10-1-1988

AIDS and Immigration: The United States Attempts to Deport a Disease

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COMMENTS

AIDS AND IMMIGRATION: THE UNITED STATES ATTEMPTS TO DEPORT A DISEASE

I. INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS)[1] presents the scientific and medical communities with one of their greatest challenges. AIDS has become a problem for governments of all nations, and a "formidable agent of political action and socio-cultural reaction."[2] As the magnitude of the problem unfolds, and the statistics, both national[3] and international,[4] rise with alarming regularity, a

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1. Acquired Immune Deficiency Syndrome (AIDS) is a condition which causes a breakdown in the body's immune system, leaving the victims susceptible to a variety of opportunistic diseases. The symptoms of AIDS vary from person to person, but most often are afflictions that do not normally appear in healthy people. At present, AIDS is incurable and ultimately fatal. AIDS is caused by the human immunodeficiency virus (HIV), which inhibits the body's ability to resist disease by infecting and destroying white blood cells, which are an integral part of the immune system. HIV is spread through occurrences that are, for the most part, avoidable: sexual contact involving the exchange of bodily fluids; sharing of contaminated needles or syringes; receiving a contaminated blood transfusion; and transmission from an infected mother to her unborn fetus or to her infant through breast milk. HIV may have an incubation period of up to ten years. THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 2 (1988) [hereinafter COMMISSION REPORT]. It is uncertain at this time what percentage of people infected with HIV will eventually develop AIDS, but estimates run as high as 60 - 100%. *See generally* Francis & Chin, *The Prevention of Acquired Immunodeficiency Syndrome in the United States*, 257 J.A.M.A. 1357 (1987); United States Public Health Service, Pamphlet No. 19, AIDS, Sex and You (1986); Lawrence, *The Immune System in AIDS*, 253 SCI. AM. 84 (1985).

2. Letter by the American Immigration Lawyers Association to the Centers for Disease Control at A-2 (Aug. 6, 1987) (comment on the proposed regulation adding HIV infection to the list of dangerous contagious diseases) (available at offices of INTER-AM. L. REV.) [hereinafter AILA Comment].

3. By December 1987, 48,139 Americans had been diagnosed with AIDS and 27,235 had already died from the disease. An additional approximately 1.5 million are believed to be carrying the AIDS virus. Jarvis, *AIDS: A Global View*, 12 NOVA L. REV. 979, 988 (1988) (citing *Hospital Treating AIDS Closes Doors: Nation's First Private Center for Immune*

social and political context of near hysteria surrounds national efforts to keep the disease in check.[5] Congress reacted to this apparently global plague by passing Section 518 of Public Law 100-71, as part of the Supplemental Appropriations Act of 1987.[6] To implement this congressional directive, the Department of Health and Human Services (HHS)[7] amended 42 C.F.R. § 34.2(b) to add human immunodeficiency virus (HIV) infection to the list of dangerous contagious diseases.[8] Moreover, HHS amended 42 C.F.R. §

Disease Says that It Lost $8 Million, N.Y. Times, Dec. 13, 1987, §1, at 20, col. 6 (nat'l ed.); 42 U.N. GAOR (44th mtg.) at 28, U.N. Doc. A/42/PV.44 (1987) (statement of Dr. C. Everett Koop, U.S. Surgeon General); Morganthau, *AIDS: Grim Prospects*, NEWSWEEK, Nov. 10, 1986, at 20).

4. During 1986, the World Health Organization (WHO) estimated that 100,000 people had AIDS and up to 10 million people carried the virus. In March 1987, 45,747 cases had been reported to the WHO from 102 countries. One month later, 68,217 AIDS cases were reported by 128 countries. *See id.* at 992 (citing Altman, *U.N. Agency Begins Global Push on AIDS*, San Francisco Chron., Nov. 21, 1986, at 1, col. 6; Iglehart, Read & Wells, *The Socio-Economic Impact of AIDS on Health Care Systems*, 6 HEALTH AFF. 137, 138 (1987); 42 U.N. GAOR (45th mtg.) at 37, U.N. Doc. A/42/PV.45 (1987)). As of October 31, 1988, a cumulative total of 124,114 cases of AIDS were officially reported by 142 countries; one month later, an additional 4,296 cases were reported. WORLD HEALTH ORGANIZATION, UPDATE: AIDS CASES REPORTED TO SURVEILLANCE, FORECASTING AND IMPACT ASSESSMENT UNIT (SFI) GLOBAL PROGRAMME ON AIDS (Nov. 1988). For a breakdown of AIDS cases reported to WHO by region and country, see Appendix 1.

It should be noted that global statistics are incomplete and somewhat unreliable, because many countries do not, or are unable to, give an accurate report on the number of cases appearing within their borders. PANOS INSTITUTE, AIDS AND THE THIRD WORLD: PANOS DOSSIER 1 53 (1987) [hereinafter PANOS DOSSIER]. For this reason, the director of the World Health Organization Global Programme on AIDS estimated the actual number of AIDS cases to be slightly more than twice the reported number in any given year. Address by Dr. Jonathan Mann, Fourth International Conference on AIDS, Stockholm, Sweden (June 12, 1988) (available from World Health Organization, Geneva, Switzerland and in the offices of INTER-AM. L. REV.).

5. AILA Comment, *supra* note 2.

6. Supplemental Appropriations Act of 1987, Pub. L. No. 100-71, § 518, 101 Stat. 475 (1987) (to be codified at 8 U.S.C. § 1182. The text of the provision reads as follows:

> On or before August 31, 1987, the President, pursuant to his existing power under section 212(a)(6) of the Immigration and Nationality Act, shall add human immunodeficiency virus infection to the list of dangerous contagious diseases contained in title 42 of the Code of Federal Regulations.

7. The Department of Health and Human Services (HHS) promulgated the new regulations through its agency the Public Health Service, and through the Service's Centers for Disease Control.

8. 42 C.F.R. § 34.2(b) (1987), effective August 31, 1987, now defines dangerous contagious diseases as any of the following:

(1) Chancroid
(2) Gonorrhea
(3) Granuloma inguinale
(4) Human immunodeficiency virus (HIV) infection
(5) Leprosy, infectious
(6) Lymphogranuloma venereum

34(a) to expand the scope of the medical examination of aliens applying for visas or adjustments of status to include serologic testing for HIV infection.[9] These actions add HIV infection to the list of medical grounds for which an alien may be excluded from the United States, pursuant to Section 212(a) of the Immigration and Nationality Act.[10]

At first glance, the amendments appear minor and logical; however, their brevity belies their effect. The regulations themselves contain almost no information as to how they will be implemented on a day-to-day basis. The Immigration and Naturalization Service (INS) has begun testing those immigrants who are already in the United States,[11] but even INS officials admit to having little understanding of how the new rules are meant to work, or what the ramifications of the new rules will be.[12] What is clear is that these seemingly innocuous amendments raise a host of problems and issues which may have far-reaching effects well beyond the borders of the United States.

II. The Political and Legal Contexts of the Regulations

A. Legislative History of Section 518, Public Law 100-71: A "Simple" Amendment[13]

On May 21, 1987, Senator Danforth of Missouri addressed the Senate as follows: "I think there are a lot of people in the Senate who feel that the AIDS question is maybe the largest question of

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(7) Syphilis, infectious stage

(8) Tuberculosis, active

9. 42 C.F.R. § 34.4(a) (1987) (effective December 1, 1987).

10. See Immigration and Nationality Act of 1976, Pub. L. No. 94-571, § 212(a), 90 Stat. 2703 (1976) (codified at 28 U.S.C. § 1182(a) (1982 & Supp. 1987)), for a complete listing of grounds for exclusion.

11. Wallace, *58 Aliens Tested Positive for AIDS Virus, INS says*, Miami Herald, Jan. 5, 1988, at Dl, col. 1.

12. *Id.* at D3, col. 3. Perry Rivkind, the INS District Director in Miami, said that "he does not know how illegal aliens suffering from AIDS would get the costly medical help they would need while opposing deportation." Rivkind suggested that federal treatment centers be established. However, an INS spokesman from Washington stated that it was unlikely this would happen. *Id.*

13. Senator Jesse Helms (R-NC), the sponsor of the amendment which led to the new regulations, said it would "simply amend the Immigration and Nationality Act" to make HIV infection a ground for exclusion from the United States. Helms said 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." 133 Cong. Rec. S. 6955-56 (daily ed. May 21, 1987) (statement of Sen. Helms).

our time and yet we have not really thought out exactly where we are going on it."[14] Senator Danforth was echoing the sentiments of many of his colleagues in both houses of Congress. The legislators were debating an amendment sponsored by Senator Helms of North Carolina, for mandatory testing for AIDS of all immigrants.[15] During the course of the debate, the legislators appeared to be divided into two groups. One group wanted to do something about AIDS immediately, without much debate or forethought.[16] These senators primarily were reacting to two kinds of pressure: public opinion[17] and financial concerns.[18] They were also reacting to recommendations of the Public Health Service (PHS),[19] and of the President of the United States.[20] As is the case with most legislation which costs nothing to pass,[21] even those senators who were at first opposed to the amendment ultimately voted for it.[22] Indeed, at first glance, the amendment seemed a simple way to conserve medical, and more importantly, financial resources for use by American citizens rather than by aliens. It should be noted that this first group of legislators believed that the proportionate number of immigrants bringing the virus into the United States was significant.[23]

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14. *Id.* at S. 6958 (statement of Sen. Danforth).

15. The original form of the Helms Amendment included mandatory testing for all those seeking marriage licenses. It also sought to put pressure on the President by threatening to withhold appropriations for AIDS research and control unless the amendment was signed. 133 CONG. REC. S. 6955 (daily ed. May 21, 1987).

16. 133 CONG. REC. S. 7413 (daily ed. June 2, 1987); *id.* at S. 6979 (statement of Sen. Helms).

17. Senator Helms cited various public opinion polls indicating that there was a public consensus on the desirability of mandatory testing. 133 CONG. REC. S. 6955-56 (daily ed. May 21, 1987) (statement of Sen. Helms).

18. Three senators were concerned with issues such as where to spend the money, how much money is being appropriated as opposed to how much the President requested, and the average cost of each AIDS victim. 133 CONG. REC. S. 7412-14 (daily ed. June 2, 1987) (statements by Sen. Danforth, Sen. Weicker, and Sen. Simpson). Another senator was concerned about possible financial problems in the future because of the lack of reliable information regarding the treatment of AIDS. 133 CONG. REC. S. 6975 (daily ed. May 21, 1987) (statement by Sen. Dole).

19. 133 CONG. REC. S. 7414 (daily ed. June 2, 1987) (statement of Sen. Weicker).

20. *Id.* at S. 7410, 7414 (statements by Sen. Helms and Sen. Weicker).

21. *Id.* at S. 7414. As Senator Weicker stated in urging support of the amendment: "The next matters [my colleagues] will be voting on will have very large dollar signs attached to them. That will be a tougher vote than the one they will now dispense with."

22. Senator Weicker is a case in point. On May 21, 1987, he was opposed to the amendment for various reasons. 133 CONG. REC. S. 6956 (daily ed. May 21, 1987). Although his reasons did not disappear, on June 2, 1987, he voted for the amendment. 133 CONG. REC. S. 7411-12 (daily ed. June 2, 1987).

23. 133 CONG. REC. S. 6956 (daily ed. May 21, 1987).

By contrast, the second group of legislators viewed the amendment and the ease with which it was introduced and passed, with suspicion and anxiety. They were concerned with the fact that a matter of such importance was given little thought and merely "tacked on" to the Supplemental Appropriations Bill;[24] that the amendment was being considered without the benefit of hearings and open debate.[25] They feared that hasty action would lead to grave, irreversible errors.[26] In addition, the second group was influenced by statements of the Surgeon General, the National Academy of Sciences, and the Institute of Testing, which seemed to indicate that mandatory testing would be a waste of resources which could be put to better use.[27] Most importantly, the senators were worried about the international ramifications of the amendment and its effect on the legalization and amnesty programs.[28] As Senator Weicker stated:

> The question is whether or not this Nation in a time of extreme crisis, a crisis which will become even more extreme over time, will respond out of fear and emotion, in which case we are going to lose the fight, or whether this Nation is going to use the tools that we uniquely have with the greatest scientific and educational establishment known to man. If we use those tools, we are going to win. If we react to our fear and emotion, not only will we lose our own Nation, but indeed the world, and the crisis is just that serious.[29]

Despite these reservations, Section 518 was passed in the Senate by a vote of ninety-six to zero.[30] The legislators could now tell their constituents that Congress was doing something to stop the spread of AIDS.

B. The Legal Context: Immigration Law and Public Health

Section 518 and the amendments to the Code of Federal Regulations and the Immigration and Nationality Act reflect the view that the public health of American citizens is endangered by a dis-

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24. *Id.* at S. 6956, 6967.
25. *Id.* at S. 6968 (statement of Sen. Adams).
26. *Id.* at S. 6974 (statement of Sen. Dole).
27. *Id.* at S. 6960 (statement of Sen. Danforth).
28. *Id.* at S. 6967-6981 (debate among senators regarding effect of regulations on legalization and amnesty programs).
29. *Id.* at S. 6957 (statement of Sen. Weicker).
30. 133 CONG. REC. S. 7415 (daily ed. June 2, 1987).

ease being brought into the United States from without its borders. As a corollary, the rationalization for the regulations appears to stem from a notion that the United States can successfully seal its borders and, in a self-contained war, succeed in defeating the AIDS epidemic. Certainly, one of the main factors contributing to the ease with which the instant legislation was passed is the United States long history of excluding (and deporting) aliens with defined contagious diseases.[31] Thus, one might posit that HIV has been appended to an already-existing list of diseases that require or permit an alien's exclusion or deportation. Ultimately, the serologic test could become part of the routine medical examination by which aliens (immigrants and applicants for adjustments in status) are screened for the listed diseases.[32] Notably, testing immigrants for AIDS does not involve the creation of any new structures, institutions, or agencies.

Since 1891, aliens[33] have been excluded from this country if they are afflicted with a dangerous, contagious disease.[34] Dangerous, contagious diseases are defined by the Public Health Service,[35] pursuant to statutory authority.[36] The rationale for health-related exclusion has developed through case law.[37] More recently, the Supreme Court reaffirmed the early cases,[38] articulating:

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31. As early as 1879, Congress was concerned with preventing the introduction of contagious diseases into the United States from foreign countries, and passed An Act to Prevent the Introduction of Contagious or Infectious Diseases into the United States, ch. 11, 21 Stat. 5-7 (1879). *See* Druhot, *Immigration Laws Excluding Aliens on the Basis of Health*, 7 J. LEGAL MED. 85, 88 (1986).

32. *See supra* notes 8, 9. *See also* Druhot, *supra* note 31, at 89-90.

33. An "alien" is any person not a citizen or national of the United States. 8 U.S.C. § 1101 (1982 & Supp. 1987). However, there are different types of aliens. An "immigrant" is every alien except a non-immigrant. A "non-immigrant" may be any one of a variety of temporary visitors, such as foreign students, tourists, and international businessmen. The main distinction between non-immigrant and immigrant aliens is that non-immigrant aliens usually have a residence in a foreign country which they have no intention of abandoning. *See id.* The mandatory testing program that is the subject of this comment is largely directed at immigrant aliens, although it also includes non-immigrant aliens who wish to adjust their status to that of immigrant aliens, immigrant aliens seeking adjustment of status to permanent residents or to naturalized citizens, and illegal aliens seeking legalization through amnesty.

34. *See* Comment, *Re-evaluating Alien Exclusion in Light of AIDS*, 6 DICKINSON J. INT'L L. 119, 125 (1987).

35. For the current list, see *supra* note 8.

36. *See further*, Comment, *supra* note 34, at 126.

37. *See, e.g.*, Zartarian v. Billings, 204 U.S. 170 (1907); Gee Shew Hong v. Nagle, 18 F.2d 248 (9th Cir. 1927); United States v. Reimer, 25 F. Supp. 552 (S.D.N.Y. 1938).

38. United States v. Brignoni-Ponce, 422 U.S. 898, 902 (1975).

> Illegal aliens pose a potential health hazard to the community since many may seek work as nursemaids, food handlers, cooks, housekeepers, waiters, dishwashers, and grocery workers. Immigration and Medical officials in Los Angeles, for example, have discovered that the illegal alien population . . . is infected with a high incidence of typhoid, dysentery, TB, tapeworms, VD and hepatitis.[39]

Furthermore, the courts have determined that the medical certificates issued by the Public Health Service's examining doctors regarding the health status of each alien are conclusive and irrebuttable, and that the decision to exclude aliens solely on the basis of such certificates is constitutional, and consistent with legislative intent.[40] Excluding aliens with contagious diseases is within the plenary power of Congress with regard to immigration. Indeed, the Supreme Court of the United States has stated that "the rights of aliens seeking admission to the United States are limited and . . . Congress has exceedingly broad discretion in determining the procedures to be followed in immigration proceedings."[41]

Procedurally, the Secretary of Health and Human Services, through the Public Health Service, is responsible for formulating and implementing immigration regulations regarding medical examination of aliens in foreign countries and in the United States.[42] American consuls in foreign countries are responsible for issuing visas to United States-bound immigrant and nonimmigrant aliens.

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39. *Id.* at 902.

40. Wulf v. Esperdy, 277 F.2d 537 (2d Cir. 1960).

41. *Id.* at 539 (citing Shaughnessy v. Mazei, 345 U.S. 206 (1953); Knauff v. Shaughnessy, 338 U.S. 537 (1950)).

42. The Department of Health and Human Services is one of the enforcement agencies for immigration law. The statutory scheme is as follows: The Attorney General, as head of the Department of Justice, has primary responsibility for enforcing immigration laws. The rulings of the Attorney General are controlling. In practice, the duties of the Attorney General with regard to immigration are delegated to the INS and to the Executive Office for Immigration Review. The Commissioner of the INS, appointed by the Attorney General, has regulatory authority to administer and enforce all immigration laws. The Executive Office for Immigration Review is headed by a Director, who is responsible for general supervision of the Board of Immigration Appeals (the general administrative appeals board), as well as of the Office of the Chief Special Inquiry Officer. Appeals of exclusion orders are taken to the Board of Immigration Appeals from decisions of the special inquiry officers (immigration judges). Another enforcement agency for immigration is the Department of State, and the Secretary of State is responsible for the diplomatic and consular officers under the aegis of the Bureau of Consular Affairs. The Department of Health and Human Services, through the Public Health Service, controls and enforces the medical standards involved in the immigration process, including the medical examinations of aliens both here and at American consuls in foreign countries. *See* Druhot, *supra* note 31, at 91-94.

An alien applying for an immigrant visa must submit to physical and mental examination. If the alien is applying for a nonimmigrant visa, the consular officer may exercise discretion in deciding whether or not the alien must be examined.[43] Moreover, the denial of a visa by the American consul is not a judicially reviewable decision.[44]

An alien arriving at a United States port of entry, an alien already in the United States and seeking adjustment of status, and any alien referred by the INS for examination to determine admissibility, must be examined by a Public Health Service physician.[45] After the examination, the medical examiner issues to an immigration officer a certificate containing the doctor's findings and conclusions as to the mental and physical health of the alien.[46]

From this point on, the avenues of appeal open to an alien are few because generally, any procedure authorized by Congress constitutes sufficient due process for an excludable alien.[47] Although certain aliens may appeal the findings in the certificate to a board of medical officers of the Public Health Service, there is no administrative appeal from a medical certificate based on the existence of a dangerous, contagious disease.[48] The rationale here is that the medical certificate is a purely medical matter. For the same reason, there is no judicial appeal from the certificate.[49] Judicial review of the exclusion order itself is limited to habeas corpus relief and a determination of whether the reasons given for the exclusion are in accordance with the terms of the Immigration and Nationality Act and of whether the alien comes within the Act's provisions.[50]

Although the Immigration and Nationality Act provides for

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43. *Id.* at 94.

44. *Id.*

45. Specific requirements of the examination are derived from two sources: medical examination regulations and Public Health Service guidelines. *Id.* at 95. The Public Health Service policy is to exclude an alien only for a disease with which the alien is actually afflicted, not for those diseases with which the alien may become afflicted in the future. *Id.* at 111. Thus, it appears that the Public Health Service has had to change its policy in order to add HIV infection to the exclusion list, because presence of HIV does not mean the alien has AIDS, or even that she will contract it in the future.

46. *Id.* at 97. The Public Health Service has determined that a positive HIV test will result in a Class A certificate, which indicates the active stage of contagion and is statutory grounds for exclusion. 42 C.F.R. § 34.4 (1987).

47. Druhot, *supra* note 31, at 98.

48. *Id.* at 100.

49. Wulf v. Esperdy, 277 F.2d 537 (2d Cir. 1960).

50. Druhot, *supra* note 31, at 101.

exclusion of aliens with dangerous, contagious diseases,[51] the exclusionary provisions, in practice, amount to deportation for aliens in the United States who wish to adjust their status, either from nonimmigrant to immigrant, or from permanent resident alien to naturalized American citizen. An alien desiring to adjust her status is once again considered an applicant for entry and, as such, is required to undergo a physical and mental examination.[52] In *Matter of Longstaff*,[53] the court used statutory interpretation to make the leap from exclusion to deportation of a resident alien who had been in this country for fifteen years and was seeking naturalization:

> The term "lawfully admitted for permanent residence" means the status of having been lawfully accorded the privilege of residing permanently in the United States as an immigrant in accordance with the immigration laws, *such status not having changed*. . . .
>
> An alien is subject to deportation if "at the time of entry [he] was within one or more of the classes of aliens excludable by the law existing at the time of such entry."[54]

An alien facing deportation generally has a number of substantive and procedural rights not available to one who is initially denied admission. In most deportation proceedings, the alien must be given seven days' notice of the charges against her.[55] If ordered to be deported, the alien may appeal the results of a deportation proceeding directly to a federal court of appeals,[56] or she may choose an administrative appeal before the Board of Immigration Appeals.[57] If the judicial or administrative tribunal affirms an INS decision to deport, the alien may either designate the country of deportation, choose voluntary departure (at her own expense) in order to avoid the stigma of deportation, or seek suspension, with-

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51. 8 U.S.C. § 1182 (1982 & Supp. 1987).

52. Druhot, *supra* note 31, at 107.

53. 716 F.2d 1439 (5th Cir. 1983).

54. *Id.* at 1441-42 (emphasis supplied) (citations omitted). *See also* Boutilier v. INS, 363 F.2d 488, 492 (2d Cir. 1966) (psychopathic personality); Doukas v. Wiley, 160 F.2d 92 (7th Cir. 1947) (gonorrhea at time of entry).

55. Immigration and Nationality Act § 242(b) (as amended and codified at 8 U.S.C. § 1252(b)(1982 & Supp. 1987)). The INS may, at its discretion, give less notice if it is in the public or national interest to do so. *Id.*

56. Immigration and Nationality Act § 106(a), (b) (as amended and codified at 8 U.S.C. § 1105 (a), (b) (1982 & Supp. 1987)).

57. The decision reached in an administrative appeal is *administratively* final, but may be appealed judicially. Druhot, *supra* note 31, at 100-01.

holding, or stay of deportation.[58] Waivers of deportation are always at the discretion of the Attorney General of the United States, and may be granted only to ameliorate harsh consequences upon a showing of extreme hardship or threat to life or freedom.[59]

C. The New Regulations: What They Say vs. How They Work

A cursory reading of the new regulations suggests that they fit neatly into the framework of traditional immigration law. However, in practice, more has changed than meets the eye. The deviation from standard immigration policy and law stems, in large part, from the nature of AIDS as compared with any other contagious disease presently on the list. First, HIV seropositivity is not a disease at all; rather, it is a condition of infection which may or may not lead to symptomatic AIDS.[60] Second, a person who is HIV positive carries the virus (and is therefore contagious) for life,[61] whether or not he or she ever develops AIDS. Third, HIV infection is the only listed disease for which there is no vaccine and no cure and which, if AIDS develops, is almost always fatal.[62] Finally, the tests to detect HIV antibodies are far from foolproof.[63]

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58. Immigration and Nationality Act §§ 212(a) (16), (17), 242(b), (e), 243(a), 244(e) (as amended and codified at 8 U.S.C. §§ 1182(a) (16), (17), 1252(b), (e), 1253(a), 1254(e) (1982 & Supp. 1987)). *See* Landon v. Plasencia, 459 U.S. 21 (1982) (alien who loses his right to reside in the United States in a deportation hearing can, within certain limits, designate the country of deportation and depart voluntarily).

59. 8 U.S.C. § 1253(h) (1982 & Supp. 1987). This provision would apply to refugees seeking asylum in the United States. *See also* Polites v. Sahli, 302 F.2d 449 (6th Cir. 1962).

60. *See supra* note 1. It is significant that the conception of the problem is presently evolving from a disease and symptom-centered definition of AIDS to the new definition of the disease as a continuum or spectrum of HIV infection. The CDC now divides HIV infection into a four-tiered classification scheme. "CDC I" occurs within three weeks of exposure to HIV and is a self-limiting syndrome with symptoms of acute infection which disappear after seroconversion. "CDC II" is the asymptomatic phase. "CDC III" affects a portion of HIV-infected persons with no other symptoms but a generalized persistent lymphadenopathy (swollen lymph glands). "CDC IV" is subdivided into what used to be called ARC (AIDS-related complex) and any other symptomatic illnesses, including neurologic manifestations. COMMISSION REPORT, *supra* note 1, at 7-8. The Presidential Commission recommends focusing on this "full course of HIV infection rather than concentrating on later stages of the disease" because early diagnosis of HIV is "essential to deal adequately with the epidemic, not only for proper medical treatment and counseling . . . but also for proper follow-up by the public health authorities." *Id.* at 17.

61. Tramont, *AIDS in Perspective*, 12 NOVA L. REV. 1071, 1075 (1988).

62. Brennan, *Ensuring Adequate Health Care for the Sick: The Challenge of the Acquired Immunodeficiency Syndrome as an Occupational Disease*, 1988:29 DUKE L.J. 29, 33-34 (1988).

63. For a fuller discussion of the reliability of HIV tests, see *infra* notes 102-120 and

Because of HIV's unique characteristics, many of the forms of relief from exclusion or deportation that are usually available to carriers of dangerous, contagious diseases are inapplicable to HIV afflicted aliens. For example, waivers of exclusion or deportation are available, at the discretion of the Attorney General, for aliens with either active or inactive tuberculosis.[64] The rationale behind the tuberculosis waiver is that the disease can be cured and that the alien, in requesting waiver, automatically agrees to submit herself for treatment and monitoring. However, because there is no cure for AIDS or HIV infection, there appears to be no reason to allow the alien to remain in the United States for treatment. Similarly, the choice of voluntary deportation[65] in order to leave open the possibility of future return to the United States seems highly unlikely when applied to HIV carriers. Even the ability to designate the country of destination may be of little solace to an alien who has tested positively and whose test results are not kept confidential.[66]

Unfortunately, a literal reading of the new regulations does not make clear the extent to which mandatory testing for HIV (and the effects of such testing) will deviate from usual immigration practice. Confusion as to the actual scope of the testing program was apparent early on. For instance, Congressman Weiss of New York read Senator Helms' amendment to be applicable only to those seeking entry into the United States, not to those already within its borders.[67] Adding to the confusion was a September 1987 Immigration Law and Procedure Reporter column acknowledging that under the new regulations, aliens in the United States seeking adjustment of status would be tested, but that the test results would not be used as a basis for deportation.[68] The final published rule[69] sheds some light, but leaves many questions unanswered.

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accompanying text.

64. Druhot, *supra* note 31, at 106.

65. *See supra* note 58.

66. See *infra* notes 134-35 & 147 and accompanying text for a discussion of the confidentiality issue with regard to AIDS test results.

67. Senator Weiss stated:

> It is only [aliens who will be seeking entry] who can be excluded. Those who are already within our borders without citizenship status . . . would not, by definition, be covered by this provision. That is in essence the position that the AMA has recently adopted. It is the only position that makes any sense.

133 CONG. REC. H. 5909 (daily ed. June 30, 1987).

68. 29 IMMIGR. L. & PROC. REP. 4 (1987).

69. 52 Fed. Reg. 32,540 (1987) (to amend 42 C.F.R. § 34).

Most important among these are questions regarding the confidentiality of HIV test results and the availability of waivers of exclusion and deportation based on the tests.[70]

Those who have tried to understand exactly how this program will be implemented have met with little success. For example, one attorney was told by Charles McCann, Acting Director of the Division of Quarantine at the Centers for Disease Control, that under the Immigration and Nationality Act, the Attorney General will issue waivers only for tuberculosis and that legislation would be necessary to provide waivers for HIV.[71] Indeed, one of the reasons given by the Public Health Service for requiring the HIV test to be conducted before entry into the United States (and not at United States ports of entry, as is often done when testing for other diseases) is that HIV infection will not be waiverable for those seeking permanent admission.[72] In its comments on the proposed regulations, the Justice Department[73] and the INS[74] made it clear that there will be no waivers issued for those seeking immigrant or fiance visas, and that the intent of the regulations would be to "identify and remove, if possible, those aliens already present who have this disease."[75]

Although there is no existing statutory authority pointing to the granting of waivers for HIV-infected aliens, it is proposed that, at the discretion of the Attorney General, in refugee, legalization, and nonimmigrant cases, waivers may be available based on three criteria. The alien must establish that: (1) the danger to the public

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70. *Id.* at 32,541-42. For a more complete discussion of how the testing program will be implemented, see *infra* notes 102-06 and accompanying text.

71. Letter from Elliott C. Lichtman, Esq. to Jeff T. Appleman, Esq. (members of the American Immigration Lawyers Association) (July 16, 1987) (commenting on proposed regulation adding HIV infection to the list of dangerous contagious diseases and discussing a telephone interview of the same date with Charles McCance, Acting Director, Centers for Disease Control) (available at offices of INTER-AM. L. REV.) [hereinafter Lichtman Comment].

72. 52 Fed. Reg. 32,540, 32,542 (1987) (to amend 42 C.F.R. § 34).

73. Telex, Justice Dept. to INS at 7 (July 6, 1987) (stating that there is no statutory authority to accept applications for waivers because of AIDS in immigrant and fiance visa cases) (available at offices of INTER-AM. L. REV.) [hereinafter Telex].

74. Letter by the Assistant Commissioner of the INS to Regional Commissioners, District Directors, Officers in Charge (Nov. 18, 1987) (attaching addendum to Guidelines for Medical Examination of Aliens in the United States) (available at offices of INTER-AM. L. REV.) [hereinafter INS Letter].

75. Letter by the Acting Commissioner of the INS to the Centers for Disease Control (Aug. 7, 1987) (commenting on the proposed regulations adding HIV infection to the list of dangerous contagious diseases) (available at offices of INTER-AM. L. REV.) [hereinafter INS Comment].

health created by her admission is minimal; (2) the possibility of spread of the disease because of her admission is minimal; and (3) there will be no cost incurred to a government agency of the United States without the prior consent of that agency.[76] It is not likely that many aliens infected with HIV will be able to meet these tests.

As yet, there is little data regarding the application of the new regulations. An early application of the new regulations occurred in January 1988, when the INS tested Haitians in Florida who were applying for legalization under the Cuban-Haitian Adjustment Program.[77] Each of these aliens had been in the United States since 1982, or earlier. According to the INS, fifty-eight of the Haitians tested positive. The INS District Director, Perry Rivkind, commented:

> Like any other people who have a communicable disease or other kind of defect . . . they would be placed under deportation . . . it could take a couple [sic] months . . . . They could delay deportation for years.[78]

Thus, it would appear that the INS, at least outwardly, maintains that the agency is treating HIV-positive aliens like other aliens harboring dangerous, contagious diseases. However, in addition to the unique procedural aspects of mandatory HIV testing of aliens, the program upon which the United States has embarked presents unique legal issues and practical ramifications.

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76. Telex, *supra* note 73, at 7-8.

77. Wallace, *supra* note 11.

78. *Id.* at D3. It appears that the INS has begun deportation proceedings with regard to at least some of those Florida immigrants who were found to be seropositive. On September 15, 1988, the INS sent one such immigrant a "Notice to Applicant for Admission Detained for Hearing Before Special Inquiry Officer." This notice advised the immigrant that he or she "may come within the exclusion provisions of Section 212(a)(6) of the Immigration and Nationality Act . . . in that [you] are afflicted with a dangerous contagious disease." It informs the immigrant that a hearing will be scheduled, during which the burden is on the immigrant to establish that he or she is admissible to the United States. It is signed by the Immigration Examiner. The Legal Aid Society of Palm Beach County, Florida is handling the immigrant's case. Letter from Victor Panoff, Esq., Legal Aid Society of Palm Beach County, Inc. to Cheryl Little, Haitian Refugee Center (Sept. 26, 1988) (transmitting INS Form I-122, received by one of the immigrants whose HIV test was positive) (available at offices of INTER-AM. L. REV.).

III. Deporting A Disease: National and International Ramifications

A. Potential Legal Issues

A full discussion of the potential legal issues involved in mandatory HIV testing of aliens is beyond the scope of this paper and may be premature, where no case challenging the testing has come before the courts as yet.[79] However, a few salient problems should be addressed.

1. Limited Judicial Review and the Finality of the Medical Certificate

The political power of Congress to expel or exclude aliens is largely immune from judicial control.[80] The fact that judicial review of administrative immigration decisions is so limited lends added significance to the examining doctors' medical certificate. At the same time, especially with regard to HIV testing and because of the non-reviewability of the examining doctor's certificate, the reliability of HIV test results becomes crucial.

Judicial review of exclusion orders is limited to *habeas corpus* relief. The contents of the medical certificate itself may not be appealed.[81] Judicial review of deportation orders is more extensive, and must be based on "clear, unequivocal, and convincing evidence that the facts alleged as grounds for deportations are true."[82] The deportation order itself, however, need only be supported by reasonable, substantial, and probative evidence.[83] Thus, aside from errors in administrative proceeding, an alien faced with exclusion or deportation will have his entire case turn on the medical certificate which, in exclusion cases, is presumed to be conclusive,[84] and in deportation cases, is only slightly less conclusive.

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79. For two excellent analyses of immigration law and legal issues, see generally *Developments in the Law, Immigration Policy and the Rights of Aliens*, 96 Harv. L. Rev. 1286 (1983) [hereinafter Harvard]; Notes, *Constitutional Limits on the Power to Exclude Aliens*, 82 Colum. L. Rev. 957 (1982).

80. Fiallo v. Bell, 430 U.S. 787 (1977).

81. *See supra* notes 40-50 and accompanying text.

82. Woodby v. INS, 385 U.S. 276, 282-86 (1966).

83. *Id.* at 283.

84. Wulf v. Esperdy, 277 F.2d 537 (2d Cir. 1960); Johnson v. Watkins, 170 F.2d 1009 (2d Cir. 1948).

The potential issue here involves the standard of proof as applied to the tests that will form the sole basis of the doctor's findings on the medical certificate (unless, of course, the alien is exhibiting clinical symptoms of AIDS). The reliability of HIV tests will be addressed in a later section of this paper.[85] However, it is worth noting that with regard to a medical certificate based on an HIV test, there may exist a legal basis for challenge that is unavailable for medical certificates based on the much more reliable tests used to detect other dangerous, contagious diseases.

2. Lack of Notice in Deportation Cases

It is well settled that in exclusion cases, Congress has unbounded power to bar admission of aliens into the United States without offering them due process or equal protection.[86] By contrast, deportation proceedings (especially in connection with denial of adjustment of status), although certainly not affording an alien nearly as many rights as has an American citizen,[87] do require that some due process — e.g., advance notice of the charges — be given.[88] Interestingly, nowhere in the published regulations is it stated that aliens already in the United States who test positive for HIV may be deported.[89] In addition, the INS Instructions to Designated Physicians (published by the Centers for Disease Control), while requiring doctors to advise aliens of the possibility that test results will not be held confidential, merely states:

> A positive test result will mean that you may not be eligible for adjustment of status. A positive test result could also have other local consequences on your day-to-day activities.[90]

Even the post-test counseling instructions fail to provide guidance as to the effects of a positive test result on the alien's ability to remain in this country.[91] Thus, it is possible that a person who

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85. *See infra* notes 102-120 and accompanying text.

86. Matter of Longstaff, 716 F.2d 1439, 1442-43 (5th Cir. 1983).

87. HARVARD, *supra* note 79, at 1391-92.

88. Landon v. Plasencia, 459 U.S. 21 (1982).

89. 52 Fed. Reg. 32,540 (1987). The regulations only speak to denial of admission to aliens abroad who are seeking entry.

90. INS Letter, *supra* note 74, at 3.

91. Letter by the National Council of La Raza to the Centers for Disease Control at 2 (Jan. 11, 1988) (updating comments on the proposed regulations adding HIV infection to the list of dangerous contagious diseases) (available at offices of INTER-AM. L. REV.) [hereinafter La Raza Comment].

has lived in the United States for a number of years can be deported with virtually no notice. This situation is exacerbated by the fact that the medical certificate issued as a result of the test is virtually unappealable.

Furthermore, an alien can be deported for an HIV condition which she may or may not have had upon entry to the United States, and of which she might not have been aware at that time. Indeed, even without regard to prior knowledge, an alien harboring HIV might have entered the United States at a time when HIV was not yet an excludable condition. As one judge has commented regarding the retroactive application of grounds for exclusion:

> Of far greater importance . . . is the subjection to deportation of . . . persons against whom a governmental agency may assert as a reason for deportation — perhaps . . . many years after presumably lawful entry into the United States — a newly discovered pre-admission "medical" cause for exclusion from entry. This is especially troublesome when the medical condition is one in the diagnosis of which medical experts may differ, and in which medical "diagnosis" as to whether or not the condition existed at the time of entry may be wholly speculative. The continued stay in the United States . . . is thus made dependent on the uncertainties and indefiniteness of medical science. . . .[92]

3. International Legal Issues

The United States, as a member of the United Nations, has international legal duties, inasmuch as it is bound by the provisions of the United Nations Charter and other related human rights provisions.[93] By conducting its national affairs in a manner inconsistent with the Charter, the United States might become involved in international legal controversy, thus subjecting itself to international pressure and/or retaliation.[94]

The Department of Health and Human Services, in promul-

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92. Matter of Longstaff, 716 F.2d 1439, 1453-54 (5th Cir. 1983) (Tate, J., dissenting).

93. Under principles of international law, the United Nations Charter is a treaty to which all members of the United Nations are bound. The preamble to that Charter refers to mutual respect for fundamental human rights and requires all parties to the treaty to mutually promote, generally and through specific *specialized agencies*, "solutions of international economic, social, *health*, and related problems." U.N. CHARTER arts. 55, 56, 57 (emphasis added).

94. For a discussion of possible retaliatory measures, see *infra* notes 151-57 and accompanying text.

gating the new regulations, stated that:

> This rule does not conflict with the report of the World Health Organization consultation on international travel and human immunodeficiency virus held in Geneva on March 2-3, 1987.[95]

At least one legal organization, the American Civil Liberties Union, found this HHS assertion disingenuous, and commented:

> Although it is true that the proposed rule covers only immigration and not travel, it is difficult to imagine how its rationale can be reconciled with the principles underlying the conclusion reached at the W.H.O. conference.[96]

The conclusion reached by the World Health Organization at that conference was that:

> No screening programme of international travellers can *prevent* the introduction and spread of HIV infection. Therefore the consultation concludes that HIV screening programmes for international travellers would, at best and at *great cost*, retard *only briefly* the dissemination of HIV both globally and with respect to any particular country.[97]

Furthermore, in October 1987, the United Nations adopted a General Assembly Resolution[98] 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."[99] The Resolution refers to and incorporates the World Health Organization resolution and calls upon states "to take into account the legitimate concerns of other countries and the interests of inter-State relations."[100] The reports submitted by various countries in connection with the Resolution make it clear that cooperation among countries, not isolation, conflict, or systematic and compulsory screening, are the keys to defeating the global pandemic. As the delegate from the United Kingdom noted: "The third trap, perhaps the most dangerous of all, is to try to isolate

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95. 52 Fed. Reg. 32,540, 32,541 (1987). The World Health Organization (WHO) is a "specialized agency" of the United Nations. *See supra* note 93.

96. Letter by the American Civil Liberties Union to the Centers for Disease Control at 20 (Aug. 3, 1987) (comment on the proposed regulations adding HIV infection to the list of dangerous, contagious diseases) (available at offices of INTER-AM. L. REV.) [hereinafter ACLU Comment].

97. *Id.* at 20-21.

98. G.A. Res. 31232, 25 U.N. GAOR, U.N. Doc. A/42/L.7/Rev.1 (1987).

99. *See* Jarvis, *supra* note 3, at 1012.

100. G.A. Res. 31232, *supra* note 98, at 2.

one's country completely from the spread of the infection."[101]

B. Practical Ramifications

Ultimately, because the formulation of, and decision-making power under United States immigration policy is left largely to Congress and administrative agencies, judicial review of any immigration-related legal issues will be severely limited. However, practical ramifications, both national and international, will have to be dealt with on a day-to-day basis. The following section offers an overview of the practical effects of mandatory testing of aliens for HIV seropositivity. Although many of these issues are properly the subject of extensive research and analysis which is beyond the scope of this paper, brief discussion of them serves to paint a broad picture depicting the possible results of the testing program.

1. Domestic Issues

a) Reliability and administrability of the tests.[102]

The new regulations call for mandatory HIV testing of all aliens over the age of fifteen[103] seeking admission to the United States on an immigrant visa, or seeking adjustment of status. The rules provide for "a sensitive and specific test, confirmed when positive by a test such as the Western blot blood test or an equally reliable test."[104] In its published guidelines for physicians, the Centers for Disease Control elaborates on the testing process by naming the ELISA test as an example of the first test to be used and again names the Western blot as an example of the confirming test if the first test is positive.[105] The guidelines leave to the doctor's discretion both the actual choice of test and the choice of laboratory from which to obtain the results.[106]

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101. Report of Mr. Moore, Delegate to the United Nations from the United Kingdom, U.N. Doc. A/42/PV.44 at 38 (1987), *reprinted in* Jarvis, *supra* note 3, at app. E, 1034.

102. It should be borne in mind that HIV testing is a rapidly changing field. As time passes, the scientific medical community may find ways to increase the reliability of existing tests and/or create new tests. It is therefore extremely difficult to keep current on the data relating to test reliability.

103. 52 Fed. Reg. 32,540 (1987). Note that people under fifteen may be tested if there is a suspicion of high risk.

104. *Id.* at 32,544. *See also* ACLU Comment, *supra* note 96, at 4-7.

105. INS Letter, *supra* note 74.

106. *Id.*

There are two basic problems associated with the reliability of HIV tests. First, the frequency of false positive test results has been found to be as high as 6.8% among hospital patients.[107] This problem is exacerbated when a low-risk population, such as the immigrant population as a whole, is tested.[108] In fact, the State Department estimates that only about 250 aliens seeking to enter the United States from outside the country will actually be excluded annually for HIV exposure.[109] Even the Western Blot test, generally thought to be most reliable, is not considered by many investigators to be specific for HIV infection because "its techniques have not been standardized and the magnitude and consequences of interlaboratory variations" are unknown.[110] Furthermore, criteria for interpreting its results vary from laboratory to laboratory and from month to month.[111] As those in the medical community point out:

> [P]ositive initial and confirmatory tests in someone at low risk of HIV infection are by no means synonymous with infection, because of the possibility of false positive results. Furthermore, any increase in the false positive rate could turn a screening program into a social catastrophe.[112]

One might argue that a mass testing program such as the one contemplated by the new regulations provides precisely the kind of

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107. *Sounding Board: Screening for HIV: Can We Afford the False Positive Rate?*, 317 NEW ENG. J. MED. 238 (1987) [hereinafter NEW ENG. J. MED.]. The reported range of false positives varies greatly. Moreover, there have even been reported variations in false positive rates among different batches of one manufacturer's testing kit. *Id.*

The ELISA test is extremely sensitive, that is, it registers positivity in a high proportion of AIDS patients but also may register false positivity when detecting the presence of similar non-HIV antibodies against other diseases. The confirming Western Blot test is said to be specific, in that it registers negativity in a high proportion of healthy volunteer blood donors. *See, e.g.*, Comment, *The Impact of AIDS on Immigration Law: Unresolved Issues*, 14 BROOKLYN J. INT'L L. 223, 238 n. 100. The Western Blot can be confirmed by additional techniques, but they are more costly and also produce false negatives and positives. *Id.*

108. Comment, *supra* note 107.

109. ACLU Comment, *supra* note 96, at 10. In 1986, a total of 601,700 immigrants entered the United States from other countries. BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 10-11 (1988) (108th ed.). If the State Department estimate of 250 exclusions annually for HIV infection is confirmed, the immigrant population would appear to be at extremely low risk for AIDS. In light of these figures, the rationality and utility of the testing regulations are questionable. Furthermore, these statistics may indicate that the new regulations are aimed more at "cleaning house" by deporting HIV-infected immigrants who are already in this country, than at excluding those not yet within our borders.

110. NEW ENG. J. MED., *supra* note 107, at 238.

111. *Id.*

112. *Id.*

situation that will increase the false positive rate as it puts more strain on existing laboratory facilities. In addition, because choice of the laboratory is discretionary with the physician, interlaboratory variations will be greater. Ultimately, "if the false positive rate is not virtually zero, screening a population in which the prevalence of HIV is low will unavoidably stigmatize and frighten many healthy people."[113]

The second problem associated with the reliability of HIV tests is that of false negatives. Persons exposed to HIV may not develop an antibody against the virus for up to one year after infection.[114] Thus, a person may have been exposed to the virus and yet test negatively if the test is done during the first few weeks or even months of HIV infection. Confirmatory tests cannot and will not be used to re-check negative results. Therefore, an alien who is truly infectious may not be detected and may return to the community and infect others.

In reality, then, mandatory testing of immigrants for the presence of HIV antibodies could lead to the anomalous result of erroneous exclusion or deportation of persons who are not infectious, *and* the erroneous admission of infectious persons. From a personal perspective, a false negative test result may give an infectious person (and those around her) a dangerously false sense of security. Such a situation can become more acute where the testing is performed in another country, prior to the immigrant's departure for the United States.[115]

In addition to unreliability, there are other basic problems in the administration of the testing program with respect to the immigrant and the United States agencies responsible for implementing immigration rules. An applicant for legalization or adjustment of status must pay the cost of her medical examination. The addition of HIV testing to the examination places another financial burden on the immigrant which may, in some cases, prove to be a complete bar to the potential applicant. This is true especially where the more expensive confirmatory test must be used. Fur-

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113. *Id.*

114. Comment, *supra* note 107, at 239. This is commonly called the "window period" between exposure and development of HIV antibodies. Scientists had previously thought that the outer limit of the window period was six months. *See* ACLU Comment, *supra* note 96, at 10.

115. For a discussion of the problems surrounding testing in other countries, see *infra* notes 145-47 and accompanying text.

thermore, the federal government and, therefore, the taxpayer must pay the added administrative costs involved in testing refugees abroad. The potential cost to the government resulting from HIV screening of refugees overseas has been estimated by the United States Department of State to be four million dollars per year.[116] As of April 1988, four months after the start of the testing program, six prospective refugees had been detected with HIV. The Presidential Commission on HIV recommended that the Departments of State, Health and Human Services, and the INS should re-evaluate the policy of testing refugees one year after implementation (i.e., December 1988). This re-evaluation would include consideration of how much protection the United States is really offered by this policy, as well as consideration of potential impact on refugee populations and host governments, and consideration of costs and benefits.[117]

Furthermore, the tests are time-consuming and may create a severe bottleneck in the immigration process. Indeed, existing voluntary test sites cannot accommodate all persons seeking the test and waiting lists are weeks or months long in some cities.[118] The addition of applicants for legalization during the amnesty period and of another immigrants in the United States seeking a change of status may "nearly double the total number of HIV tests administered in certain areas of the country."[119] The Department of Health and Human Services, while acknowledging that local testing facilities may be overtaxed, has offered no solution beyond that of dealing with the problem "on a case-by-case basis."[120]

b) Rational relation and counterproductivity.

The history of United States immigration law is replete with examples of judicial deference to Congressional interpretation and application.[121] Indeed, the Supreme Court has refused to review the rationale underlying a legislative decision on immigration and

116. 52 Fed. Reg. 32,540, 32,541 (1987).

117. COMMISSION REPORT, *supra* note 1, at 156. Although the Report deals only with the portion of the new regulations regarding testing of refugees, the reasoning seems equally applicable to the testing of the immigrant population as a whole, especially in light of its low risk status.

118. 133 CONG. REC. S. 7247 (daily ed. May 28, 1987).

119. La Raza Comment, *supra* note 91, at 2.

120. 52 Fed. Reg. 32,540, 32,542-43 (1987).

121. Comment, *supra* note 34, at 124.

has likewise refused to examine legislative intent.[122] Thus, it would appear that in the realm of Congressional immigration law, the judicial rational relation test is moot. In addition, the Public Health Service, acting as a Congressional regulatory agency and pursuant to statutory authority, makes the determination as to what constitutes a dangerous, contagious disease.[123] At least one scholar has opined that the Public Health Service's determination cannot be challenged if there is any rational basis for such a decision.[124] However, in a practical sense, it is worth analyzing whether these regulations bear any rational relation to Congress' stated goal of sealing our borders against the spread of AIDS, or whether they are, in fact, counterproductive and wasteful of already limited resources.

Those in favor of the regulations have pointed out that the United States admits more immigrants than all other countries combined, and that failure to implement a mandatory testing program would lead other countries to send their infected citizens to this country. They point to the likelihood of a drain on United States resources, because the United States would have to assume the cost of medical care for terminally diseased people. Thus, they conclude the testing program is entirely justified in the national interest on public health grounds.[125]

Others, while still supporting the objective of attempting to limit the spread of AIDS, question whether the means chosen will actually achieve that objective. The United States has the largest number of reported cases of AIDS in the world.[126] Therefore, the United States is actually a net *exporter* of AIDS. Thus, banning immigration by HIV-infected individuals bears no logical relationship to stopping the spread of AIDS in this country. Indeed, it is likely that most of the infected applicants for legalization under the amnesty program contracted the virus in the United States, because anyone applying under the amnesty program must have been in this country for five years or longer.

There is an even more striking logical inconsistency in the regulations in that they do not provide for testing of aliens who apply

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122. *See* Fiallo v. Bell, 430 U.S. 787 (1977).

123. *See* 42 C.F.R. § 34 (1986).

124. Comment, *supra* note 34, at 126 (citing Bogatin, *The Immigration and Nationality Act and the Exclusion of Homosexuals*, 5 IMMIGR. & NATIONALITY L. REV. 95, 121 (1981-2)).

125. 52 Fed. Reg. 32,540, 32,543 (1987).

126. Jarvis, *supra* note 3, at 981. "By 1991, the United States government estimates that 179,000 Americans will be dying of AIDS." PANOS DOSSIER, *supra* note 4, at Intro.

for or hold non-immigrant visas (including foreign students, international businessmen, tourists, and other visitors, etc.). In fact, it is precisely this gap in the rules that has led some legislators to propose that the testing program does not go far enough and should be extended to include all aliens, whether immigrant or non-immigrant.[127] Ironically, despite its great concern for the national interest and public health, the reason given by HHS for not testing temporary visitors is that it would create unnecessary and undesirable complexities and problems, including expenses and delays in travel.[128]

Even mandatory testing of all aliens entering the United States borders would not stop the spread of HIV or AIDS.[129] The World Health Organization reasonably points out that "no screening system can prevent the introduction and spread of HIV infection; a programme for screening of international travellers would have to involve nationals returning from travel abroad, as well as foreign entrants."[130]

In addition to pointing out the flaws in the logic of the regulations, critics of the testing program point out that not only is it an irrational means to the desired end, but it is counterproductive as well. The testing program diverts resources away from medical research and educational measures, and it severely undermines amnesty and legalization programs, as well as the Congressional goal of unification of immigrant families. Moreover, AIDS is an extremely costly disease, and will grow more costly in years to come.[131] The mandatory testing program expends public money and resources on an acknowledged low risk group. Most people and organizations involved in fighting the AIDS pandemic agree that money and resources are best spent on education, research, and counseling directed especially to high-risk groups.[132]

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127. 133 CONG. REC. S. 6958 (daily ed. May 21, 1987) (statement of Sen. Kennedy).

128. 52 Fed. Reg. 32,540, 32,543 (1987).

129. *Acquired Immune Deficiency Syndrome (AIDS): Consultation on International Travel and Human Immune Deficiency Virus (HIV)*, 62 WKLY. EPIDEM. REC. 77 (1987) (published by the WHO) [hereinafter EPIDEM. REC.].

130. *Id.*

131. It is estimated that the average cost of each AIDS victim, from hospitalization until death, will be $146,000. In 1987, Congress appropriated $413 million for AIDS funding and will have appropriated an estimated $1 billion in 1988. 133 CONG. REC. S. 7413-14 (daily ed. June 2, 1987) (statements of Sen. Weicker and of Sen. Simpson)

132. *See, e.g.*, EPIDERM. REC., *supra* note 129, at 77; Letter by Legal Services of Greater Miami to the Centers for Disease Control at 7 (Aug. 5, 1987) (comment on proposed regulations adding HIV to the list of dangerous contagious diseases) (available at offices of INTER-

The new regulations directly contradict and defeat the stated purpose of the Immigration Reform and Control Act of 1986 (IRCA).[133] Although this issue was perceived and discussed at length by the legislators debating the Helms Amendment,[134] the discussions died out and the vote did not reveal the apparent concern. The extent to which aliens who feared a positive HIV test result did not apply for legalization under IRCA, realizing that they would face not only denial of legalization, but actual deportation remains to be seen. Thus, the very people targeted by the regulations (and by IRCA) may have been driven underground, where they are not likely to receive proper information, counseling, or access to precautionary measures.

The regulations also contradict the strict and specific confidentiality requirements of IRCA, where both HHS and INS have made it known that the results of the tests will not be kept confidential if local disease reporting requirements demand disclosure.[135] The specter of being shunned by family and community because of a disclosed positive test result is yet another factor that will discourage aliens from coming forward. This situation, coupled with the fact that there is no recourse to waivers for HIV infection, will assure that, rather than moving this class of aliens into the mainstream of society, there will be created a new class of aliens in limbo and still in hiding. The formation of a large population in need of care and receiving none will nullify the goals of IRCA and will result in the spread of AIDS among uninformed, uncounseled people. This situation can be likened to the case of a resident alien who, under the Narcotic Addict Rehabilitation Act (NARA),[136] vol-

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AM. L. REV.) [hereinafter Legal Services Comment].

133. The Immigration Reform and Control Act of 1986 (IRCA), Pub. L. No. 99-603, 100 Stat. 3359 (to be codified at 7 U.S.C. § 2025, 8 U.S.C. §§ 1101-1365, 20 U.S.C. §§ 1091, 1096, 29 U.S.C. §§ 1802-51) was passed in order to grant amnesty to undocumented aliens (illegal aliens) who have resided continuously in the United States since at least January 1, 1982. Under IRCA, these aliens would be eligible for legal "temporary resident" status, leading to permanent resident ("green card") status within 18 months, and ultimately to citizenship. *See* ACLU Comment, *supra* note 96, at 13. President Reagan, when signing the bill, stated:

> The legalization provisions in this Act will go far to improve the lives of a class of individuals who now must hide in the shadows, without access to many of the benefits of a free and open society. Very soon many of these men and women will be able to step into the sunlight and ultimately, if they choose, they may become Americans.

Legal Services Comment, *supra* note 132, at 6.

134. *See generally* 133 CONG. REC. S. 7246-79 (daily ed. May 28, 1987).

135. *See* 52 Fed. Reg. 32,540, 32,541-42 (1987); INS Letter, *supra* note 74, at 3.

136. 42 U.S.C. §§ 3401-26 (1982 & Supp. 1987).

untarily submits himself for commitment and treatment of his addiction, only to find that the NARA proceedings are used to deport him on the grounds that he is a narcotic drug addict.[137] There, as in the case with mandatory HIV testing and IRCA, the reformative purpose of the Act was defeated because alien addicts would be discouraged from taking advantage of benefits. It is worth noting that in the case of the drug addict, the court used the standard rationale that the proper forum for arguing for a change in immigration policy is Congress, not the courts.[138]

One of the prime purposes behind the current system of immigration quotas and preferences is the reunification of families.[139] In fact, in suspension of deportation proceedings, the alien must establish, among other things, that her deportation would result in extreme hardship to herself or to members of her immediate family who are citizens or permanent resident aliens.[140] For long-term resident aliens who wish to be naturalized, applicants who wish to change from nonimmigrant to immigrant status (such as fiances of citizens or resident aliens), or applicants for legalization under the amnesty program, a positive test result could mean the splitting up of a family and the breaking of long-standing community ties, with almost no hope for a waiver. Thus, instead of reunifying families, the new regulations may destroy them.

c) Possibility of extreme measures: quarantine.

If an alien is denied legalization or adjustment of status as the result of a positive HIV test administered in the United States, a host of problems arises with regard to what to do with the individual in the interim period of non-status. Even if deportation proceedings are begun, there will be a substantial time lag between the start of proceedings and the ultimate date of deportation especially if the alien appeals the deportation order. During this time, the alien is able to communicate the virus to others. Although it is hoped that the counseling provided by INS and Public Health Service doctors will alert the infected person to the measures she can take to avoid spreading the virus, there are groups within the United States calling for extreme measures, such as quarantine, to

137. This was the case in McJunkin v. INS, 579 F.2d 533 (9th Cir. 1978).
138. *Id.* at 535.
139. HARVARD, *supra* note 79, at 1351.
140. *Id.* at 1395.

isolate infected people. As Senator Simpson of Wyoming stated:

> These [aliens who test positive for HIV] are already here in the United States of America. They are here with us and they have been here for at least five years. . . . If . . . they have come through the confidential [medical] examination they need not divulge that. . . . Then do you exclude them and deport them to a country that will not take them? Then what are we talking about? Leaving them here illegally in a status with a communicable disease? That is a possibility. Or are you talking about detention or areas where they will be kept quarantined? That is really where we are headed here.[141]

England and Australia have already adopted quarantine proposals.[142] However, the United States Public Health Service emphasizes education rather than quarantine as the principal means of controlling AIDS.[143] Some doctors believe that quarantine and other such proposals stem from a lack of understanding with regard to the manner of acquisition of the AIDS virus:

> Quarantine has a limited role in the control of some communicable diseases, but there is little or no role for it in the prevention of AIDS. . . . HIV is transmitted almost exclusively between consenting adults, both of whom have some choice regarding the AIDS risks they are willing to take. Thus, transmission of this virus in our society is preventable by individual action, not government-imposed isolation. The threat of quarantine hinders AIDS prevention.[144]

2. International Issues

In addition to the multitude of domestic issues raised by the new regulations and the implementation of the mandatory testing program, some important international considerations must be taken into account. AIDS is a global pandemic, affecting a large number of nations all over the world. For those nations that at present are seemingly unaffected, it appears to be only a matter of

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141. 133 CONG. REC. S. 7415 (daily ed. June 2, 1987).

142. Jarvis, *supra* note 3, at 1009. A full discussion of the legal and practical issues surrounding quarantine of AIDS victims or HIV carriers can be found in Elsberry, *AIDS Quarantine in England and the United States*, 10 HASTINGS INT'L & COMP. L. REV. 113 (1986).

143. Nelson, *International Travel Restrictions and the AIDS Epidemic*, 81 AM. J. INT'L L. 230, 231 (1987).

144. Frances & Chin, *supra* note 1, at 1363.

time before the disease reaches within their boundaries.[145] Each government is faced with the task of protecting its own citizens, and the means chosen will likely be influenced by, and may in some cases be a reaction to what other governments have done.

a) Effect of lack of available and reliable testing facilities in other countries.

Perhaps the most immediate problem for aliens wishing to emigrate to the United States, especially from Third World countries, is the fact that many of these countries have either inadequate testing facilities or no testing facilities at all.[146] Unless the alien is already in the United States, no allowance will be made for testing at United States ports of entry. The reason given by HHS for this rigid procedural rule is troubling in many respects. The Department of Health and Human Services states that the procedure will be actually less of a burden on the alien because her eligibility will be determined before travel expenses are incurred, and because "some countries might refuse repatriation to applicants with HIV infection."[147]

Thus, an alien who is otherwise qualified to be admitted into the United States and who is not HIV-infected would be precluded from entering if the country from which she is applying has no testing facilities. The Department of Health and Human Services states that in such cases, it "believes that there will be regional labs available where sera can be transported for testing,"[148] but offers no evidence to support this belief. Furthermore, even if test facilities and laboratories are available, there is no way to monitor testing facilities in other countries and inaccurate test results may abound.

b) Deportation to where?

If an alien already in the United States tests positively, she may find herself in a desperate position if the country from which she came refuses to repatriate her and no other country will accept her. In many countries, people infected with HIV are barred from

145. Jarvis, *supra* note 3, at 992-93.
146. *See* PANOS DOSSIER, *supra* note 4, at 48.
147. 52 Fed. Reg. 32,540, 32,543 (1987).
148. *Id*, at 32,541.

major sectors of employment and, even worse, are being persecuted as outcasts.[149] Furthermore even if an alien is allowed to re-enter the country from which she emigrated (or another country), there is no assurance that she will receive counseling or treatment there. As was stated in *Ieronimakis v. Spence*, the INS "has no facilities to supervise treatment in a foreign country."[150] Thus, it seems especially cruel to deport an alien — especially one who has lived in this country for some time and who probably became infected with HIV in the United States — to a hostile environment where she will not be counseled or adequately treated.

c) Retaliation by other countries leading to worldwide restrictions on travel.

Many commentators are concerned that the new regulations will encourage retaliation by foreign governments against United States citizens.[151] Several countries, including Belgium, China, Australia, Japan, India, United Kingdom, and France, are requiring some or all long-term visitors to prove that they are HIV-negative as a prerequisite for entry.[152] It seems obvious that tourism and international business may suffer severely from such travel restrictions.[153]

Further, there is concern that escalating quarantine wars between two or more nations will occur and that costs to United

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149. *See generally* Jarvis, *supra* note 3, at 1005-11; PANOS DOSSIER, *supra* note 4, at 53-77.

150. 257 F.2d 874, 877 (4th Cir. 1958).

151. 52 Fed. Reg. 32,540, 32,541 (1987).

152. *See* Letter from Jeff Appleman, Esq. to Elliot[t] Lichtman, Esq. at 6 (July 6, 1987) (commenting on the proposed regulations adding HIV infection to the list of dangerous contagious diseases) (available at offices of INTER-AM. L. REV.); PANOS DOSSIER, *supra* note 4, at 76-77.

153. Various countries have passed AIDS prevention and control laws. Examples of the types of laws passed are as follows:

West Germany: In Bavaria, all prostitutes, drug addicts, prison inmates, civil servants, and some foreigners must submit to AIDS tests.

England: Quarantine proposals have been adopted; doctors who are likely to come into blood-to-blood contact with their patients must reveal the fact that they have AIDS.

Australia: Quarantine proposals have been adopted.

Saudi Arabia and Liberia: AIDS-free certificates required from Americans seeking to enter those countries.

Japan: Currently considering requirement of AIDS-free certificates.

Jarvis, *supra* note 3, at 1007-11. For a more complete list of AIDS-related laws, see Appendix 2 herein.

States trade interests will be extreme.[154] Americans who wish to work abroad may be subjected to discrimination based upon test results. As a mirror image of that situation, the United States may lose potential employees from abroad who possess special skills or talents. What is more, United States corporations doing business overseas may feel compelled to violate United States civil rights laws by testing Americans before assigning them to work in other countries.[155] This, in turn, may lead to expansion of the U.S. testing program to include non-immigrant visa applicants.[156] Ultimately, rather than international cooperation, there will be rivalry and tension. Perhaps most unfortunately, as nations try to compete in these "testing wars," costs of implementing testing programs will escalate and much needed economic resources will be diverted from treatment, research, and international programs directed to both national and international travelers.[157]

d) Discrimination against certain groups and nationalities.

In the midst of AIDS hysteria, much injustice may occur in the name of the national public health interest. This issue is made more poignant because of the limited nature of judicial review of INS decisions to deport. Indeed, the fact that "the structure and mission of the INS decrease the likelihood that the agency will be particularly sensitive to the protection of aliens' rights in the deportation process,"[158] is exacerbated by the difficulty of meeting the great burden of proving abuse of discretion by the agency.[159] For example, cases involving challenges to the Carter Administration's policy of selectively enforcing immigration laws against Iranian nationals have "clearly established the validity of politically motivated enforcement aimed at particular nationalities, even if such enforcement is ordered by executive branch officials who have power to make foreign policy."[160]

Given this framework, it is easy to see the danger of possible stigmatization of certain high-risk groups. Dr. Jonathan Mann, Di-

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154. *See* Lichtman Comment, *supra* note 71, at 4.

155. *See id.* at 6.

156. The INS has already suggested expansion of the program. *See* INS Comment, *supra* note 75.

157. EPIDEM. REC., *supra* note 129, at 77.

158. HARVARD, *supra* note 79, at 1371.

159. *Id.* at 1398-99.

160. *Id.* at 1398.

rector of the World Health Organization Special Programme on AIDS, described prejudices that have been growing along with the spread of AIDS: "We are witnessing a rising wave of stigmatization: against Westerners in Asia, against Africans in Europe, of homosexuals, of prostitutes, of hemophiliacs, of recipients of blood transfusions."[161] The rise of prejudice on such a global scale will do nothing to defeat the AIDS pandemic and much to distract people from the real medical and educational issues.

e) Humanitarian considerations.

At the core of all of the issues raised by the new regulations is the delicate balance between provisions restricting immigration and those encouraging it, that is, the balance between instrumental and humanitarian provisions, which has always characterized United States immigration policy and law.[162] "Humanitarian provisions — intended mainly to benefit refugees — are evident in even the earliest pronouncements of United States immigration policy."[163]

In emergency situations, where an alien is fleeing persecution and seeking admission to the United States as a refugee, her life and freedom may be endangered as she waits to be tested for HIV in the country from which she is fleeing. Furthermore, in political situations, that country may, in fact, refuse to administer the test.

Recognizing that unpredictable emergency situations may occur, HHS, citing similar provisions in the Refugee Act of 1980 and in IRCA, has provided for flexibility in appropriate situations, as determined by the Attorney General after consultation with the Secretary of State and the Secretary of the Department of Health and Human Services.[164] While this provision appears on the surface to solve the problem, HHS has provided no guidance as to the definition of an "appropriate emergency situation." Furthermore, in reality, those seeking emergency asylum usually have very little time to wait for the Attorney General to consult with two other administrative agency officials, and the regulations do not put a time limit on the decision-making process.

Perhaps the most important humanitarian consideration, and

161. ACLU Comment, *supra* note 96, at 12.
162. HARVARD, *supra* note 79, at 1336.
163. *Id.* at 1335.
164. 52 Fed. Reg. 32,540, 32,542 (1987).

the one that will ultimately affect the most people, involves the international sharing of medical and other resources. As Dr. Mann has stated: "This new health problem cannot be stopped in one country until it is stopped in all countries."[165] Dr. Mann, among others, has called for a "global perspective" on AIDS.[166] There is a marked contrast between resources available in different parts of the world. As the Panos Institute reports, "while the U.S. government has allocated $2,000 million to AIDS research and control, a hospital dealing with AIDS in Kampala cannot obtain bleach to disinfect its test tubes."[167]

Clearly, all countries benefit from an exchange of resources. Because AIDS is transmitted in the same ways everywhere, educational efforts to inform people of how to avoid the spread of infection can be truly global. In a very profound sense, the manner in which we respond to the AIDS crisis will be a test of our collective moral fiber.

IV. COMMENT

AIDS is a world-wide problem which is presently concentrated in the United States. America cannot possibly hope to insulate itself from the spread of the disease. The best the United States can do is to embark on a program of massive public education and health counseling, while encouraging voluntary HIV testing. It is a waste of resources to mandate HIV screening of immigrants. Further, it is counterproductive, and raises numerous issues and problems, both on a national and international level. The new United States immigration regulations are a misguided attempt by Congress to respond to a public health crisis by targeting the one group of people in this country who are, for the most part, without

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165. ACLU Comment, *supra* note 96, at 12.

166. Mann, *Worldwide Strategies for HIV Control: WHO'S Special Programme on AIDS*, 14 LAW, MED. & HEALTH CARE 290 (1986); *see also* PANOS DOSSIER, *supra* note 4, at 48.

167. PANOS DOSSIER, *supra* note 4, at 48.

political influence or legal rights. Legislators should be urged to reassess the value of the regulations before more precious medical resources and time are lost.

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* The author wishes to express her kind appreciation to Ira Kurzban, Esq., President, American Immigration Lawyers Association; and Professor Robert M. Jarvis of the Nova University Law Center. A special debt of gratitude is owed to Nancy Barshter, Esq. and Judith A. Jarvis, for their guidance, support, and inspiration.

APPENDIX 1

AIDS Cases Reported to WHO by Region and Country
Based on Reports Received through 01/11/1988†

AFRICAN REGION Country	1979-1986 Cases	<--1987--> Cases	 Rate(a)	1988 Cases to date	Last Report	Cumulative Cases
ALGERIA	3	5	0.0	5	26/03/1988	13
ANGOLA	9	32	0.3	24	01/07/1988	65
BENIN	3	6	0.1	6	30/06/1988	15
BOTSWANA	7	9	0.7	18	31/03/1988	34
BURKINA FASO	0	26	0.3	0	30/06/1987	26
BURUNDI	269	652	13.0	487	30/06/1988	1408
CAMEROON	21	4	0.0	28	16/06/1988	53
CAPE VERDE	2	2	0.6	0	30/04/1987	4
CENTR.AFR.REP.	254	178	6.5	0	15/06/1988	432
CHAD	1	6	0.1	0	15/06/1988	7
COMOROS	0	0	0.0	1	31/05/1988	1
CONGO	250	1000	45.8	0	31/12/1987	1250
COTE D'IVOIRE	118	132	1.2	0	20/11/1987	250
EQUATORIAL GUINEA	0	0	0.0	0	16/05/1988	0
ETHIOPIA	0	19	0.0	35	17/08/1988	54
GABON	0	18	1.5	0	31/03/1988	18
GAMBIA	13	22	2.7	17	29/08/1988	52
GHANA	73	72	0.5	0	25/05/1987	145
GUINEA	0	4	0.0	6	22/07/1988	10
GUINEA BISSAU	0	29	3.2	0	15/06/1988	29
KENYA	109	1388	6.2	1235	30/06/1988	2732
LESOTHO	1	1	0.0	0	26/08/1988	2
LIBERIA	0	2	0.0	0	11/03/1988	2
MADAGASCAR	0	0	0.0	0	25/04/1987	0
MALAWI	144	860	11.6	1582	30/06/1988	2586
MALI	6	23	0.2	0	14/01/1988	29
MAURITANIA	0	0	0.0	0	15/06/1988	0
MAURITIUS	0	1	0.0	0	27/07/1988	1
MOZAMBIQUE	1	3	0.0	6	31/08/1988	10
NIGER	0	9	0.1	0	14/10/1987	9
NIGERIA	0	9	0.0	2	31/05/1988	11
REUNION	0	1	0.1	2	28/04/1988	3
RWANDA	705	196	2.8	86	31/03/1988	987
SAO TOME/PRINCIPE	0	0	0.0	1	11/02/1988	1
SENEGAL	0	66	0.9	65	09/06/1988	131
SEYCHELLES	0	0	0.0	0	13/11/1986	0
SIERRA LEONE	0	1	0.0	4	18/08/1988	5
SOUTH AFRICA @	45	38	0.1	52	19/08/1988	135
SWAZILAND	1	6	0.8	7	16/06/1988	14
TANZANIA	699	909	3.8	1447	31/07/1988	3055
TOGO	0	2	0.0	0	15/06/1988	2
UGANDA	911	1789	11.2	1306	15/06/1988	4006
ZAIRE	0	335	1.0	0	30/06/1987	335
ZAMBIA	250	286	4.0	457	05/08/1988	993
ZIMBABWE	0	119	1.2	0	30/04/1988	119
Total for the Region	3895	8260	1.7	6879		19034

(a) Rate: 1987 Reported Cases / 100,000 Population
(b) Number of countries or territories reporting to WHO
* Updated report
** Given date corresponds to PAHO review of 13 September 1988. National cut-off dates will appear in the next report.
@ Not an active member of the Region
† *Source*: WORLD HEALTH ORGANIZATION, UPDATE: AIDS CASES REPORTED TO SURVEILLANCE, ANCESTRY AND IMFLUENT ASSESSMENT UNIT (SFI), GLOBAL PROGRAMME ON AIDS (Nov. 1988).

AMERICAN REGION Country	1979-1986 Cases	<--1987--> Cases	Rate(a)	1988 Cases	Last Report to date	Cumulative Cases
ANGUILLA	0	0	0.0	1	30/06/1988	1
ANTIGUA	2	1	1.0	0	30/06/1988	3
ARGENTINA	69	72	0.2	56	30/06/1988	197
BAHAMAS	86	90	39.1	38	30/06/1988	214
BARBADOS	31	24	8.0	8	30/06/1988	63
BELIZE	1	6	3.0	1	31/03/1988	8
BERMUDA	51	21	26.2	9	30/06/1988	81
BOLIVIA	1	5	0.0	2	13/09/1988	8**
BR. VIRGIN ISLANDS	0	0	0.0	0	31/03/1988	0
BRAZIL	1390	1068	0.7	1229	30/06/1988	3687
CANADA	1049	658	2.5	294	13/09/1988	2001**
CAYMAN ISLANDS	1	2	10.0	1	30/06/1988	4
CHILE	22	41	0.3	20	30/06/1988	83
COLOMBIA	80	94	0.3	70	30/06/1988	244
COSTA RICA	16	27	0.9	23	13/09/1988	66**
CUBA	1	26	0.2	7	13/09/1988	34**
DOMINICA	0	4	4.0	2	31/03/1988	6
DOMINICAN REPUBLIC 116	294		4.5	156	30/06/1988	566
ECUADOR	11	19	0.1	15	13/09/1988	45**
EL SALVADOR	6	17	0.3	9	13/09/1988	32**
FRENCH GUIANA	58	45	56.2	10	31/03/1988	113
GRENADA	3	5	4.5	3	31/03/1988	11
GUADELOUPE	38	36	10.9	0	31/12/1987	74
GUATEMALA	15	19	0.2	5	13/09/1988	39**
GUYANA	0	14	1.4	2	31/03/1988	16
HAITI	795	477	7.2	183	30/06/1988	1455
HONDURAS	15	66	1.4	83	13/09/1988	164**
JAMAICA	16	33	1.3	17	30/06/1988	66
MARTINIQUE	16	22	6.6	0	31/12/1987	38
MEXICO	789	499	0.6	214	30/06/1988	1502
MONTSERRAT	0	0	0.0	0	31/03/1988	0
NICARAGUA	0	0	0.0	1	30/06/1988	1
PANAMA	18	12	0.5	34	13/09/1988	64**
PARAGUAY	1	7	0.1	0	31/12/1987	8
PERU	9	60	0.2	29	30/06/1988	98
ST. KITTS & NEVIS	1	0	0.0	0	31/03/1988	1
ST. LUCIA	3	7	5.3	1	31/03/1988	11
ST. VINCENT	3	5	5.0	2	31/03/1988	10
SURINAME	4	5	1.2	0	31/03/1988	9
TRINIDAD & TOBAGO	141	86	6.6	75	30/06/1988	302
TURKS & CAICOS	2	3	30.0	0	31/12/1987	5
UNITED STATES AM.	37749	23491	9.6	15430	26/10/1988	76670*
URUGUAY	8	9	0.2	9	30/06/1988	26
VENEZUELA	69	71	0.3	67	13/09/1988	207**
Total for the Region	42686	27441	3.9	18106		88,233

SOUTH EAST ASIA REGION	1979-1986	<--1987-->		1988	Last	Cumulative
	Cases	Cases	Rate(a)	Cases	Report	Cases
Country				to date		
BANGLADESH	0	0	0.0	0	15/06/1988	0
BHUTAN	0	0	0.0	0	14/04/1987	0
BURMA	0	0	0.0	0	14/04/1987	0
INDIA	5	4	0.0	0	09/05/1987	9
INDONESIA	0	1	0.0	2	30/07/1988	3
KOREA, DPR	0	0	0.0	0	10/05/1988	0
MALDIVES	0	0	0.0	0	30/06/1987	0
MONGOLIA	0	0	0.0	0	30/09/1988	0*
NEPAL	0	0	0.0	0	15/06/1988	0
SRI LANKA	0	1	0.0	0	19/05/1988	1
THAILAND	6	2	0.0	0	01/07/1988	8
Total for the Region	11	8	0.0	2		21

WESTERN PACIFIC REGION	1979-1986	<--1987-->		1988	Last	Cumulative
	Cases	Cases	Rate(a)	Cases	Report	Cases
Country				to date		
AUSTRALIA	386	345	2.1	293	11/10/1988	1024*
BRUNEI DARUSSALAM	0	0	0.0	0	08/09/1987	0
CHINA	1	1	0.0	1	31/07/1988	3
CHINA (TAIWAN)	1	0	0.0	0	26/01/1986	1
COOK ISLANDS	0	0	0.0	0	08/09/1987	0
FIJI	0	0	0.0	0	08/09/1987	0
FRENCH POLYNESIA	0	1	0.5	0	31/01/1988	1
HONG KONG	3	6	0.1	4	16/08/1988	13
JAPAN	25	34	0.0	31	31/08/1988	90
KIRIBATI	0	0	0.0	0	18/01/1988	0
KOREA, REP.	0	1	0.0	2	23/04/1988	3
MALAYSIA	1	1	0.0	2	27/09/1988	4*
MARIANA ISLANDS	0	0	0.0	0	05/08/1987	0
NEW CALEDONIA	0	0	0.0	0	08/09/1987	0
NEW ZEALAND	33	34	1.0	22	15/09/1988	89
PAPUA NEW GUINEA	0	0	0.0	4	01/08/1988	4
PHILIPPINES	3	9	0.0	5	17/10/1988	17*
SAMOA	0	0	0.0	0	14/07/1988	0
SINGAPORE	2	2	0.0	0	31/01/1988	4
SOLOMON ISLANDS	0	0	0.0	0	08/09/1987	0
TONGA	0	1	0.9	0	06/10/1987	1
TUVALU	0	0	0.0	0	08/09/1987	0
VANUATU	0	0	0.0	0	05/07/1988	0
VIET NAM	0	0	0.0	0	08/09/1987	0
Total for the Region	455	435	0.0	364		1254

EUROPEAN REGION	1979-1986 Cases Country	<--1987--> Cases	Rate(a)	1988 Cases to date	Last Report	Cumulative Cases
ALBANIA	0	0	0.0	0	13/09/1988	0
AUSTRIA	54	85	1.1	72	01/10/1988	211*
BELGIUM	230	85	0.8	53	30/06/1988	368
BULGARIA	0	1	0.0	2	30/06/1988	3
CZECHOSLAVAKIA	6	2	0.0	3	30/06/1988	11
DENMARK	142	97	1.8	80	30/09/1988	319*
FED.REP.GERMANY	1018	918	1.5	552	30/09/1988	2488*
FINLAND	14	10	0.2	8	30/06/1988	32
FRANCE	1221	1852	3.3	1138	30/06/1988	4211
GERMAN DEM.REP.	1	5	0.0	0	30/06/1988	6
GREECE	35	53	0.5	39	30/06/1988	127
HUNGARY	1	7	0.0	6	30/09/1988	14*
ICELAND	4	0	0.0	2	30/06/1988	6
IRELAND	14	19	0.5	16	30/06/1988	49
ISRAEL	34	13	0.3	18	30/06/1988	65
ITALY	590	888	1.5	1078	30/09/1988	2556*
LUXEMBOURG	6	3	0.7	3	30/06/1988	12
MALTA	5	3	0.7	4	30/06/1988	12
MONACO	0	1	3.7	0	31/12/1987	1
NETHERLANDS	236	224	1.5	145	30/09/1988	605*
NORWAY	35	35	0.8	21	04/10/1988	91*
POLAND	1	2	0.0	0	30/09/1988	3*
PORTUGAL	46	44	0.4	83	30/09/1988	173*
ROMANIA	2	2	0.0	4	30/06/1988	8
SAN MARINO	0	0	0.0	0	15/10/1988	0*
SPAIN	264	862	2.2	345	30/06/1988	1471
SWEDEN	90	73	0.8	60	13/10/1988	223*
SWITZERLAND	192	163	2.4	147	30/06/1988	502
TURKEY	7	2	0.0	0	31/05/1988	9
UNITED KINGDOM	571	651	1.1	572	07/10/1988	1794*
USSR	1	3	0.0	0	30/06/1988	4
YUGOSLAVIA	8	18	0.0	14	30/06/1988	40
Total for the Region	4828	6121	0.7	4465		15414

EASTERN MEDITERRANEAN REGION Country	1979-1986 Cases	<--1987--> Cases	Rate(a)	1988 Cases to date	Last Report	Cumulative Cases
AFGHANISTAN	0	0	0.0	0	31/12/1987	0
BAHRAIN	0	0	0.0	0	11/07/1988	0
CYPRUS	1	2	0.2	2	30/07/1988	5
DEMOCRATIC YEMEN	0	0	0.0	0	25/09/1988	0
DJIBOUTI	0	0	0.0	0	01/10/1987	0
EGYPT	0	1	0.0	5	30/07/1988	6
IRAN	0	0	0.0	0	31/12/1987	0
IRAQ	0	0	0.0	0	31/12/1987	0
JORDAN	0	3	0.0	0	01/07/1988	3
KUWAIT	0	1	0.0	0	31/12/1987	1
LEBANON	0	5	0.1	0	31/12/1987	5
LYBIA	0	0	0.0	0	31/12/1987	0
MOROCCO	0	9	0.0	3	15/06/1988	12
OMAN	0	0	0.0	6	30/04/1988	6
PAKISTAN	0	1	0.0	5	25/09/1988	6
QATAR	0	15	4.6	6	25/09/1988	21
SOMALIA	0	0	0.0	0	31/12/1987	0
SUDAN	0	53	0.2	15	30/06/1988	68
SYRIA	0	3	0.0	1	30/07/1988	4
TUNISIA	2	17	0.2	2	30/07/1988	21
YEMEN	0	0	0.0	0	31/12/1987	0
Total for the Region	3	110	0.0	45		158

AIDS CASES REPORTED TO WHO BY YEAR AS OF: 01/11/1988

Continent	?	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	Total
Africa	1	0	0	0	2	14	82	682	3116	8340	6904	19141
Americas	0	14	73	298	1092	3272	6419	12036	19482	27441	18106	88233
Asia	0	0	1	0	1	8	4	28	47	107	85	281
Europe	6	0	4	17	67	216	564	1334	2579	6106	4447	15340
Oceania	0	0	0	0	1	6	45	124	243	381	319	1119
Total	7	14	78	315	1163	3516	7114	14204	25467	42375	29861	124114

CUMULATIVE AIDS CASES REPORTED TO WHO BY YEAR AS OF: 01/11/1988

Continent	?	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	Total
Africa	1	0	0	0	2	16	98	780	3896	12236	19140	19141
Americas	0	14	87	385	1477	4749	11168	23204	42686	70127	88233	88233
Asia	0	0	1	1	2	10	14	42	89	196	281	281
Europe	6	0	4	21	88	304	868	2202	4781	10887	15334	15340
Oceania	0	0	0	0	1	7	52	176	419	800	1119	1119
Total	7	14	92	407	1570	5086	12200	26404	51871	94246	124107	124114

CASES REPORTED BY CONTINENT AS OF: 01/11/1988

Continent	Number of Cases	All Countries(b)	Countries or Zero Cases	Territories Reporting 1 or more cases
Africa	19141	51	6	45
Americas	88233	44	2	42
Asia	281	38	16	22
Europe	15340	30	2	28
Oceania	1119	14	9	5
Total	124114	177	35	142

APPENDIX 2

Summary of Selected Legal Instruments Dealing With AIDS and HIV Infection: As of June 1988*

Barbados: Establishment of an AIDS committee, June 1985.

Belize: Infectious Disease Order on AIDS (declaring AIDS to be an infectious disease "within the meaning of the Public Health Ordinance"), 1987.

Bermuda: Public Health (Communicable Diseases/AIDS) Order (declaring AIDS to be a "communicable disease of the first category" and thus a notifiable disease), 1985; Public Health (Communicable Diseases/HTLV-III Virus Infection) Order (declaring HTLV-III to be a "communicable disease of the first category" and thus a notifiable disease), 1986.

Brazil: Order No. 199 (Advisory Commission on AIDS is established; duties include: advising the Minister of Health on all matters concerning the control of AIDS in Brazil; monitoring the implementation of the AIDS control programme and its monthly evaluation; and monitoring, at the international level, developments in AIDS research), April 25, 1986; Order No. 542 (AIDS is added to the list of notifiable diseases), December 1986; Interministerial Order MPAS/MS No. 14 (blood and blood products to be tested for HIV; quality control measures for transfusions; reference centres for carrying out laboratory examinations to be established), May 18, 1987.

Canada: Amendment to the Medical Devices Regulations (test kits for the detection of AIDS-associated retroviruses are added to the list of new medical devices in respect of which the manufacturer is required to submit specific information and materials prior to sale, and at any time after a notice of compliance or supplementary notice of compliance has been issued for the device), July 5, 1985.

Alberta: Bodies of Deceased Persons Regulation (AIDS is added to the list of "specified communicable diseases" in respect of which various safeguards are to be taken regarding the bodies of persons who have died as a result of such diseases), July 31, 1985, amended September 11, 1986; Communicable Diseases Regulation

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* Source: WORLD HEALTH ORGANIZATION, TABULAR INFORMATION ON LEGAL INSTRUMENTS DEALING WITH AIDS AND HIV INFECTION WHO/GPA/HLE/88.1. Please note that this list is not intended to be a comprehensive one, but only to provide a starting point for those who wish more information as the AIDS-related laws of any particular country covered.

(a number of safeguards provided for in the Public Health Act are to be taken in respect to AIDS, particularly that no case or suspected case may donate blood, that blood, tissues, and fluids from a case are to be disposed of so as not to constitute a risk of infection to other persons, and that no case may engage in any activity that may transmit the disease), July 31, 1985.

British Colombia: Health Act Communicable Disease Regulation (AIDS is made a reportable communicable disease), no date available.

Manitoba: Regulations under the Public Health Act respecting Sexually Transmitted Diseases, Revised Regulation P210/R2, Div. II, Ch. P210 (AIDS is added to the list of notifiable diseases; laboratories required to report all positive results of serological tests and positive results of laboratory identification of HIV), May 1987.

New Brunswick: Regulations under the Health Act, 96(1)(s) (AIDS, ARC confirmed presence of HTLV-III, and seropositivity are made notifiable), December 7, 1984, amended April 29, 1986.

Newfoundland: Newfoundland Regulation 60/87, Order re Communicable Diseases Schedule Amendment (AIDS, ARC, and HIV added to the list of communicable diseases, and made notifiable), March 20, 1987.

Nova Scotia: Amendments made by the Minister of Health to the Regulations in Respect of the Communicable Diseases and approved by an Order in Council (series of 3 amendments intended to ensure the communication of relevant information concerning AIDS to the appropriate authorities; diagnosis of AIDS or one positive result in an ELISA test are made notifiable), October 9, 1985, December 12, 1985, May 14, 1987.

Ontario: Ontario Regulations 161/84, 162/84, and 490/85 (providing for the classification of AIDS as a communicable disease for the purposes of the Health Protection and Promotion Act, 1983, and for its designation as a reportable disease for the purposes of that Act. Details are given in the 1985 Regulation of the information to be reported), December 22, 1983, October 3, 1985.

Prince Edward Island: AIDS made reportable in 1985, and seropositivity in 1987.

Quebec: Regulations respecting the application of the Public Health Protection Act (AIDS added to list of notifiable diseases), October 1, 1986.

Saskatchewan: AIDS made notifiable in 1984; HIV no-

tifiable in 1988.

Yukon Territory: AIDS has been made notifiable.

Chile: Circular No. 3F/165 (information given on risk groups, modes of transmission, laboratory examination, prevention, and precautions; diagnosis and treatment of AIDS to be undertaken in specialized centres), July 31, 1984; Decree No. 294 amending Supreme Decree No. 362 of September 28, 1983 (AIDS is added to the list of sexually transmitted diseases), September 10, 1984; Decree No. 11 approving the Regulations on the reporting of diseases subject to compulsory notification on a daily basis, January 3, 1985; Supreme Decree No. 197, establishes anonymity for all notifications in respect of AIDS, June 28, 1985; Order No. 3F/3919, promulgating rules for dealing with patients suffering from AIDS, including provisions on precautions for dentists and those who work in pathology, on autopsies, and funeral procedures, July 3, 1985; Resolution No. 328 establishing minimum biosafety standards for handling, in clinical laboratories, all specimens from patients where there is a risk of infection by the HTLV-III virus, March 5, 1986; Decree No. 08 establishing a National Commission on Sexually Transmitted Diseases with a subcommission on AIDS, May 20, 1986.

Costa Rica: Decree No. 17187-S (AIDS, ARC and confirmed seropositivity are made notifiable), September 12, 1986; Decree No. 17239-S (persons belonging to high-risk groups ["homosexuals, prostitutes, etc."] are prohibited from donating blood), September 23, 1986.

Cuba: Ministerial Resolutions Nos. 42 and 68 and No. 129 (provides for compulsory serological testing of Cubans returning to Cuba from "endemic areas"), February 20, 1986 and July 3, 1986; Resolution No. 144 (testing of foreigners intending to reside in the country for more than 3 months, and repatriation of seropositives), date unknown.

Dominican Republic: Resolution of the Secretary of State for Public Health and Social Welfare (condoms to be available on premises of hotels, motels, bars, restaurants, etc.), April 13, 1987; Resolution (blood supplies to be used for therapeutic purposes to be tested for antibodies to hepatitis B and HIV, April 21, 1987; Resolution (establishing National Commission for the Study of AIDS, April 21, 1987; Circular of the Secretary of State for Public Health and Social Welfare (reuse of syringes and needles prohibited), April 29, 1987; Regulations No. 536-87 of the President of the Republic for blood banks (highly detailed conditions and re-

quirements to be fulfilled by blood banks, notably with a view to preventing the transmission of HIV), October 1987.

Grenada: Food and Drugs Act (except as prescribed or exempted by regulations, it is an offense to advertise any food, drug, cosmetic, or device to the general public as a "treatment, preventive, or cure" for various diseases and conditions, including AIDS), 1986.

Guatemala: Government Order No. 342-86 promulgating Regulations on the control of sexually transmitted diseases (AIDS classified as an STD; series of measures, including periodical examinations of female prostitutes, are laid down), June 10, 1986.

Mexico: Technical Rule No. 25 on epidemiological information (suspected or confirmed cases of AIDS, and death due to AIDS, subject to immediate notification), July 7, 1986; Order of the General Health Council (AIDS made subject to epidemiological surveillance activities for prevention and control purposes), November 28, 1986; Decree revising and amending the General Law on Health (AIDS added to the list of communicable diseases in respect of which the Secretariat for Health and the governments of the federative entities are to carry out epidemiological surveillance and prophylactic and control activities; cases of seropositivity are made notifiable), April 25, 1987.

Panama: Circular No. 793/DGS/VED/85 of the Director-General of Health concerning AIDS (requests exclusion from blood donation of homosexuals, bisexuals, and drug abusers (by inhalation or parenterally), pending further research on AIDS), May 13, 1985; Memorandum No. 2020-DGS-VE-85 of the Director-General of Health on screening for antibodies to HTLV-III (requests the introduction, by blood banks, of a routine test to determine the presence of HTLV-III antibodies), November 19, 1985; Memorandum No. 2055-DGS-VE-85 on screening of hemophiliacs for antibodies to HTLV-III, November 22, 1985; Resolution No. 01327 of the Ministry of Health establishing the National AIDS Commission, July 21, 1987; Resolution No. 01363 of the Ministry of Health (lays down measures to ensure that imported blood derivatives and other biological products of human origin are free of HIV), July 27, 1987; Decree No. 346 making AIDS a notifiable disease in Panama and laying down notification procedures applicable throughout the national territory; notification includes full name and address of the patient or suspected patient, September 4, 1987.

District of La Chorrera: Municipal Decree No. 4 promulgating measures on public decency and the presence of

women in bars, boarding-houses, hotels, brothels, and other similar places (women in these establishments are to undergo three-monthly (sic) tests for HIV), October 1987.

Paraguay: Resolution S.G. No. 11 (AIDS made subject to compulsory notification, within 24 hours of diagnosis), January 31, 1985.

Peru: Supreme Decree No. 013-87-SA declaring the control, notification, certification, classification, and treatment of diseases of viral origin to be matters of necessity and of public and social utility (providing for notification of "all suspected cases of diseases . . . affecting the human immune system" and for establishment of Technical Commission, April 2, 1987; Supreme Resolution No. 011-87-SA approving the National Multisectoral Programme for the Prevention and Control of AIDS (involving participation of the Ministry of Health, Ministry of Education, the Interior, Office of the President, and Justice, and the public and private agencies concerned), April 2, 1987.

Uruguay: Ordinance No. 7/88 rendering compulsory the systematic screening for HIV of all blood to be used in the country for transfusions and for the production of blood products, March 17, 1988.

Venezuela: Resolution No. 5 establishing a standing honorary commission named the National Commission for the Study of AIDS to collect data obtained nationally and internationally on the etiology and epidemiology of AIDS and relevant therapeutic programmes and measures; recommending the establishment of an appropriate system of surveillance; proposing rules, guidelines and administrative procedures to deal with and control AIDS; promoting and stimulating health and education in the field, October 4, 1984; Resolution No. G 755 (requiring compulsory testing of all blood and blood derivatives for HIV antibodies, and reporting of the results to the Division of Communicable Diseases and Accidents of the Ministry of Health and Social Welfare; contaminated blood to be discarded and donor to be informed of results), December 18, 1986; Resolution No. 1 (diagnosed cases of AIDS and HIV antibodies made compulsorily notifiable), March 13, 1987.