRCA TEST FOR PERMANENT RESIDENCY (1989).
intended to allow immigrants to "come out of the shadows."  

Third, the Immigration Act of 1990 does not provide relief for individuals already denied legalization or waivers. The portion of the House of Representatives measure which did create remedies was deleted in the compromise bill enacted as the Immigration Act of 1990. Moreover, the deleted section dealt only with contested provisions of IRCA and not the HIV amendment explicitly. Consequently, HIV positive immigrants who have been denied waivers are still left in a legal quandary. Furthermore, guidelines have not been issued from the INS's specially created appellate level, the Legalization Appeals Unit (hereinafter LAU), concerning these cases. It has yet to be decided whether existing regulations, which govern regular immigration appeals usually adjudicated by the Bureau of Immigration Appeals, will apply to decisions rendered by the LAU. Acknowledging the current uncertainty regarding IRCA in general, the managers of the House and Senate Conference Committee did, however, "believe that the series of court decisions overturning various INS regulations, policies and practices warrant address of these issues in separate legislation in the next Congress." Currently, no cases involving HIV waiver denials have gone to court. Nevertheless, court decisions overturning INS regulations and policies regarding legalization decisions may have positive carryover effect on HIV waiver denials especially if remedial legislation is enacted in the 102nd Congress.

Finally, we should not lull ourselves into complacency just because the problem appears to only affect an already marginalized subset of American society—legalization applicants. That the HIV amendment was passed at all should sound a warning bell to all persons concerned with the issue of mandatory testing. The HIV amendment was the product of a fractured national policy on how to approach the myriad issues presented by AIDS. If Congress, through willful ignorance of existing health policy and manipulation of legislative process, can mandate testing of an entire group of immigrants without first establishing that they have engaged in high risk behavior, what is to stop Congress from deciding that other "high risk" groups should be the next class subjected to mandatory testing? We should be concerned with the politics of a policy-

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26. This was a statement made by Representative Fish in discussing objectives of the legalization program. 132 CONG. REC. H9711 (daily ed. Oct. 9, 1986).

27. In discussing IRCA related provisions and the problems encountered by legalization applicants trying to meet onerous requirements established by INS regulations and practices, the House version of the Immigration Act of 1990 (H.R. 4300) reported, "The bill responds to this problem by authorizing federal courts to order the Attorney General to accept new applications and re-adjudicate them in instances in which the court has found that [the] INS had improperly applied the law." H.R. REP. No. 723, 101st Cong., 2d Sess. 50 (1990).

making process which allows significant issues affecting the health and welfare of citizens and non-citizens alike to be tacked onto bills without the benefit of notice or hearings. Also of concern is the treatment of immigrants as scapegoats in a tragedy centered around a disease which affects the entire population.

III.
THE SETTING

A. Historical U.S. Exclusion of Aliens

Aliens have been legally excluded from the United States for various reasons for over a century. Before that time, the immigration restrictions only covered minimum space and provisions standards for overseas vessels. During the early and mid 19th century, political and economic conditions in Europe prompted a great number of Irish and German Catholics to immigrate to the United States. Great resentment abounded in our country and the anti-Catholicism that had prevailed in colonial days was resurrected. Some groups, including social reformers, the Order of the Star Spangled Banner, and the Know-Nothing Party were somewhat successful at the state level in restricting political participation of the newly arrived immigrants. However, because the new groups constituted a large voting block, they were accepted at the federal level. Hence, until 1875, immigration to the United States was fairly welcomed.

In 1875, Congress passed the first restrictive immigration statute. At this time, prostitutes and convicts were barred entry into the United States. This was the first of many enactments which legislated morality, racial purity, and assimilation as criteria for admission. In 1882, Congress passed the Chinese Exclusion Act, barring immigrants from China, lunatics, idiots, and those likely to become public charges. In

29. See, e.g., Passenger Act of 1855, 10 Stat. 715.
31. See EMBERSON EDWARD PROPER, COLONIAL IMMIGRATION LAWS (1967).
32. HUTCHINSON, supra note 30, at 37-46.
33. Id.
34. Act of March 3, 1875, ch. 141, 18 Stat. 477. This Act also disallowed "coolie labor" contracts and immigration for lewd and immoral purposes which resulted from the import of Chinese labor for completion of U.S. railroads.
35. Id.
1891, Congress added paupers and polygamists to the list. Act of March 3, 1891, ch. 551, 26 Stat. 1084. Additionally, the diseased were deemed fit for exclusion.

Thus, the exclusion of immigrants from United States ports of entry on medical grounds dates back to 1891 when Congress first excluded immigrants "suffering from a loathsome or a contagious disease." After the 1891 Act, exclusion extended to epileptics, the insane, beggars, and anarchists. Pub. L., ch. 1012, 32 Stat. 1213 (Mar. 3, 1903). In 1907, tuberculosis, feeblemindedness, and mental or physical defects which might affect the ability to earn a living were added to the list. Pub. L., ch. 1134, 34 Stat. 898 (Feb. 20, 1907).

Due to the difficulty of establishing uniform enforcement under such broad definitions and the pitfalls of devising a long-term, comprehensive list of excludable illnesses, Congress removed the names of all specific diseases from the law in 1961 and replaced them with the general phrase "dangerous contagious disease," leaving it up to public health officials to add definition to it.

B. Historical Treatment of U.S. Citizens with AIDS

When first reported in the United States, AIDS was known as gay-related immune deficiency (GRID) because experts believed its impact was limited to the gay population. The perception of AIDS as a gay plague, sanctioned the heightened stigmatization of an already marginalized group. At this point, public hysteria had local, state, and federal

38. After the 1891 Act, exclusion extended to epileptics, the insane, beggars, and anarchists. Pub. L., ch. 1012, 32 Stat. 1213 (Mar. 3, 1903). In 1907, tuberculosis, feeblemindedness, and mental or physical defects which might affect the ability to earn a living were added to the list. Pub. L., ch. 1134, 34 Stat. 898 (Feb. 20, 1907).
41. The current list includes chancroid, gonorrhea, granuloma inguinale, HIV infection, infectious leprosy, lymphogranuloma venereum, infectious syphilis, and active tuberculosis. 42 C.F.R. § 34.2(b) (1989). See infra note 60 for other exclusions which do and do not apply to legalization applicants.
43. The first five reported cases were gay men. See, Centers for Disease Control, First 100,000 Cases of Acquired Immune Deficiency Syndrome-United States, 38 MORB. & MORT. WEEKLY REP. 561 (1989). Others hypothesized that U.S. action might have taken a different course, "[h]ad this disease been first recognized in Central Africa, where there appears to be no homosexual link whatsoever involved in its transmission, and had it then, later on, been discovered among those people whom it is known to affect in other parts of the world, it would, I suspect, have been seen by all of us very differently." Dennis Altman, Dilemma of the Homosexual Connection, a paper presented at the "AIDS: Ethics, Law and Social Policy" conference organized by the Center for Human Bioethics (Monash University, 1986) (cited in AIDS: ETHICS AND PUBLIC POLICY, 9 (Christine Pierce & Donald Van De Veer eds., 1988)). Furthermore, outside U.S. environs, other AIDS researchers considered the preoccupation with the gay angle of AIDS to be a strange American idiosyncrasy. See SHILTS, supra note 42, at 511.
44. Unfortunately, even then Secretary of Health and Human Services, Margaret Heckler, was not beyond making careless and insensitive remarks: "We must conquer AIDS before it affects the heterosexual population and the general population. . . . We have a very strong public interest in stopping AIDS before it spreads outside the risk groups, before it becomes an overwhelming problem." SHILTS, supra note 42 at 554 (quoting the only departure made from her prepared text to the first International AIDS Conference in Atlanta, Georgia on April 15, 1985). Arguably, remarks like this,
officials offering a multitude of AIDS proposals, some bordering on the absurd and all obscuring the real issue: how best to devise a rational approach to the legitimate protection of the general population. There were demands for quarantine and screening of suspect individuals in schools and work settings. Politicians made the issue of mandatory reporting and contact tracing a centerpiece of their response to the AIDS epidemic. One of the most egregious measures was proffered by William F. Buckley Jr.: tattooing all those infected with HIV for identification purposes. While these measures were being offered piecemeal around the country, the federal government was relatively silent. Federal complacency was furthered by the later discovery that other marginalized persons were disproportionately affected by AIDS: intrave-
ous drug users, blacks, latinos, and the poor.51

Despite the consensus of public, private, and international health officials that AIDS was a threat to all individuals, the Reagan administration still lacked a uniform policy on AIDS as late as 1987.52 Over half a decade into the epidemic, Reagan finally appointed a national advisory commission to research and make findings and recommendations on the disease.53 To its credit, the administration instituted a recordation system at the Centers for Disease Control (CDC), initiated research on AIDS through the National Institutes of Health (NIH) and CDC, and provided technical assistance to state and local governments.54 However, even Senators noted the parsimonious nature of the administration’s request for AIDS funds.55 It is against this backdrop of historical exclusion of immigrants, a belief that AIDS was discriminating in who it chose to afflict, and the indecisiveness of the federal government that we now turn to the legislative history of the HIV amendment, its effect on legalization applicants under IRCA, and what relief immigrants can expect under the Immigration Act of 1990.

IV.
LEGISLATIVE FRAMEWORK

A. Immigration Reform and Control Act of 1986 (IRCA)


After more than half a decade of intense debate and proffered and


52. With the exception of the Surgeon General, Dr. C. Everett Koop, the Reagan Administration engaged in little or no advancement of a national health plan strategy concerning the emerging epidemic. As late as 1987, Reagan’s public statements regarding AIDS were morally judgmental and naive (although he did admit it was now a national concern): “Both medicine and morality teach the same lesson about prevention of AIDS. The Surgeon General has told all Americans that the best way to prevent AIDS is to abstain from sexual activity until adulthood and then to restrict sex to a monogamous, faithful relationship. This advice and the advice to say no to drugs, can, of course prevent the spread of most AIDS cases. Millions already follow this wise and timeless counsel, and our Nation is the poorer for the lost contributions of those who, in rejecting it, have suffered great pain, sorrow, and even death.” Proclamation No. 5709, 52 Fed. Reg. 36,889 (1987) (AIDS Awareness and Prevention Month). The Surgeon General noted that he encountered “considerable opposition within the Reagan Administration” for his efforts to promote explicit AIDS education nationwide. Ken Adelman, Do the Right Thing, WASHINGTONIAN, 81, 87 (April 1990).


55. “I want the money for research and for life. Believe me, I cannot get that out of this administration or this Congress. . . .[i]n 1984, the President, and I am talking about AIDS funding, requested $33.8 million; Congress appropriated $61.4 million. In 1985 the President requested $60 million; Congress appropriated $108.6 million. In 1986 the President requested $128 million; Congress appropriated $244 million. In 1987, $213 million from the President; Congress appropriated $413 million.” 133 CONG. REC. S6957-61 (selected statements made by Senator Weicker (D-Conn.) at the Senate debate on whether to institute mandatory premarital and immigrant HIV testing).
rejected bills, 1986 saw a major reform in United States immigration law with the passage of IRCA. The major objective of the legislation was to control illegal immigration. To achieve this end, the Act imposed severe sanctions on United States employers of undocumented workers. The legislation did offer, however, certain types of immigrants the opportunity to legalize their status, including those aliens who had resided in this country illegally since January 1, 1982.

2. General Legalization

There are two phases to general legalization under this category of IRCA: Phase I involved adjustment to lawful temporary residence; Phase II involves adjustment from lawful temporary residence to lawful permanent residence. In both phases an applicant must be deemed "admissible to the United States as an immigrant."

Aliens were eligible for "Lawful Temporary Resident Status" (LTR) if they had (1) "entered" the United States before January 1, 1982, (2) "resided continuously" in the United States since January 1, 1982, and (3) been physically present in the United States from November 6, 1986 until the date that their application to adjust status was filed. Aliens must have entered illegally or have had any period of authorized stay expire before January 1, 1982 (this would occur if an alien had entered

59. Phase I is discussed in the past tense because the date for filing has passed. Phase II is discussed in the present tense because the legalization process is still underway for adjusting applicants.
60. INA § 245A, 8 U.S.C. § 1255a(a)(4)(A) and (b)(1)(C)(i) (West Supp. 1990). Currently the following grounds of exclusion do not apply to legalization applicants: skilled or unskilled laborers, undocumented persons, improperly issued visa holders, illiterates over the age of 16, and unaccredited medical school graduates. Id. at § (d)(2)(A). Waiver is available for all immigrant applicants for the following exclusions: mental retardation, insanity, psychopathology, sexual deviance, mental defect, drug addiction, chronic alcoholism, dangerous contagious disease, other defects which may affect the ability to earn a living, pauperism, being a professional beggar, vagrancy, polygamy, prostitution, being an alien who came to the United States to engage in any immoral sexual act, being a deportee, being a stowaway, being an alien who procured a visa through fraud, being a service avoider, being a nonimmigrant without a valid visa, or being an alien who abetted in the illegal entry of another alien. INA § 245A, 8 U.S.C. § 1255a(d)(2)(B)(i). No waivers are available for the following exclusions: aliens convicted of a crime of moral turpitude, aliens who have admitted committing such a crime, aliens who have been convicted of two or more offenses, aliens who are likely to become public charges, aliens who violate or conspire to violate drug laws, aliens who endanger the public welfare, safety, or security of the United States, anarchists, members of the Communist Party of the United States or any foreign state, spies, subversives, and aliens who assisted Nazi persecutions. Id. § (d)(2)(B)(ii). For a comprehensive list of U.S. exclusions see INA § 245A, 8 U.S.C. § 1182.
on a non-immigrant visa and stayed past its expiration date) or have had their unlawful status known to the federal government as of January 1, 1982.\textsuperscript{62}

Aliens had to demonstrate continuous residence since January 1, 1982 as defined by regulations.\textsuperscript{63} Aliens also had to demonstrate continuous physical presence since the date of IRCA's enactment,\textsuperscript{64} as defined by regulations.\textsuperscript{65} Application for adjustment of status to temporary resident was made by filing at a designated INS Legalization Office (LO),\textsuperscript{66} or at the office of a Qualified Designated Entity (QDE).\textsuperscript{67}

Applications must have been filed between May 5, 1987 and May 4, 1988.\textsuperscript{68} This gave eligible aliens only one year in which to file for legal status. Additionally, the HIV amendment, which went into effect on December 1, 1987, was applicable to all applicants for temporary residence. Those applicants who filed before the HIV amendment went into effect were required to submit an HIV test with their application to adjust to permanent residence.\textsuperscript{69} Therefore, not even those aliens submitting an application before the HIV amendment became effective escaped the testing requirement. Applicants were, however, allowed to apply for a waiver of the HIV ground of excludability based on "family unity, humanitarian reasons, or if otherwise in the public interest."\textsuperscript{70}

All aliens who were granted LTR status were then required to file for an adjustment to "Lawful Permanent Resident Status" (LPR) after residing in the United States for eighteen months following their initial adjustment of status.\textsuperscript{71} Again, applicants had to prove continuous residence in the United States as defined by regulations since being granted temporary resident status.\textsuperscript{72} Aliens had twelve months in which to file

\textsuperscript{63} The requirement of continuous residence since January 1, 1982 was satisfied when (1) no single absence was longer than 45 days, unless emergent reasons existed; (2) the aggregate absences from January 1, 1982 until the date of application for adjustment was filed did not exceed 180 days; (3) the alien had a residence in the United States; and (4) departure was not based on a final order of deportation. 8 C.F.R. § 245a.1(c) (1989).
\textsuperscript{65} The requirement of continuous physical presence was satisfied when there was actual physical presence from November 6, 1986 to the date of application. Eligible aliens who were outside the United States on the date the statute was enacted, or who departed thereafter, could apply if they returned prior to May 1, 1987. 8 C.F.R. § 245a.1(f) (1989).
\textsuperscript{66} 8 C.F.R. § 245a.1(j) (1989).
\textsuperscript{67} A Qualified Designated Entity was defined as any organization certified by the INS as qualified to assist in the preparation of legalization applications. Id. at 245a.1(l).
\textsuperscript{68} 8 C.F.R. § 245a.2(a) (1989).
\textsuperscript{69} 8 C.F.R. § 245a.3(d)(4) (1989).
\textsuperscript{70} 8 C.F.R. § 245a.2(k)(2) (1989). These requirements are discussed infra in section IVB1.
\textsuperscript{71} 8 C.F.R. § 245a.3(a) (1989).
\textsuperscript{72} Continuous residence in Phase II is defined as having (1) no single absence greater than 30 days, and (2) the aggregate of all absences not greater than 90 days, unless emergent reasons exist which prevent return. 8 C.F.R. § 245a.3(b)(2) (1989).
their application for adjustment to permanent residence status. This deadline was extended by one year by the Immigration Act of 1990. The following section focuses on the enactment of the HIV amendment, its impact on legalization applicants, and the inferences about national policy regarding the AIDS epidemic which can be drawn from it.

B. The HIV Amendment (The Helms Amendment)

The HIV exclusion amendment was spearheaded by Senator Jesse Helms (R. North Carolina) as a minute part of an enormous spending bill. Although the amendment passed by a vote of ninety-six to zero, the record suggests that the seemingly unanimous consensus on the desirability of wholesale testing of immigrants rested on several reasons, some of which had nothing to do with the issue of whether immigrants pose a national threat to the United States population. The consensus was not derived from unanimous belief as to which categories of immigrants the amendment would affect or whether immigrants were even a high risk group for the infection.

On the one hand, Senator Helms believed that the number of immigrants bringing the virus into the United States was significant. On the other hand, his opponents were influenced by statements of the Surgeon General, the National Academy of Sciences, and the Institute of Testing, which indicated that mandatory testing would be a waste of resources which could be put to better use. This second group of legislators were greatly concerned with the effect the amendment would have on international relations, existing legalization programs, and the newly enacted amnesty program - IRCA.

Senator Helms stated that the amendment would “simply amend the Immigration and Nationality Act” to make HIV infection a ground of excludability and that it was “only elementary that as the epidemic continues to spread abroad, immigrants in greater numbers will be bringing the AIDS virus to the United States.” This simple statement is belied by the fact that under IRCA, applicants are required to have al-

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73. 8 C.F.R. § 245a.3(b)(1) (1989).
75. Pub. L. 100-71, § 518; 101 Stat. 391, 475 (Supplemental Appropriations Act of 1987 or the “Helms Amendment”) (to be codified at 8 U.S.C. § 1182). The original form of the Helms amendment included mandatory testing for all those seeking marriage licenses. It also sought to put pressure on Congress by threatening to withhold appropriations for AIDS research and treatment unless the amendment was passed. 133 CONG. REC. S6955 (daily ed. May 21, 1987).
76. 133 CONG. REC. S7415 (daily ed. June 2, 1987).
77. 133 CONG. REC. S6956 (daily ed. May 21, 1987).
78. Id. at S6960 (statement of Sen. Danforth).
79. Id. at S6967-6981 (debate among senators regarding the effect of regulations on legalization and amnesty programs).
80. Id. at S6955-56.
ready resided in the United States for a significant number of years; thus
the notion that they are "bringing" the AIDS virus into the United States
is quixotic at best. Furthermore, the United States has the most reported
cases of AIDS in the world, making it a more probable "exporter" of the
infection and disease through international travel. 81

Indeed, if Senator Helms' statement is to be taken to its logical con-
clusion, the legislation would have required mandatory testing of all per-
sons wishing to visit the United States. However, no legislation exists
which requires testing of non-immigrant visitors to the United States.
Ironically, the Department of Health and Human Services has not stated
that non-immigrant visitors do not pose an AIDS health threat to the
United States. Rather, the Department has stated that it does not test
temporary visitors because of testing's unnecessary and undesirable com-
plexities and problems, including expenses and delays in travel. 82 How-
ever, the INS does have the discretion to detain suspect people at the
border and deny them entry. 83

The State Department has estimated that only 250 aliens seeking to
enter the United States from outside the country would actually be ex-
cluded annually because they tested HIV positive. 84 Thus, it appears
that the immigrants who were to be the real focus of this exclusionary
legislation were the mass of applicants under IRCA, people who have
resided in the United States for several years and who may have con-
tracted the virus while in residence. The HIV amendment was aimed at
these immigrants, despite their long-term connections to the United
States and the fact that no conclusive proof existed that they arrived in
the United States with the infection.

The scant legislative history only leaves room for thoughtful specu-
lation as to why the HIV amendment was passed or even proposed. This
article hypothesizes that this paternalistic and xenophobic legislation
found its way into our lives because immigrants are the least likely class
of people to challenge such exclusionary practices. Immigrants have lim-
ited rights, which vest only upon legalization. More importantly, immi-
grants do not have the right to vote until they are naturalized, which
could take several years. Moreover, judicial interpretation of the Consti-

81. "We in the United States have a world-class epidemic on our hands, which we have ex-
ported so effectively that the rest of the world is only a little bit behind us." RONALD BAYER,
PRIVATE ACTS, SOCIAL CONSEQUENCES, 3 (1989) (quoting statement by June Osborn, Dean of the
School of Public Health at the University of Michigan, made at her fall 1985 address to the Institute
of Medicine)
83. AIDS THE LEGAL ISSUES, 240 (Discussion Draft of the American Bar Association AIDS
Coordinating Committee) (1988).
84. Rona Morrow, Comment, AIDS and Immigration: The United States Attempts to Deport a
Disease, 20 U. MIAMI INTER-AM. L. REV. 131, 149 (Fall 1988).
tution has historically left immigrants with little or no protection from exclusionary congressional action.\textsuperscript{85}

After state attempts to require mandatory testing or reporting of citizens who test HIV positive failed,\textsuperscript{86} immigration law became an attractive vehicle to set a precedent for compulsory testing. In hindsight, it thus appears that congressional support for the HIV amendment did not stem from a desire to contribute to medical research, education, or treatment efforts. Rather, Congress responded to political pressure to isolate and stigmatize suspect groups - pressure that was magnified because one prominent advocate, Senator Helms, held 30 million dollars for AZT funds hostage.

Borne of a misunderstanding of the proper ways to stem the spread of AIDS, the HIV amendment, from its inception, was bad law. That the amendment was even passed was the product of several complex factors. First, Congress was ill-informed about the issues associated with AIDS in general, and uninformed about the likely ramifications of mandatory HIV testing of immigrants. This was the first debate on the HIV amendment in general, embarked upon without the aid of hearings, and attached as a rider to an appropriations bill. While Congress was perhaps aware of the privacy and civil liberty issues involved as they inured to citizens of the United States, it considered immigrants outside the scope of such protection.

Second, since congressional authority over immigration is undisputed, the testing of aliens would not be as easily attacked legally as the testing of citizens. The original version of the amendment made the appropriation of 30 million dollars in AZT funds contingent upon mandatory testing of all marriage applicants and immigrants; the final version only mandated testing of immigrants, persons without a political voice in the United States.

Third, the HIV amendment was a response to those who believed that mandatory testing and reporting, among other things, were key to the fight against AIDS. Unsuccessful at the state level, these proponents of intrusive and potentially punitive measures sought federal vindication and leadership. As Senator Helms said, "I want an expression on what this Congress intends to do with respect to a disease that is life-threaten-

\textsuperscript{85} Article 1, section 8, of the Constitution expressly grants Congress the power to establish a "uniform Rule of Naturalization." The power to exclude and deport has been subsequently held to derive as an incident of national sovereignty inherently enabling the federal government to protect the national public interest. See, e.g., Fong Yue Ting v. U.S., 149 U.S. 698, 13 S.Ct. 1016 (1893). Federal immigration power thus seems plenary and limitless as the Court's comment attests, "over no conceivable subject is the legislative power of Congress more complete." See Fiallo v. Bell, 430 U.S. 787, 792, 97 S.Ct. 1473, 1478 (1977); Kleindienst v. Mandel, 408 U.S. 753, 92 S.Ct. 2576 (1972)

\textsuperscript{86} See supra note 45.
...ing in increasing numbers to innocent people." Thus, Mr. Helms intimated that the "guilty" had to be dealt with before innocent victims were affected. Due to the shrewd maneuverings of Mr. Helms on the Senate floor, the HIV amendment was passed in exchange for the release of 30 million dollars in funds for AZT treatment under the appropriations bill which was under consideration. It was politics as usual on the Senate floor; the HIV amendment was passed without proper thought as to the far-reaching ramifications it would have on the country.

The HIV amendment was not the product of careful congressional deliberations. As a consequence, the bill delegated much of the responsibility for implementation to the INS and Public Health Service but provided little guidance on how to fulfill the conflicting and vague directives of legislative intent. More importantly, the HIV amendment neither comporteded with the intent of Congress in allowing for amnesty nor established valid and viable criteria for waiver of the ground of excludability. In the end, the waiver regulations promulgated by the INS contradicted the national immigration policy upholding family unity and IRCA's goal of allowing immigrants to "come out of the shadows."

According to the House Judiciary Committee:

The Committee expects the Attorney General to examine the legalization applications in which there is a waivable ground of exclusion carefully, but sympathetically. The committee's intent is that legalization should be implemented in a liberal and generous fashion, as has been the historical pattern with other forms of administrative relief granted by Congress. In most cases, denials of legalization on the basis of waivable exclusions should only occur when the applicant falls within one of the specified nonwaivable grounds of exclusion.

1. The Problem within the Problem: Requirements for Waiver

Under IRCA and applicable regulations, legalization applicants, at the discretion of the Attorney General, could apply for waiver of the HIV ground of exclusion based on "family unity, humanitarian reasons, or when it is otherwise in the public interest."
Although these statutorily based waiver criteria already existed, the INS created additional requirements for waiver under the HIV amendment which were much more difficult and sometimes impossible for immigrants to meet. The INS determined that before it would consider the traditional and more generous waiver criteria, a legalization applicant who tested HIV positive must first establish that: (1) the danger to the public health of the United States created by admission is minimal, (2) the possibility of the spread of the disease created by admission to the United States is minimal, and (3) there will be no cost incurred by any government agency of the United States without its prior consent. The INS, in effect, required “hyper-citizenship” of all the immigrants who sought waiver of the HIV ground of excludability. Furthermore, the INS in its notice of denial and certification to legalization applicants did not give examples of the type of documentation that would satisfy the requirements.

2. Waiver Adjudications

This section will focus entirely on the adjudications to date of waiver applications. In general, the approvals have required continuous employment, health insurance, and medical treatment and/or counseling. They have not, for the most part, considered factors such as an alien having children who are United States citizens or personal affidavits concerning knowledge of how to prevent the spread of the disease as favorable evidence for approval of a waiver application.

What follows is an example of one of the more egregious denials of an HIV waiver application. Mr. X is married to a legalized alien and has two children who are United States citizens. Accordingly, keeping the family together would and should have been considered under the “family unity” prong of the statutory grounds for waiver. In developing strategies for future immigration policy, the Select Commission on Imm
migration and Refugee Policy, the agency that wrote the report which pro-
vided the foundation for IRCA, recommended that the "reunification of
families should continue to play a major and important role in U.S. im-
migration policy." Supra note 15. Keeping the family together is as vital an interest as
reunification. A clear intent of Congress in formulating immigration law
has been to ensure the stability of the family unit.

Moreover, President Reagan directed all executive departments and
agencies to "ensure that the autonomy and rights of the family are con-
sidered in the formulation and implementation of policies." Mr. X,
however, was denied a waiver because his application did not contain
enough evidence that risk of the spread of the disease was "minimal" and
the record was bereft of any reference to health insurance or employ-
ment. While not separating the family per se, the denial of a waiver likely
will result in severe stress on the entire family’s stability since Mr. X can
no longer legally get a job. In applying the congressionally mandated
waiver criteria, the INS supplanted Congress’ directives with its own
guidelines in direct contravention of family unity considerations.

An analysis of the pattern of adjudications reveals that the INS is
trying to identify and exclude those who are incapable of paying for
treatment and possible hospitalization. However, responding to the per-
ceived future strains on health care by singling out illegal aliens with
HIV and denying them waivers does not seem to be the rational ap-
proach. First, IRCA regulations state that newly legalized aliens are not
eligible for most forms of federal assistance for five years following legali-
zation. Thus, whether or not aliens can prove they will not pose a finan-
cial burden to the United States government is moot since they are
proscribed from these types of assistance by law.

Second, INS criteria do not take into account that many HIV posi-
tive legalization applicants are asymptomatic and may not become ill for
years. Studies show that the median time from infection with HIV until

97. SELECT COMM’N ON IMMIGRATION AND REFUGEE POLICY, U.S. IMMIGRATION POLICY
House and Senate Committee on the Judiciary).
98. See, e.g., Alien Contract Labor Act of 1885, 23 Stat. 332 (measure to reduce excludability);
Act of July 29, 1953, 67 Stat. 229 (liberalized restrictions on adopted children); Act of September 11,
1957, 71 Stat. 639 (measure to reduce deportability).
100. Mr. X cannot be deported on the basis of his application because of legal confidentiality
requirements. See supra note 15.
101. In 1989 the INS issued a final rule amending § 245A of the INA (amended IRCA section)
to bar, with certain exceptions, newly legalized aliens from "receipt of benefits from programs of
financial assistance furnished under Federal law on the basis of financial need." 54 Fed. Reg. 29434
(Sept. 12, 1989) (to be codified at 8 C.F.R. § 245A). Among other benefits, the rule would bar receipt
of AFDC payments, state Medicaid plan payments, and food stamps. Id.
AIDS symptoms appear is eight years. Given the chance, these asymptomatic legalization applicants would have the opportunity of obtaining "private" health insurance through their employers; thus, relieving the United States government from the financial burden of caring for these individuals once they are stricken with full blown AIDS. Hence, any argument that the five year ban on public benefits is an insufficient safeguard against future financial burdens on the government is significantly weakened. However, the possibility of obtaining private health insurance is foreclosed for these individuals by waiver denial.

The INS seemed to treat immigrants who are "likely to become a public charge," a category of immigrants who are not allowed waivers, and immigrants infected with HIV as being in the same category: persons who are not likely to be able to support themselves in the event of legalization. However, being HIV positive, in and of itself, is not an indicator that an applicant will become a public charge. An applicant's asymptomatic condition should be taken into account in adjudicating waiver applications. Many individuals with HIV are capable of and willing to lead a productive life. Further, with federal assistance temporarily denied under IRCA, an applicant is proscribed from applying for government assistance in the first instance. If the government is concerned about legalization applicants who might become drains on the economy, they should pursue the "public charge" route explicitly rather than make tacit, categorical judgments about all HIV-positive immigrants. The Immigration Act of 1990 seemed to offer a solution to the problems generated by the HIV amendment.

C. Immigration Act of 1990

The Immigration Act of 1990 was the product of major compromise between the House and Senate. Among other things, the Act revamps the entire list of outdated excludable conditions, including medical ones. While the Act did not repeal the HIV amendment, it did provide that "dangerous contagious disease" be replaced with "communicable disease of public health significance," leaving the definition of such disease to the discretion of the Secretary of Health and Human Services.

103. Immigration and Nationality Act § 212(a)(15), 8 U.S.C. § 1182. The standard is objective and examines the totality of the circumstances at the time of application and makes a prospective assessment as to whether the applicant is "likely to become a public charge." Factors assessed are age, health, income, vocation, ability and willingness to work and no one factor is determinative. 8 C.F.R. § 245a.3 (1991).
Pursuant to the Act, the Secretary of Health and Human Services proposed that only active tuberculosis remain as an excludable medical condition.\textsuperscript{106} The Public Health Service reviewed the previous list of “dangerous contagious diseases” in January and February of 1990 and concluded that only active tuberculosis should remain as a ground of exclusion since the other five sexually transmitted diseases, including HIV, are not transmitted by casual contact, through air (active tuberculosis can be transmitted in this manner), or from common vehicles such as food or water.\textsuperscript{107} As the Public Health Service stated, “a careful consideration of epidemiological principles and current medical knowledge leads us to believe that allowing persons with these conditions to enter the United States will not pose a significant risk to the general population, where there is already wide prevalence of the disease.”\textsuperscript{108}

Thus, the Immigration Act of 1990 and the subsequently proposed rule to delete HIV from the list of excludable diseases would have likely offered future immigrants a chance to legalize their status without punitive measures that target their medical condition. Unfortunately, the proposed rule has yet to be finalized and did not meet the June 1, 1991 effective date for the Act’s amendment to the INA which changed “dangerous contagious disease” to “communicable disease of public health significance.” Therefore, cases will continue to be adjudicated under the old HIV exclusion. Moreover, the Act does not offer remedial measures for those who have already been denied waivers.\textsuperscript{109}

The Act also does not provide for any type of judicial remedy for past denials of waiver applications.\textsuperscript{110} However, the regulations governing IRCA and waiver applications provide that after exhaustion of an appeal,\textsuperscript{111} “an applicant who believes that the grounds for denial have been overcome may submit another application with fee, provided that the application is submitted within his or her one-year eligibility pe-

\textsuperscript{107} Id. at 2,485.
\textsuperscript{108} Id.
\textsuperscript{110} The regulations provide that after the LAU has rendered a final decision, “[n]o further administrative appeal shall lie from this decision, nor may the application be filed or reopened before an immigration judge or the Board of Immigration Appeals during exclusion or deportation proceedings.” 8 C.F.R. § 103.3(a)(3)(iii) (1991). The INS may not, however, use information from a legalization application for purposes of detection or deportation. The information on a legalization application is solely to be used for determining eligibility or prosecuting an applicant for fraud. 8 U.S.C. § 1255a(c)(5) (Supp. 1991).
\textsuperscript{111} This would occur after denial at the regional level is affirmed by the LAU on certification.
Nevertheless, the appellate focus will be confined to the prior record, and new evidence previously unavailable. Moreover, the one-year window does not allow reconsideration of those applicants for whom the statutory adjustment date has already expired.

Another recourse under the regulations is the provision that the Regional Processing Facility may *sua sponte* reopen and reconsider any adverse decision. In this situation, a legal recognition that HIV is not a bar to legalization should be viewed in the reconsideration as a favorable factor. This, however, offers no remedy to those whose application denials have already been affirmed by the LAU since it requires that the Regional Processing Facility reopen the case while the appeal is still pending.

The best source for remedy, then, is the provision which allows the LAU to *sua sponte* reopen and reconsider decisions. This does not allow the applicant, herself, to move the LAU to reconsider her case, which seems the preferred and most likely way to succeed. Nothing in the regulations, however, prohibits an applicant from *requesting* that the LAU reopen her case *sua sponte*. Thus, an applicant may have some chance to have her file reopened in light of the proposed rule to delete HIV from the list of excludable medical conditions. All of the above theories of remedy are contingent upon the promulgation of a final rule deleting HIV from the list of excludable diseases.

V. ANALYSIS OF COMPETING NORMS

Few issues have divided a country so starkly and bitterly as the AIDS epidemic. One faction, which can be characterized as the ideo-
logical right, has focused on certain groups of individuals as culprits behind the spread of the disease, rather than on the disease itself. From this faction’s point of view, AIDS can be controlled only by targeting the guilty through coercive measures such as mandatory testing and reporting. The second group, which can be characterized as the medical and scientific community, has focused on the nature of the disease itself; the body in which HIV is housed is regarded as only another factor to take into account in preventing the spread of the disease.

The dichotomy is underscored by the rhetoric of guilt versus innocence employed by the ideological right. Proponents of exclusionary measures iterate the need to protect innocent victims and the general public. Yet, early efforts to disseminate AIDS education in the public schools were rebuffed by the ideological right, who believed AIDS only affected certain groups of “guilty” people. The right therefore felt that the innocence of children should not be compromised with the necessary tools to prevent a disease which would not, in their estimation, affect the youth of this country.

Proponents of education and morally non-judgmental measures, on the other hand, recognize no such discrimination in the swathe that AIDS has cut across the population. The medical community’s efforts to combat AIDS can be described as purely scientific, pursued without regard to underlying civil liberty or anti-discrimination concerns. In effect, however, the medical and scientific communities’ position in the fight against AIDS naturally aligns it with civil rights and civil liberties proponents who advocate equal treatment without regard to medical condition or lifestyle. Even if the source for support on non-punitive AIDS policy is different, the effect is the same: prevention of the disease through non-coercive measures that do not seek to single out certain groups as blameworthy. The following debates about AIDS illustrate and are inter-related facets of the tensions that these competing factions have generated.

A. Control v. Prevention

Proponents of the control model focus on the allegedly blameworthy attributes of people with HIV, namely homosexuality, drug use, poverty, and race, as support for their proffers of punitive measures to control the spread of AIDS. By focusing on the individual in such a way, efforts


120. Under this reasoning, one commentator has stated, “If the first U.S. cases had not been described in sexually active gay men and intravenous drug users, but in the white, heterosexual sons of congressional leaders, for instance, the emotional response and mobilization of resources would have been substantially different from what they were.” Marshall Forstein, M.D., Understanding the Psychological Impact of AIDS, in THE AIDS EPIDEMIC, PRIVATE RIGHTS AND THE PUBLIC INTEREST, 159, 167 (Padraig O’Malley ed. 1989) (quote from Forstein article which stated that HIV cre-
at prevention through wide-spread education were dismissed as unnecessary for the general public. Instead, control proponents continued to pursue the more coercive measures such as mandatory testing. On the other hand, proponents of the medical model focused on the disease and modes of transmission rather than the individual. Their efforts to promote education on how the HIV virus was transmitted and to alleviate public hysteria that AIDS could be contracted through casual contact were stymied; in an American population characterized by ignorance, the disease began to spread.

In the quest to control AIDS and those it perceived to be its sources, control proponents advocated mandatory testing under the guise of an effective public health measure designed to protect the public. This seemingly protective measure is belied by the fact that relatively few numbers of aliens were identified as having HIV.\textsuperscript{121} It then appears that the purpose behind the coercive measure was hidden and generated by something other than a concern for the public health.\textsuperscript{122}

America has suffered the consequences of administrative infighting regarding how best to formulate AIDS policy. The divided opinion in the White House was manifested on the Senate floor during the debate on the HIV amendment.\textsuperscript{123} As the scientific and health community relentlessly worked to isolate the virus and educate the public on modes of prevention,\textsuperscript{124} the conservative element of the federal government fought such educational measures every step of the way.\textsuperscript{125} In the interim, America lost great headway in the struggle to save lives, or at the least, to extend them.

Prevention can be a method of control. But control, in and of itself, can never be a method of prevention, especially if it focuses on characteristics of the individual rather than their medical condition. Individuals do not like to be "controlled" because it goes against the very nature of self-determination. If the Governor of California were to announce two epidemics, one of disease, the other the consequence of the psychological response to that disease).

\textsuperscript{121} As of July 1990 only 59 legalization applicants have been diagnosed with HIV. See Appendix I.

\textsuperscript{122} "[I]f a measure does not produce results and yet is supported by officials and the public, one must suspect secondary reasons for that support. Such measures tend to transform protection of the public into punishment of victims of disease. ALLAN BRANDT, A Historical Perspective, in AIDS AND THE LAW: A GUIDE FOR THE PUBLIC 41 (Harlon Dalton & Scott Burris eds., 1987).

\textsuperscript{123} See supra note 89.

\textsuperscript{124} See, e.g., SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME at 33 (1986)(Surgeon General Koop stated that mass mandatory testing would be "unnecessary, unmanageable, and cost prohibitive").

morrow that all Californians were to report for mandatory HIV testing, it is doubtful that, like sheep, we would go. Some might rationalize that they have nothing to worry about, so why not take the test. But others might have a lot to worry about, and government imposed testing would be the least likely incentive for them to seek help. Imagine the costs, emotional and financial, in trying to test everyone for HIV, not to mention the drain on resources that would occur if they were diverted where least needed. In the end, AIDS is, and should be, a national concern; but that concern should focus on education, voluntary testing, confidentiality, health care, and humane treatment. The quest for "control" is not likely to reach those who most need assistance and education.

The HIV amendment and applicable regulations illustrate the impotence of exclusionary legislation as an effective prevention or control method. The HIV amendment does not provide for deportation of an infected immigrant. On the contrary, once an immigrant has been tested, he or she has the option of proceeding with the application process if the HIV test is positive. If immigrants do not choose to proceed with the amnesty application process, many who test positive probably remain in this country, living in fear of INS detection.

HIV-related discrimination is impairing the nation's ability to limit the spread of the infection. People with HIV are thus faced with two battles, one against the disease itself and the other against discrimination. Furthermore, the discrimination has spread to "innocents," such as school-age children, because prejudice was fostered by the lack of widespread education. Discrimination allows one to vent emotion at the expense of examining rational policies aimed at preventing the disease.

In light of the great gains the United States has achieved with respect to AIDS in disseminating information, researching new treatments, and treating persons at the infectious stage, the solution to the problem of undocumented aliens with AIDS should not be constructive deportation. A better response would be extensive counseling, education and

126. See, Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic 119 (June 1988). ("[D]iscrimination against persons with HIV infection in the workplace setting, or in the areas of housing, schools, and public accommodations, is unwarranted because it has no public health basis").

127. "One of the primary causes of discriminatory responses to an individual with HIV infection is fear, based on ignorance or misinformation about the transmission of the virus. We cannot afford to let such ignorance or misinformation persist. Each publicized incidence of discrimination, such as the picketing of a school that has admitted a child with HIV infection, perpetuates this ignorance and sows doubt in the minds of those who hear it. This undermines current and future HIV education programs as well as rational HIV policies." Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic, 120 (June 1988) (statement in chapter on legal and ethical issues). The reader is advised to read this report and the second report for a discussion on why federal anti-discrimination laws should be amended to cover private as well as governmental sectors.
treatment of those legalization applicants who voluntarily take an HIV test that yields a positive result. Of course, this logic assumes that there was not a hidden agenda behind the regulations.

B. High Risk "Groups" v. High Risk "Behavior"

As early as six years ago, medical experts advised that the breakdown of reported cases of AIDS into “risk groups” be abandoned. Dr. Mathilde Krim, who chaired the AIDS Medical Foundation in New York, stated the following:

[S]ince [this practice] highlights the sexual inclinations of one group and does not do so for others, it has contributed significantly to the erroneous interpretation that AIDS was, one, exclusively a ‘gay disease’ and, two, a disease of a world alien to that of most ‘good Americans.’ In New York, the public is now astounded to learn suddenly that over 30 percent of AIDS patients are heterosexuals, whether drug abusers or not, and that there may be close to half a million people infected by [HIV] in this city, many of whom are heterosexuals who certainly are having sexual relations with other heterosexual men and women, and so pass on the infection.128

For epidemiological purposes, it is useful to categorize classes of persons in order to understand better whom the disease affects and to establish through empirical data why and how it affects such people. However, one serious drawback of such categorization is that it does not take into account crossovers.129 Moreover, in the case of HIV, such categorization stigmatizes already marginalized groups such as gays without proof that they, based on their sexuality, are the source of the infection. The Surgeon General summed it up effectively and urged readers to battle AIDS as a disease, not people with AIDS:

At the beginning of the AIDS epidemic many Americans had little sympathy for people with AIDS. The feeling was that somehow people from certain groups ‘deserved’ their illness. Let us put those feelings behind us. We are fighting a disease, not people. Those who are already afflicted are sick people and need our care as do all sick patients. The country must face this epidemic as a unified society. We must prevent the spread of AIDS while at the same time preserving our humanity and


129. For example, a homosexual can also be a drug user. Likewise, a heterosexual can engage in sex with multiple partners. Moreover, such classification appends high risk behavior to persons who belong to a high risk group regardless of whether such persons engage in high risk behavior in fact. “A gay who never engages in unprotected anal intercourse or an IV drug abuser who always uses a clean needle is not a high-risk group member, notwithstanding the public perception to the contrary.” Martin Gunderson, David Mayo & Frank Rhame, AIDS: Testing and Privacy, 2 ETHICS IN A CHANGING WORLD at 5 (1989).
Ignoring high risk behavior allowed the more conservative element of our country to resort to sanctions aimed at those people in society to whom they had deep-seated psychological and moral aversions. The issue of AIDS presented a philosophical and moral dilemma for the Reagan administration because of early perceptions of the epidemic as a "gay disease" or disease of the "other." Therefore, any pronouncements of a national policy of non-discrimination would have been seen as publicly sanctioning homosexuality or immoral behavior. This sort of reasoning is never effective when utilized in the decision making process regarding health epidemics and methods of prevention.

The better response is an attempt to reach high risk behaviors such as use of a contaminated needle, whether it be in a hospital or "shooting gallery," or the practice of unprotected sexual activity. By targeting immigrants, another group historically subject to moral aversion and distrust, Congress shifted the focus from its duty to disseminate information about the transmission of the HIV virus and treat patients with AIDS to a piecemeal effort to quell the rising hysteria of an ignorant public.

C. Parochialism v. Visions of a Global Village

The United States, as a permanent member of the Security Council and a member of the General Assembly, is bound by basic human rights provisions in the United Nations Charter and other documents of the United Nations. Thus, the United States' use of exclusionary laws to deport constructively those infected with the HIV virus therefore must be measured against its international obligations. By this measure, the United States through its shortsighted policies, has failed to meet its...
commitment to global human rights and the prevention of AIDS. The promulgation of the HIV amendment and related regulations is at odds with international law as set forth by the United Nations. Article 1 of the Universal Declaration of Human Rights states that all persons are born free and equal in dignity and rights. Article 2 emphasizes this by stating that no one is to be discriminated against by reason of their race, color, sex, language, religion, political opinion, national or social origin, property, birth or other status. Therefore, aliens seeking amnesty should not be discriminated against based on the "status" of HIV infection. Furthermore, Article 9 states that no one may be exiled in an arbitrary fashion and Article 13(2) ensures the right to travel across national borders. Additionally, in October of 1987, the United Nations 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."\textsuperscript{134} Despite these measures, the United States sought to constructively deport HIV positive immigrants by enacting exclusionary laws.

The isolationist position created by the HIV amendment does not further the goal of shared international progress toward AIDS prevention. Discrimination against immigrants, who are supposedly eligible for "amnesty," based on a virus that leads to a deadly and frightening disease affecting the entire world can only increase international hostility against the United States\textsuperscript{135} since it has the highest number of reported cases of AIDS in the world. It does, however, compromise the United States' position as a world leader in the international fight against AIDS. One of the top twenty recommendations of the Presidential Commission on the HIV virus stated, "[i]nternational efforts to combat the spread of HIV infection should be encouraged and assisted by the United States, through our research community and our national contribution to the World Health Organization and the Global Programme on AIDS."\textsuperscript{136}

International and United States health policy has focused on the primacy of education, counseling, and early detection and treatment of the HIV infection as the best preventive measures. The HIV amendment furthered none of those primary objectives.\textsuperscript{137} To the contrary, by adopt-

\textsuperscript{135} For two articles on international concerns and ramifications regarding the AIDS pandemic see Robert M. Jarvis, "Advocacy for AIDS Victims: An International Law Approach," 20 U. MIAMI INTER-AM. L. REV. 2 (1988); see generally, Rona Morrow, Comment, "AIDS and Immigration: The United States Attempts to Deport A Disease," Id. at 146. Much of my discussion was drawn from their works.
\textsuperscript{136} REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC XIX (June, 1988).
\textsuperscript{137} While the mandatory HIV test prescribed by the Public Health Service regulations does provide confidential counseling and the INS waiver guidelines do take into account such counseling in their adjudication of waiver applications, counseling has not been a conclusive factor in approvals.
ing exclusionary legislation that places the issue in an "us" versus "them" posture, the United States may only provoke retaliatory measures, further frustrating efforts to obtain international cooperation. In fact, other countries have implemented stringent testing requirements for foreign visitors.\textsuperscript{138} By adopting an isolationist stance that stigmatizes HIV-positive immigrants, the United States has jeopardized its chances to work with other countries in the global village to combat AIDS through public health measures.

VI.
THE SHIFTING BALANCE OF POWER

The retreat from isolationist, exclusionary legislation in the Immigration Act of 1990 did not result from an enlightened recognition of the need to approach the battle against AIDS in less punitive, stigmatizing ways. Rather, increasing pressure from health experts, including the federal government's own National Commission on AIDS,\textsuperscript{139} has coerced the Bush Administration into implementing a better coordinated national AIDS policy.\textsuperscript{140} From the onset of the AIDS epidemic, the position of health officials has focused on the need for statistics, research, and education as the most effective strategies.\textsuperscript{141}

Thus, after a decade of lobbying by health experts, the administration could no longer ignore the fact that AIDS does not affect only a marginalized subset of the population, nor is it primarily "imported" by immigrants.\textsuperscript{142} "By substituting the words 'public health significance' for 'dangerous,' Congress intends to insure that this exclusion will apply only to those diseases for which admission of aliens with such diseases


\textsuperscript{139} The Commission found that "coordination of the government's efforts is the missing link to an effective national strategy." \textit{National Commission on AIDS, Report Number Two: Leadership, Legislation, and Regulation} (1990).

\textsuperscript{140} However, the National Commission on AIDS has characterized national AIDS policy, even in 1990, as "...an orchestra without a conductor." \textit{Id.}

\textsuperscript{141} Experts have long contended that education and environmental support, such as access to health care, psychological and social support, economic sufficiency, and non-discrimination are the keys to enabling individuals to modify their behavior to prevent the spread of the HIV infection. See, e.g., Jonathan Mann, \textit{Global AIDS: Epidemiology, Impact, Projections, Global Strategy, AIDS Prevention \\& Control}, at 3 (1988).

would pose a public health risk to the United States."\textsuperscript{143} This change in attitude is reflected in the reworking of the Immigration Act of 1990 regulating medical examination of aliens. Regarding HIV, the Public Health Service made the following statement:

The risk of (or protection from) HIV infection comes not from the \textit{nationality} of the infected person, but from the specific \textit{behaviors} that are practiced. Again, a careful consideration of epidemiological principles and current medical knowledge leads us to believe that allowing HIV infected aliens into this country will not impose a significant additional risk of HIV infection to the U.S. population, where prevalence of HIV infection is already widespread. Our best defense against further spread of HIV infection, whether from a U.S. citizen or alien, is an \textit{educated} population.\textsuperscript{144}

By recognizing the superiority of the Public Health Service over the INS as an authority on the threat to public health posed by HIV positive immigrants, the Bush administration has taken one small step toward the humanitarian treatment of immigrants and the prevention of AIDS.

The HIV amendment appears to have been a barometer of the route that the federal government would have followed regarding mandatory testing, and necessarily, then, its policy on AIDS prevention. Had Congress failed to address the HIV amendment issue in the Immigration Act of 1990, it might have paved the way for domestic mandatory testing. Indeed, since HIV remains an excludable condition, lack of mandatory domestic testing is not a foregone conclusion. With mandatory testing entrenched and basically immune from legal challenge for immigrants at low risk of contracting HIV, it appears that little stands in the way of legislating mandatory testing for those United States citizens perceived as high risk. This assertion is not the product of paranoia. For example, recall the unsuccessful attempt to institute mandatory testing for all marriage applicants in New Hampshire advocated by then Governor Sununu.\textsuperscript{145} Fortunately, the federal government appears to be shifting to a more humane and effective approach to combatting AIDS. For the moment,\textsuperscript{146} the medical community with its emphasis on education, counseling, and voluntary testing\textsuperscript{147} appears to have prevailed over those who demand more punitive, stigmatizing approaches for those infected

\begin{quote}
145. See supra note 45.
146. Resolution of the HIV mandatory testing of immigrants issue is currently subject to the Public Health Service's proposed rule deleting HIV from the exclusionary list of medical conditions. See supra note 22.
147. Regarding any testing for HIV, the recommendations of the Presidential Commission on HIV should be incorporated into the national strategy, which describes the need for quality assured testing which is easily accessible, confidential, voluntary and associated with appropriate counseling
\end{quote}
with HIV. Still, the AIDS debate remains a volatile one, and it is therefore imperative to examine how the federal government can reinforce its commitment to intelligent public health policy with respect to immigrants and testing in the future.

VII.
PROPOSALS FOR THE FUTURE

A. Legislative Process Reform

The most urgent, but least likely, type of reform is needed in the hallowed halls of the United States Congress. A spending bill is not the appropriate forum in which to debate urgent and complex issues such as AIDS. Moreover, the procedural rules in the Senate maximize individual freedom rather than fair and efficient institutional processes. Thus, "[t]he Senate is run for the convenience of one Senator, to the inconvenience of 99." Although technically illegal, substantive amendments can be attached to legislation in the Senate because "it functions to a large extent by unanimous consent, in effect adjusting or disregarding its rules as it goes along."

Practical reasons account for differences in procedure between the Senate and the House. Since the House is larger, it has a more structured body than the Senate. House rules "show a constant subordination of the individual to the necessities of the whole House as the voice of the national will." Therefore, a determined majority rather than one individual prescribes the path that legislation will follow. Moreover, non-germane amendments are not as common in the House as in the Senate because House rules, in theory, require that amendments be relevant to the bill itself. The burden of proof rests with the sponsor of the amendment to establish germaneness.

The Senate should review its procedures and formulate a workable structure whereby non-germane issues are scrutinized closely before they

and care services. THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC (June, 1988).


149. Id. at 185 (Calling for unanimous consent to set aside rules is a Senate device primarily used to expedite business).

150. WALTER J. OLESZEK, CONGRESSIONAL PROCEDURES AND THE POLICY PROCESS 24 (3d ed. 1989). The restraints on the House are much more severe than those on the Senate. More than 650 pages are needed to describe the House rules for the 100th Congress while the Senate’s rules are contained in 90 pages. Id.

151. 1 ASHER C. HINDS, HIND’S PRECEDENTS OF THE HOUSE OF REPRESENTATIVES OF THE UNITED STATES at v (1907).

152. Id. at 157.

153. Id.
are attached to legislative bills, especially if they involve complex issues such as those encompassed by AIDS. As it is, "any measure is open to virtually an unlimited number of amendments unless a unanimous consent agreement specifies otherwise."\(^{154}\) Unlike the more orderly procedure followed in the House,\(^{155}\) Senators can propose amendments at any time to any section of a bill.\(^{156}\)

In addition, experienced Senators can incorporate crucial portions of an original bill into an amendment thereby increasing the likelihood that the amendment will pass. In the HIV amendment debate, for instance, if any Senator had challenged Helms' amendment as non-germane and hence stricken it, the Senator also would have killed the 30 million dollar AZT funding contingent upon the passage of the Helm's amendment.\(^{157}\) Moreover, if the amendment had been eliminated in response to a point of order alleging that it was illegal substantive legislation, it could not have been re-offered unless a substantive change had been made.\(^{158}\)

Wily manipulation of procedure is still likely to occur, especially by seasoned veterans who know how to control the legislative process.\(^{159}\) However, this reform measure would reduce inequities engendered by non-germane amendments which require senators to make difficult trade-offs. If the HIV amendment had not been a rider to an appropriations bill, for example, Senator Weicker would not have had to make a choice between losing 30 million dollars in AZT funding and testing immigrants for HIV.

**B. Government Agency Reform**

The second area of reform should occur at the federal agency level.

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154. *Walter J. Oleszek, Congressional Procedures and the Policy Process* 210 (3d ed. 1989). Oleszek defines the agreement as a device used by the Senate to expedite legislation. On major legislation, such agreements are usually printed and transmitted to all senators in advance of floor debate. Once agreed to, they are binding on all members unless the Senate, by unanimous consent, agrees to modify them. *Id.*

155. The House has what is called a "closed" rule which prohibits floor amendments. In the contemporary House it is not a pure rule but restricts floor amendments unless offered by the reporting committee or committees. *Id.* at 126. The House also has an open rule that permits floor amendments but still requires, in theory, that all amendments be germane. *Id.* at 123.

156. *Id.* at 211.

157. Even though the 30 million dollar for AZT research was a separately offered committee amendment, because Helms attached it to his own HIV amendment, the presiding chair held that any point of order brought against the HIV amendment would necessarily kill the AZT amendment as well. 133 CONG. REC. S6954, 6976. (daily ed. May 21, 1987).


159. For example, Senate rules may grant inordinate parliamentary power to individual members and determined ideological minorities. *Id.* at 24. When the HIV amendment was introduced, Helms, as a senior senator with a strong minority concern, was afforded great deference in his pursuit of mandatory testing for immigrants.
Agencies, as specialized arms of the federal government, should be the policymakers in their particular areas of expertise. In health related areas, the Public Health Service, not the INS, should be setting the policy and criteria for admission of immigrants. The INS is better suited to enforcement of already promulgated health criteria; leaving the proclamation of new health regulations to the Public Health Service. According the Public Health Service a more prominent role would not unduly disrupt immigration proceedings. The INS would still be charged with barring entry by ineligible aliens and deporting those illegally in the United States. Immigration judges would still decide questions of law, such as whether an immigrant is legally eligible for suspension of deportation or whether an immigrant is likely to become a public charge. However, Public Health Service experts would establish legal criteria relevant to health matters, such as whether the legalization of amnesty applicants who test HIV-positive would pose a threat to the public safety of the United States.

Given the stringency in application of the INS waiver guidelines, it now seems apparent that INS officials were sorely uneducated about the nature of AIDS. For example, it is doubtful that Public Health Service officials would have required health insurance as a prerequisite to legalization since asymptomatic HIV individuals are healthy and may remain so for some time in the future, making it likely that they can continue to work and pay for health care. Additionally, the difference between the two agencies' approach is manifested in their views regarding the treatment of infected immigrants. Although both agencies recognize the need for HIV testing and counseling, the Public Health Service focuses on early treatment and counseling for psychological and prevention purposes, while the INS would deny legalization based on testing results. Denying legalization is not an effective prophylactic given that it constructively denies immigrants access to counseling, treatment and jobs. While the Immigration Act of 1990 transferred the authority over health matters to its rightful policymakers, the Public Health Service must remain vigilant to ensure that policy reversals do not occur in the future.

C. Building and Maintaining Coalitions

Coalitions that advocate fairness and humanity in the treatment of immigrants and others with AIDS must remain active and attentive.\textsuperscript{160} Until immigrants become naturalized, their most powerful protection resides not with politicians, legislators, or executives, but with allies who

share their political concerns and who continually lobby for change.\textsuperscript{161} Likewise, citizens with AIDS or HIV, although arguably a stronger political force than immigrants, need the continued support of coalitions in what is sure to be a long and arduous journey through the morass of insurance, job and housing discrimination, as well as other legal problems.

Legislation such as the HIV amendment which was passed with little or no notice, curbs the effectiveness of direct participation by advocacy groups at hearings. When this occurs, reform efforts must not stop. Coalitions must continue to document deficiencies of laws passed without full deliberation and demand their reexamination and change.

The unified front presented by a coalition of immigration lawyers, immigrant and human rights advocates, health officials, and AIDS activists presented drafters of the Immigration Act of 1990 with no alternative but to rethink the purposes of the outdated list of "dangerous contagious disease[s]." These advocates carefully documented the deleterious effects the HIV amendment had not only on immigrants but on the integrity of the United States as a world leader in the fight against AIDS. Without the ongoing efforts of this coalition, the HIV amendment will probably remain on the books.

VIII.

CONCLUSION

It is heartening that the HIV amendment may be deleted after being exposed as an ill-equipped measure in the fight against AIDS. Yet, it is disheartening overall that reaction to AIDS took the form of legislation which has as its goal constructive deportation of a group of immigrants who otherwise would have been eligible for amnesty under IRCA. Such legislation flies in the face of a global consensus that the only effective means of AIDS prevention is education, not prohibitive screening programs which, in the case of amnesty applicants, may force them back into the shadows.

No one would deny our elected representatives the opportunity to protect citizens from disease. But we should deny them the opportunity to use this noble purpose in defense of means which in no way serve the American public. If the regulations are taken to their logical conclusion, they will create a permanent underclass of HIV positive individuals when applicants go underground rather than submit to testing. Such a state of affairs is surely a threat to the civil rights and civil liberties of all

\textsuperscript{161} Immigrants, even those who have attained permanent residency, are denied the power to vote until they become citizens of the United States.
persons. 162

This article argued that however great the authority of Congress and the INS over immigration, the pandemic of AIDS requires that the expertise and consensus of health officials, public and private, be taken into account in any future enactment of legislation and regulations regarding immigrants with HIV. If this occurs, as it has in the case of the Immigration Act of 1990, support services could be directed to the more pressing need of immigrants trying to adjust to life in the United States as legalized residents with HIV.

As we are slowly learning, AIDS is not just a gay disease nor a disease of "the other." AIDS affects us all. If we allow politics, in any form, to foreclose the human rights of those considered marginal, one can be sure that the first incursion on humanitarian treatment of those persons with AIDS will be followed by more, until our commitment to civil rights and civil liberties becomes lost in the struggle for moral superiority by those without AIDS against those with AIDS.

The acknowledgment by the Public Health Service that immigrants with HIV do not pose a public health threat, although as of yet not finalized in regulations, evidences a growing awareness that the solution to the AIDS pandemic will not result from discrimination against those who are easily and historically excludable. Such punitive measures blind policymakers to the overwhelming need for national and global acceleration of medical research, education, and treatment. This realization is perhaps best captured by Camus in his book *The Plague*:

Dr. Rieux resolved to compile this chronicle, so that he should not be one of those who hold their peace but should bear witness in favor of those plague-stricken people; so that some memorial of the injustice and outrage done them might endure; and to state quite simply what we learn in time of pestilence; that there are more things to admire in men than to despise. 163

162. See Plyler v. Doe, 457 U.S. 202, 102 S.Ct. 2382, 72 L.Ed.2d 786 (1982). The Court decided that even undocumented alien children are entitled to equal protection. While reaffirming that education is not a fundamental right and noting that undocumented aliens are not a suspect class to which "strict scrutiny" would apply, the Court nevertheless concluded that any state statute which created special burdens for undocumented alien children to receive an elementary education would be void unless the state could show that it furthered some substantial state interest. In this case the Court found no showing of a substantial state interest which could justify the statute. By analogy, the waiver regulations promulgated by the INS created special burdens, which, if we take the number and analysis of approved waivers as our yardstick, can be categorized as insurmountable for immigrants with HIV. These special burdens cannot be defended as furthering some substantial national interest if one takes into account the overwhelming consensus of the scientific community as to the best way to prevent AIDS.

### APPENDIX I

**LAU Decisions - HIV Waivers of Excludability**

The First 59 Decisions

<table>
<thead>
<tr>
<th>Region</th>
<th>Approvals(^{164})</th>
<th>Denials</th>
<th>Remands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western</td>
<td>5 (63%)(^{165})</td>
<td>0 (0%)</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Southern</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Northern</td>
<td>1 (12%)</td>
<td>9 (24%)</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Eastern</td>
<td>2 (25%)</td>
<td>28 (76%)</td>
<td>11 (7%)</td>
</tr>
</tbody>
</table>

\(^{164}\) All approvals had legal representation. In addition, all LAU approvals stated that the three additional INS criteria - that danger to the public health of the United States created by admission is minimal, that possibility of the spread of the disease created by admission is minimal, and that there will be no cost incurred by any government agency of the United States without its prior consent - must be met before the Attorney General's criteria of family unity, humanitarian, or public interest would be applicable.

\(^{165}\) % figures are percentages of total number of approvals, denials, or remands.
THE FIRST 59

<table>
<thead>
<tr>
<th>REGION</th>
<th>Approval</th>
<th>Denial</th>
<th>Remand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Northern</td>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Western</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Eastern</td>
<td>28</td>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>

n = 59

- 8 Approvals (14%)
- 37 Denials (63%)
- 14 Remands (23%)
## Appendix II
### LAU Decisions - HIV Waivers of Excludability Approvals

<table>
<thead>
<tr>
<th>REGION</th>
<th>LAU Reason for Approval</th>
<th>Applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western</td>
<td>Humanitarian/Public Interest</td>
<td>Single Male</td>
</tr>
<tr>
<td>Western</td>
<td>Humanitarian; Also waived 212(a)(19) on same grounds w/out discussion</td>
<td>Single Male</td>
</tr>
<tr>
<td>Western</td>
<td>Humanitarian/Public Interest</td>
<td>Single Male</td>
</tr>
<tr>
<td>Western</td>
<td>Family Unity/Humanitarian</td>
<td>Married Male w/ LTR wife, LTR son, and three U.S. children</td>
</tr>
<tr>
<td>Western</td>
<td>Family Unity/Humanitarian</td>
<td>Single Female with two children</td>
</tr>
<tr>
<td>Western</td>
<td>Humanitarian/Public Interest; Also waived 212(a)(17) on same grounds w/out discussion. This waiver was a reversal of the RPF decision.</td>
<td>Single Male</td>
</tr>
<tr>
<td>Western</td>
<td>Humanitarian/Public Interest</td>
<td>Single Male</td>
</tr>
</tbody>
</table>

**NOTE:**

All eight approvals had the following documentation in common (expressly referred to in the LAU decisions):

1. Declaration/Affadavit of applicant which included:
   a. Background of applicant
   b. Applicant's knowledge of his/her HIV infection
   c. Enrollment in educational, counselling, or medical program/treatment
   d. Health insurance
   e. Employment history
2. Proof of health insurance
3. Letter from mental health counselor and/or doctor
4. Letter/Affidavits from family, friends, acquaintances either giving good character recommendations or emotional and/or financial support.

Some of the approved waivers also included (and were listed as favorable conditions in the LAU approvals):

   a. Articles on conditions in home country
   b. Letter from employer/personnel manager/supervisor
   c. Affidavit from spouse
   d. Policy letters

The following positive factors were also mentioned in the text of the LAU approvals:

   a. Applicant's stable work history
   b. Applicant's volunteer work
   c. Applicant's length of residence in the U.S.
   d. No other excludable grounds known to INS
   e. Stability and productivity of applicant

It cannot be stressed enough that the applicant must prove by documentation that he/she is aware of his/her condition, methods of prevention, has or is currently enrolled in counselling or medical treatment, and will not incur any cost to the government. As will be revealed by the LAU denials, it is not enough that the applicant submit only a statement on their own behalf or have a U.S. citizen spouse or children.
### APPENDIX III

**LAU DECISIONS - HIV WAIVERS OF EXCLUDABILITY DENIALS**

<table>
<thead>
<tr>
<th>REGION</th>
<th>REASON FOR DENIAL</th>
<th>APPLICANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>Applicant did not provide family unity, humanitarian, or public interest reasons for granting waiver</td>
<td>Male</td>
</tr>
<tr>
<td>Northern</td>
<td>Lack of evidence of waiver eligibility</td>
<td>*Male</td>
</tr>
<tr>
<td>Northern</td>
<td>No waiver application filed</td>
<td>*Female</td>
</tr>
<tr>
<td>Northern</td>
<td>No waiver application filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Northern</td>
<td>No waiver application filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Northern</td>
<td>Lack of evidence establishing the three INS criteria were satisfied</td>
<td>Male</td>
</tr>
<tr>
<td>Northern</td>
<td>Lack of evidence establishing that the three INS criteria were satisfied</td>
<td>Male</td>
</tr>
<tr>
<td>Northern</td>
<td>Failed to submit any evidence to establish he meets the three INS criteria</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>*Female</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>*Female</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver application filed</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver filed</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver file</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver file</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver file</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver file</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Lack of evidence establishing that the three INS criteria had been satisfied</td>
<td>*Female</td>
</tr>
<tr>
<td>Eastern</td>
<td>Lack of evidence supporting waiver application</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Lack of evidence establishing that the three INS criteria had been satisfied</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Lack of evidence establishing that the three INS criteria had been satisfied</td>
<td>*Female</td>
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### APPENDIX III (CONT.)
#### LAU DECISIONS - HIV WAIVERS OF EXCLUDABILITY
#### DENIALS

<table>
<thead>
<tr>
<th>REGION</th>
<th>REASON FOR DENIAL</th>
<th>APPLICANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>No waiver filed</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>No waiver filed</td>
<td>*Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Lack of evidence in support of family unity, humanitarian, or public interest considerations</td>
<td>*Female</td>
</tr>
<tr>
<td>Eastern</td>
<td>Lack of evidence establishing that the three INS criteria had been satisfied</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Lack of evidence establishing that the three INS criteria had been satisfied</td>
<td>*Male</td>
</tr>
<tr>
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<td>Lack of evidence establishing that the three INS criteria had been satisfied</td>
<td>*Male</td>
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<tr>
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<td>Lack of evidence establishing that the three INS criteria had been satisfied</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Lack of evidence establishing that the three INS criteria had been satisfied</td>
<td>Male</td>
</tr>
</tbody>
</table>

**NOTES:**

* represents that applicant was self-represented

**LAU reasons for denials based on insufficient evidence include:**

- No proof of health insurance
- No proof of counselling, education, or medical treatment
- Applicant not sufficiently “aware” of his/her HIV infection or how to prevent its spread to the public
- No information on applicant’s employment status/ability to meet future medical costs

**LAU has also stated that the following without more is not sufficient or credible evidence:**

- Applicant’s affidavit without supporting documentation
- Unsigned statements from anyone
- Letters from counselors who do not know applicant or who show little knowledge of applicant
- Birth certificates of U.S. born children
- Marriage to U.S. citizen

In instances where no waiver of excludability was filed, applicants for temporary residents under section 245A of the Immigration and Nationality Act knew of their excludability as a result of their HIV status, but for unknown reasons decided not to file waivers of excludability.

It should be noted, however, that most of these applicants were those lacking in legal representation. A few of these applicants also had other reasons for being excluded besides their HIV status.
# APPENDIX IV

## LAU DECISIONS - HIV WAIVERS OF EXCLUDABILITY

### Remands

<table>
<thead>
<tr>
<th>REGION</th>
<th>REASON FOR REMAND</th>
<th>APPLICANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western</td>
<td>Original waiver approved by RPF: Family Unity/Humanitarian. Remanded to decide other exclusionary factors: moral turpitude 212(a)(9) and prostitution arrest 212(a)(12).</td>
<td>Single male</td>
</tr>
<tr>
<td>Southern</td>
<td>Remanded to RPF for waiver adjudication. LAU decision stated that applicant was not afforded the opportunity to submit waiver at the RPF level.</td>
<td>Male</td>
</tr>
<tr>
<td>Northern</td>
<td>Remanded to RPF for waiver adjudication. LAU decision stated that applicant was not afforded the opportunity to submit waiver at the RPF level.</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Medical forms not originally filed. Remand to file medical forms along with waiver.</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Remanded to RPF for waiver adjudication. It appears that applicant was not notified that waiver was required.</td>
<td>?</td>
</tr>
<tr>
<td>Eastern</td>
<td>Remanded to RPF for waiver adjudication. It appears that applicant was not notified that waiver was required. LAU also requested that court records for applicants previous arrests be submitted.</td>
<td>?</td>
</tr>
<tr>
<td>Eastern</td>
<td>Remanded to RPF for waiver adjudication. Applicant contended that waiver was submitted in timely manner.</td>
<td>Male</td>
</tr>
</tbody>
</table>
### HIV Exclusion of Immigrants

**Appendix III (Cont.)**

**Lau Decisions - HIV Waivers of Excludability Denials**

<table>
<thead>
<tr>
<th>Region</th>
<th>Reason for Remand</th>
<th>Applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
<td>RPF mailed decision to home address rather than U.S. mailing address.</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Remanded to RPF for waiver adjudication. Applicant contended that waiver was submitted on time.</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>Remanded to RPF for waiver adjudication. Appears that applicant was not aware that waiver was required. LAU also noted 212(a)(19) exclusion.</td>
<td>?</td>
</tr>
<tr>
<td>Eastern</td>
<td>RPF mailed decision to previous address although applicant had filed change of address card.</td>
<td>Male</td>
</tr>
<tr>
<td>Eastern</td>
<td>RPF mailed decision to incorrect address.</td>
<td>Female</td>
</tr>
<tr>
<td>Eastern</td>
<td>RPF mailed decision to previous address although applicant had filed change of address card.</td>
<td>Male</td>
</tr>
</tbody>
</table>