The Impact of Removing the Immigration Ban on HIV-Infected Persons

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Dear Editor:

On January 4, 2010, a new federal rule went into effect that lifted the 22-year restriction on immigration and travel to the United States for non-U.S. citizens living with HIV/AIDS. This was a monumental achievement, accomplished through the hard work of many advocates in the field. At the same time, this change removed mandatory HIV testing from the scope of immigration examinations, allowing for a potential missed opportunity for HIV counseling and testing. As there is ample evidence that some foreign-born populations have increased rates of HIV infection, new prevention and testing strategies for all potential immigrants need to be developed in accordance with the Centers for Disease Control and Prevention (CDC) recommendations for routine opt-out HIV testing. Here, we review the historical context of the HIV immigration ban, the events that led to its removal, and the potential implications among foreign-born persons living in the United States.

Regulations restricting entrance to the United States based on medical diagnoses were first combined into one formal body of law in the Immigration and Nationality Act (INA) in 1952.¹ The medical reasons barring entrance to the United States included mental health disorders, substance abuse, epilepsy, tuberculosis, leprosy, or "any dangerous contagious disease."¹ Initially, the definition of a "dangerous contagious disease" (later changed to "communicable disease of public health significance") was left to the discretion of the U.S. Public Health Services (PHS), later the Department of Human Health and Services (DHHS) and the CDC. Over time, this list expanded to include chancroid, gonorrhea, granuloma inguinale, leprosy, lymphogranuloma venereum, and syphilis; in the 1980s, HIV/AIDS was added.²

It was not the discovery of HIV alone, but the economic and political climate of the 1980s that led to the introduction of the ban. During the economic recession of the early 1980s, the United States saw a large influx of immigrants that fueled fears of foreigners taking American jobs and becoming a burden on the health and welfare systems.³ Within the same period of time, the AIDS epidemic exploded in the United States. Public fear and misunderstanding about this disease fed into the growing fear of foreigners. It was in this environment that AIDS was first added to the list of dangerous contagious diseases in 1987 by the DHHS.⁴ Initially, only individuals who

had advanced to AIDS were excluded, based on the argument that AIDS affected a person's wage-earning capacity.³ Shortly thereafter, pressured to demonstrate efforts to combat the HIV/AIDS epidemic, President Reagan required all immigrants be tested for HIV, and that HIV infection (with or without AIDS) be included as a disease of public health significance. This change was quickly passed by Congress, making all aliens infected with HIV ineligible for admission to the United States.^{2,3} The HIV immigration and travel ban would remain essentially unchanged for the next 22 years.

This political maneuver was largely accepted among the public as a concrete action against HIV/AIDS in the United States based on two rationales. First, the ban was presented as a public health policy preventing exposure of U.S. citizens to a fatal disease. Second, the ban would prevent those living with HIV/AIDS from becoming a "public charge" and thereby draining national health care and social resources. However, the political support behind these policies failed to recognize several key realities. First, while HIV is a communicable disease, it cannot be transmitted by casual contact. Second, at the time of the ban, there were more known cases of HIV/AIDS in the United States than anywhere else in the world.⁴ Finally, while the ban was created to prevent HIV-infected persons from becoming a societal burden, immigration law already stated that all immigrants, regardless of their HIV status, must show that they have financial means as to not become a public charge.⁴

The ramifications of the HIV immigration and travel ban came to light both domestically and internationally with the case of Hans Paul Verhoef. While traveling to San Francisco to attend the 7th National AIDS Forum in 1989, Verhoef, an HIV-infected Dutch citizen and rising chair of the Dutch HIV Foundation, was detained when Immigration and Naturalization Service agents found AZT in his luggage.^{3,4} Verhoef's case set off an outcry from the international AIDS community in objection of the ban, with protests and threats of boycotts of the two upcoming international AIDS conferences, planned for San Francisco (1990) and Boston (1992). The 1990 conference was held, due to an executive order temporarily waiving the ban for all attendees, but no further conferences were held in the United States.⁴

These events triggered political debate and in the following year the DHHS attempted to remove HIV from the list of inadmissible diseases, only to be barred by Congress and the Bush Administration.²⁻⁴ Another attempt was made to

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remove the HIV ban under the Clinton administration in 1993. However, the debate in Congress resulted in enforcement of the ban including writing it into law.²

Over the following two decades, scientific understanding and treatment of HIV infection through combination antiretroviral therapy changed HIV from a fatal disease to one that could be successfully managed, but immigration policies were slow to change. As treatment advanced, AIDS deaths in the United States saw a sharp decline. The United States not only joined the fight against HIV/AIDS internationally, but became a leader with programs such as the President's Emergency Plan for AIDS Relief (PEPFAR) and significant contribution to the Global Fund. The discrepancy between the United States' medical advancements and humanitarian efforts and its immigration policies became more apparent and opposition to the ban became stronger. Additionally, other countries with more open policies regarding immigration did not experience a massive influx nor drain on resources due to HIV-infected immigrants.⁴

International opposition to the ban was voiced in the 2004 "Joint United Nations Programme on HIV/AIDS and the International Organization for Migration Statement on HIV/AIDS-related Travel Restrictions." These guidelines specifically stated that HIV-related travel restrictions had no public health justification.⁵ Only small changes in the United States ensued, such as streamlining of the waiver process for short term travelers in 2006.⁴ Further domestic political pressure came from the Center for Strategic and International Studies (CSIS), an advisory committee to Congress. CSIS published their report on HIV/AIDS and immigration in March 2007,⁴ which outlined the flaws and highlighted the contradiction of the ban with the global efforts of the United States in the HIV/AIDS epidemic. CSIS called for a change in the law, either to change the language of the INA to allow for removal of the HIV ban or to broaden the availability of waivers.⁴ In July 2008, with the renewal of PEPFAR funding, Congress removed the phrase "which shall include infection with the etiologic agent for acquired immune deficiency syndrome," from the INA.² This allowed the DHHS to reclaim authority to independently determine the definition of a "communicable disease of public health significance." The following year, under the new Obama administration, DHHS proposed a rule removing HIV from the list of inadmissible infections and with it, removing HIV testing from the scope of required immigrations examinations. In response to this proposal, there were over 20,100 comments; 19,500 supported the removal of HIV from this list, and only 600 were against. The rule was accepted by the DHHS and was enacted on January 4, 2010.²

The removal of the immigration and travel ban on HIV-infected persons was a monumental step in eliminating the exceptionalism of HIV and reducing stigma and social barriers for those living with HIV. On an individual level, it allows for safer travel for people living with HIV/AIDS; no longer do they need to consider leaving behind essential medications for fear of disclosure. It simplifies family reunification for immigrants by reducing the procedures and cost associated with obtaining a travel waiver. On a broader level, this change combats stigma of those living with HIV/AIDS, and brings the domestic policies of the United States closer in line with its global efforts to fight HIV/AIDS. For the medical and scientific community, it opens opportunities for better collabora-

tion and leadership, as highlighted by the return of the International AIDS Conference to the United States after 22 years. It will be held in Washington, D.C. in 2012.

The removal of the ban also removes mandatory HIV testing as part of the immigration examination. This examination is meant to provide specific screening and testing for those diseases that meet the definition of "communicable disease of public health significance."² This change, while consistent with the removal of the ban, may inadvertently lead to a reduction in HIV testing among foreign-born populations that is in contrast to the CDC's 2006 recommendations, calling for routine opt-out HIV testing among adults and adolescents in all medical settings.⁶ The DHHS/CDC estimates that lifting the ban will allow for an additional 4.06 per 1000 immigrants, or 4275 HIV-infected persons, to enter the United States each year, the majority from Africa.² If HIV testing is not a standard part of the immigration examination, what proportion of immigrants will know their HIV status? Our concern is not that there will be more people with HIV infection entering the United States, but that they will add to the numbers of those who are HIV-positive yet are unaware of their infection, already estimated to be 21% of all persons infected with HIV in the United States.⁶ The potential outcome of this will be a larger population of persons with undiagnosed HIV who present late in the course of their disease and who are more likely to transmit the infection to others, likely within their own immigrant communities.⁹

Several recent studies have highlighted the increased risk for HIV infection among foreign-born communities in the United States. Harawa et al.⁷ evaluated HIV prevalence among foreign and U.S.-born populations using public STD clinics and demonstrated a strong association between HIV infection and a country of birth in sub-Saharan Africa. Kent et al.⁸ described an increase in HIV incidence in foreign-born blacks from 3.5% in 1995–1997 to 7.5% in 2001–2003, while rates in U.S.-born blacks remained stable. Akinsete et al.⁹ reported an increase from 4% in 1996 to 16% in 2005 in the percentage of newly diagnosed HIV-infected persons who are African-born in Minnesota; approximately one fifth were refugees admitted through the U.S. waiver program and the majority were diagnosed at an immigration examination. Kerani et al.¹⁰ looked at the rates of HIV diagnoses in African-born persons in areas of the United States with larger African-born immigrant populations. Overall, the African-born population was reported as only 0.6% of the total population and yet accounted for 3.8% of HIV diagnoses. While the proportion of HIV-infected persons who were African-born varied from 1.3% in California to 20.2% in Minnesota, the burden of HIV in African-born was significantly disproportionate to the size of the African-born population within each area studied.¹⁰ Johnson et al.¹¹ conducted a broader evaluation of CDC data in foreign-born blacks from 33 states reporting HIV infections from 2001 to 2007. While their data show a decrease in HIV rates in both foreign-born and U.S.-born blacks, it was much less of a decrease in the foreign-born population.¹¹ Wiewel et al.¹² reviewed HIV among foreign-born persons in New York City from 2001 to 2007. While overall HIV diagnoses decreased, HIV diagnoses in foreign-born persons increased in both absolute number and percentage of total diagnoses.¹² Collectively these studies reveal increased HIV prevalence among these foreign-born populations, thus highlighting the need for intervention.

A consistent point of concern highlighted in these studies is the different risk profile in these populations as compared to U.S.-born HIV-infected persons. Specifically, HIV-infected foreign-born persons were more likely to be women and to have acquired the virus through heterosexual contact. Presumably, the majority of HIV infections in the studied populations occurred after immigration to the United States, as suggested by Harawa and colleagues, based on the fact that the HIV-testing requirement and ban were in place until recently. If many of these infections were contracted here in the United States, it would imply that there are other factors contributing to increased rates of HIV acquisition once in the United States, such as failure to disclose HIV status and unprotected sex.

With the elimination of mandatory HIV testing as part of the immigration exam, there needs to be a heightened awareness of the increased risk in many foreign-born populations and therefore, routine opt-out HIV screening at the time of entrance and while residing in the United States needs to occur. The CDC recommends routine HIV screening in medical settings for all United States residents in contact with the health system, both native-born and immigrants. Yet, this is not a simple task in populations that may be generally unfamiliar with the U.S. health care system. Language barriers, cultural beliefs regarding HIV/AIDS and health care in general, can be barriers to care and thus become obstacles to HIV prevention, testing and treatment services for immigrant populations.⁹

While the removal of the HIV travel and immigration ban is a major success, it is also a call to action. As health care providers and advocates, we need to build a stronger alliance with immigrant communities and design culturally relevant interventions promoting prevention, testing, and linkage to care. We need to support the development and dissemination of culturally appropriate education from within the community using peer educators and integrating outreach and education programs into cultural events and celebrations. Prevention education programs must focus on heterosexual transmission and on transmission among women. Additional opportunities for testing must be presented to these communities, as many are not accessing routine preventive health care. Community-based testing should be available, with counselors that have appropriate communication skills and intimate knowledge of the cultural understanding of HIV transmission, the meaning of infection and the availability of treatment options. Providers must be educated about the particular risk factors and cultural understanding of HIV/AIDS among the local immigrant communities. Only with the implementation of such interventions can we truly embrace the change in U.S. HIV immigration policy, knowing that this at-risk population will not be ignored.

Acknowledgments

This work was supported by the Lifespan/Tufts/Brown Center for AIDS Research [grant P30AI42853] and Dr. Winston was supported by the National Institute on Drug Abuse [grant 5T32DA013911].

Author Disclosure Statement

No competing financial interests exist.

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