Policies of Containment: Immigration in the Era of AIDS

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ABSTRACT

The US Public Health Service began the medical examination of immigrants at US ports in 1891. By 1924, national origin had become a means to justify broad-based exclusion of immigrants after Congress passed legislation restricting immigration from southern and eastern European countries. This legislation was passed based on the alleged genetic inferiority of southern and eastern Europeans. Since 1987, the United States has prohibited the entrance of immigrants infected with the human immunodeficiency virus (HIV). On the surface, a policy of excluding individuals with an inevitably fatal "communicable disease of public health significance" rests solidly in the tradition of protecting public health. But excluding immigrants with HIV is also a policy that, in practice, resembles the 1924 tradition of selective racial restriction of immigrants from "dangerous nations." Since the early 1980s, the United States has erected barriers against immigrants from particular Caribbean and African nations, whose citizens were thought to pose a threat of infecting the US blood supply with HIV. (*Am J Public Health.* 1994;84:2011–2022)

Two Traditions of Immigration Control

Geographic or national boundaries have been a historic first line of defense against disease and "degeneracy." The oldest means of regulating immigration to the United States has been the inspection and exclusion of individual immigrants based on behavior, mental condition, socioeconomic status, or medical history.[1] Beginning in 1882, federal law provided for the exclusion of convicts, lunatics, idiots, paupers, and those likely to become a public charge[2]; in 1903, Congress expanded the list of social misfits to include epileptics, beggars, prostitutes, and anarchists.[3] In 1891, validating the success of the new science of bacteriology introduced by Louis Pasteur and Robert Koch in the 1870s and 1880s,[4] Congress empowered the federal government to turn back immigrants who suffered from "loathsome or . . . dangerous contagious disease[s]."[5]

As a result of the new emphasis on the infectious status of individuals, the US Public Health Service (which was created in 1798 as the US Marine Hospital Service and was not renamed until 1912) began the medical inspection of immigrants at major US ports in 1891.[6] At Ellis Island, only a few seconds were devoted to the examination of each arrival, and each year only 1% to 3% of immigrants were "marked" for more careful inspection.[7] Thus, exclusion on the basis of the medical examination was rare, although during the second decade of the 20th century, medical diagnosis (or certification) became an increasingly significant reason for deportation.[8]

We can hardly speak of immigration in the modern period without speaking of boundaries that paint, with broad strokes, the outlines of nations—outlines that give ethnic, racial, cultural, and religious definition to groups of people. Individuals of a particular ethnicity, race, culture, or religion can seem as threatening to a country as criminals, prostitutes, or those with contagious disease. It is uncertain, however, to what extent race influenced Public Health Service medical certification of immigrants. Available evidence suggests that health service physicians at Ellis Island diagnosed immigrants' diseases evenhandedly.[9] As one historian argues, the physicians conducting these inspections may have been too overworked and overwhelmed by the sheer number of immigrants to act as conscious agents of immigration restriction.[10] But not all US ports experienced such heavy immigration, and physicians at smaller ports may have conducted more rigorous medical examinations. For example, proportionately more Jewish immigrants were deported from Galveston, Tex, than from any of the major ports of the Northeast.[11] But while race was a relevant distinction to some Public Health Service officers,[12] the service itself appears to have considered immigrants of all nationalities as belonging to a suspect "class" with particular "immigrant diseases."[13]

A second tradition of selective racial immigration restriction—a subset of a more general limitation of the overall number of immigrants—allowed the United States explicitly to limit the number of immigrants from particular, supposedly undesirable, nations. Beginning in 1900, immigration from southern and

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Immigrants traveling in steerage are inspected in "the line" at Ellis Island in 1904. Photo courtesy of the National Park Service, US Department of the Interior.

eastern Europe—Italy, Poland, Russia, Czechoslovakia, and Austria-Hungary—surpassed that from the familiar northern and western European countries. These new immigrants were often different in appearance, cuisine, language, and worship; to many, they seemed dirty, illiterate, and poverty-stricken. In 1924, following 3 decades of massive immigration from southern and eastern European countries, which were accompanied by growing social and economic pressures posed by industrialization, sprawling urban cities, violent labor uprisings, economic depression,[14] fears of middle-class "race suicide," the changing structure of American authority,[15] and a fractured sense of American unity,[16] Congress passed legislation selectively restricting immigration from these countries on the basis of the alleged genetic inferiority of their people.

Eugenics, both a social and scientific movement seeking to achieve "better breeding" through application of the laws of heredity,[17] served as the vehicle through which the cultural differences of southern and eastern Europeans were translated into a biological threat to the blood of the nation. At the apex of eugenic influence in the United States, those favoring immigration restriction successfully argued that the new, culturally unfamiliar immigrants were physically, intellectually, and genetically inferior to the "native" American population and that they threatened to pollute America's superior genetic stock with inferior "germ plasm."[18] Heavily influenced by these arguments, the Immigration Restriction Act of 1924 (or National Origins Act) restricted immigration from any one European nation to 2% of the number that immigrated from that country in the United States as of 1890, a year when few eastern and southern Europeans immigrated to the United States.[19]

The history of immigration control does not produce convenient lessons or policy guidelines. Medical inspection was part and parcel of a broader Progressive Era enthusiasm for scientific management, which favored systematic application of the lessons of bacteriology to screen out disease in a period in which every immigrant was considered to be part of a class at particular risk. Selective immigration restriction, driven by a complex set of social, cultural, professional, and scientific motivations, flourished in a political environment openly hostile to particular groups of foreigners. Eugenicists and immigration restrictionists sought to prevent the genetic deterioration of future generations by protecting superior American germ plasm from adulteration with inferior foreign genes; they also sought to prevent the degeneration of American society and culture. Thus, at its heart, the early history of immigration is the story of how national origin became a marker for degeneration and so a means to justify broad-based exclusion in an ideological environment where strictly "public health" or "bacteriological" arguments for immigration restriction were filtered through the lenses of racism and nativism.

Similarly, contemporary public health concerns about the threat of an acquired immunodeficiency syndrome (AIDS) epidemic are entwined in a complex mesh of anxieties. The 1980s witnessed the greatest increase in legal immigration since the period from 1900 through the 1920s.[20] Surpassing the first wave of immigration in size, this wave is expected to reach 9 to 12 million in the last decade of the 20th century.[21] Additionally, as many as 3 million illegal immigrants enter the country each year.[22] Persistent unemployment in certain sectors of the economy and uncertainty about the impact of potential social reforms have sparked American fears of immigrant competition for jobs and have raised concerns about the financial burden immigrants might place on the health and welfare systems.[23] Indeed, representatives from all parts of the political spectrum sanction more restrictive immigration policies: proposals of California Gov Pete Wilson[24] and New York State Sen Frank Padavan recommending extreme measures to curb the perceived costs of immigration[25] find tempered sympathy in the responses of President Bill Clinton,[26] US Sens Dianne Feinstein and Barbara Boxer,[27] and Secretary of Housing and Urban Development Henry Cisneros.[28]

In an era of generalized anti-immigrant sentiment, race and nationality have maintained their relevance. Today, the vast majority of immigrants come from Africa, Latin America, the Caribbean, and Asia.[29] Faced with increasing market competition from Asian nations, which are popularly depicted as competitors potentially capable of dominating the American economy,[30] the United States struggles to turn back Chinese refugees.[31] Similarly, questions regarding the economic burden posed by groups of immigrants infected with the human immunodeficiency virus (HIV) have become as pressing as those regarding their sexual "misconduct" and the concomitant danger to the public health.

Since 1987, the United States has barred the entrance of immigrants infected with HIV. On the surface, this is a public health policy to exclude individuals with a fatal "communicable disease of public health significance."[32] In that all immigrants are screened for HIV as part of the medical examination, the exclusion of infected individuals rests solidly in the tradition of protecting the public health from disease. But HIV exclusion is also a policy that has, in practice, resulted in the selective restriction of immigrants from "dangerous nations." Since the early 1980s, US immigration policy has served to erect barriers against Caribbean and African immigrants, who are believed to threaten the blood supply of this nation with HIV. The experience of Haitian immigrants, in particular, serves to expose the interplay of two historic traditions of immigration control in the policy of HIV exclusion.

The Epidemiological Construction of Dangerous Nations

A thumbnail sketch of Haiti's history reveals a pattern of subordination by and dependence on the United States and other Western nations.[33] Although not the sole foreign government to involve itself militarily in the internal affairs of this small island nation, the United States occupied Haiti with the aid of the marine force from 1915 to 1934 on the pretext of containing the threat that an impending political debacle posed to US citizens living there. The legacy of this occupation was economic, political, and military centralization that exacerbated a long-standing pattern of polarization and poverty[34] and deepened Haiti's economic dependence on the United States.[35]

Increased US support for the totalitarian regimes of François and Jean-Claude Duvalier accelerated the island's economic deterioration, political polarization, and military repression. As a result, upper-class families—many the political opponents of Duvalierism—began immigrating to the United States in 1957, followed by urban middle-class Haitians.[36] By 1971, when the presidency passed from François Duvalier to his son Jean-Claude, legal and illegal immigration northward had increased.

The United States shrank from this new class of immigrants, dismissing the most recent arrivals from Haiti as "economic" rather than political refugees. The Immigration and Naturalization Service (INS) disproportionately detained and deported those who arrived illegally.[37] During Jean-Bertrand Aristide's short tenure as Haiti's first democratically elected president, US practice remained unchanged: of those Haitians applying for asylum from 1990 to 1991, only three (0.2% and 0.1% of applicants, respectively) were accepted.[38] Actually, the percentage of asylum seekers who were granted admission is relatively low for all countries; for example, in 1990 and 1991, 247 Cubans (0.9% and 0.6% of applicants, respectively) and 1840 Nicaraguans (3.6% and 1.2% of applicants, respectively) were granted asylum.[39] Because many applications for asylum are pending at the end of each year (typically more than 60% of cases for these three countries), the percentage of applicants denied admission may be more telling. Compared with 368 (33%) Haitians denied asylum in 1990, 387 Cubans (2%) and 7460 Nicaraguans (19%) were rejected. In 1991, 100 Haitians (12%) were denied asylum, compared with 128 Cubans (0.9%) and 1727 Nicaraguans (6%).

The United States did not have a Haitian refugee program until mid-1992[40]; prior to that time, all Haitians who fled to the United States by boat were considered to be potential asylum seekers. Therefore, if the asylum data for Haiti are compared with refugee data for Cuba and Nicaragua, it appears that refugees from communist nations have received a comparatively warm welcome: 6003 (56%) of Cuban applicants and 939 (47%) of Nicaraguan applicants were granted refugee status from 1989 to 1991.[41]

Concern that a Haitian exodus might swamp the United States deepened when Aristide was thrown from power in a bloody army coup in 1991. Indeed, fearing the political persecution and economic devastation that often goes hand in hand with such events,[42] more than 40 000 Haitians attempted to enter the United States by boat[43] from the time of the coup until January 1993. In May 1992, President George Bush formalized the US position on Haitian refugees when he ordered the US Coast Guard to repatriate all Haitians found headed toward the United States by sea[44]; 75% of the fleeing Haitians were intercepted and returned to Haiti. By 1992, the political and economic imperatives to pursue policies of Haitian containment had gained even greater impetus through the HIV epidemic.

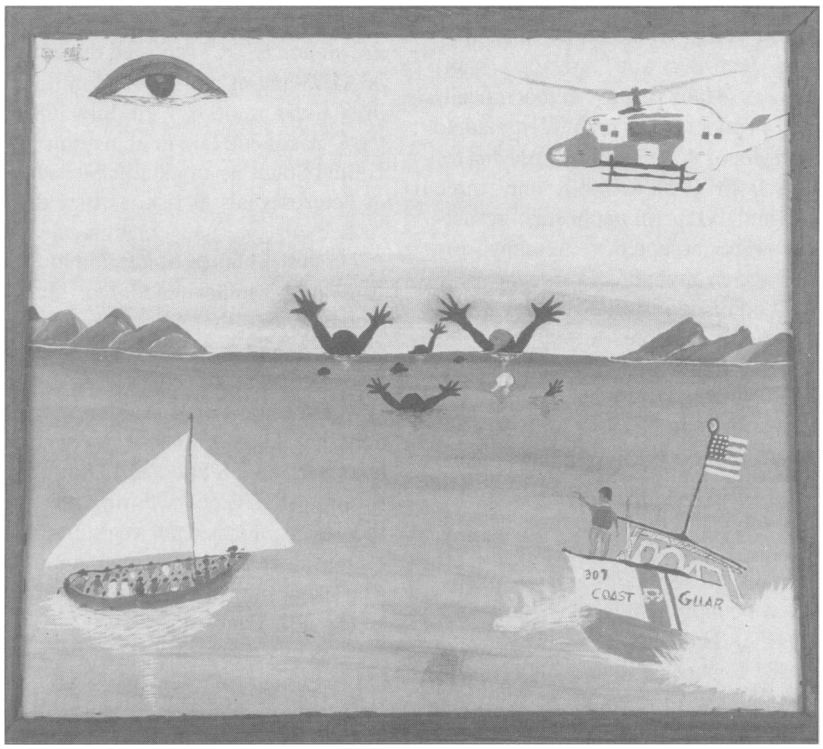
Blood and Soil

The Centers for Disease Control and Prevention (CDC) reported the first cases of AIDS among gay men and intravenous drug users in 1981.[45] In July 1982, the CDC classified Haitian immigrants to the United States as an identifiable subgroup of heterosexuals at risk, as they demonstrated an unusually high incidence of AIDS in the United States and in Haiti.[46] And in the following March, the CDC recommended that recent Haitian immigrants to the United States and members of other high-risk groups (i.e., gay men and intravenous drug users) refrain from donating blood.[47] These recommendations became US Food and Drug Administration (FDA) policy during 1984, when the FDA informed all registered blood establishments that Haitian immigrants who came to this country after 1977 should not donate blood.[48]

As evidence emerged regarding the international prevalence of AIDS, the FDA extended the blood ban in 1986 to include individuals emigrating from central African countries.[49] On February 5, 1990, the FDA's Center for Biologics Evaluation and Research extended the ban to persons from sub-Saharan African nations. In addition, all Haitians, regardless of their year of immigration, were asked not to donate blood or blood products.[50]

The AIDS epidemic did not represent the first instance in which epidemiology used the language of risk groups, nationality, or race to define the parameters of a disease. Yet for the first time, epidemiology became prominent in the attempt to contain the blood of particular nationalities. Consequently, the CDC's construction of risk-group classifications has been carefully scrutinized. Historian Gerald Oppenheimer concludes that the early epidemiological construction of AIDS as a disease associated with particular risk groups at the margins of society rather than with specific risk behaviors that were independent of group membership fostered stereotypes of gay men, intravenous drug users, and Haitians as engaging in promiscuous, irresponsible, and uncontrolled sexual and drug-using behavior.[51]

Nevertheless, in designating risk groups, the CDC drew on a logic that was neither manifestly racist nor homophobic. The designation was an epidemiologically plausible means of identifying those at risk in the absence of a diagnostic test for HIV, for in the case of both gay men and



"Rescue at Sea," by Nozier Elie. This acrylic painting by one of several artists detained at Guantanamo Bay depicts the flight of Haitians by boat. In the upper lefthand corner, the eye of God watches. Photo courtesy of Victoria Sharp, MD, director of the Spellman Center, St. Clare's Medical Center, New York.

intravenous drug users, group membership was also associated with particular risk behaviors. The classification of "IVDU," for example, implies drug use. In the case of Haitians, however, the risk group classification merely indicated an epidemiological association, and the CDC openly acknowledged that "very little is known about risk factors for Haitians with AIDS."[52] By 1986, the only risk factor the CDC could define for Haitians was heterosexual sex, and, as the FDA explained, "for the vast majority of potential donored, risk from heterosexual contact is more difficult to identify than risk from homosexual behavior or [intravenous] drug use,"[53] making deferral of Haitians and others from high-seroprevalence countries more reasonable than deferral of all sexually active heterosexuals. Perhaps, as physician and anthropologist Paul Farmer suggests, the CDC was lax in its failure to investigate aggressively the mode of transmission among Haitians,[54] but until the Pan American Health Organization began registering AIDS cases in the Caribbean in 1984, there was little evidence available to indicate that other countries had equally high or higher incidence rates.[55] The CDC had to balance scientific uncertainty regarding the causes of AIDS among Haitians against the need to protect the blood supply after it became apparent that transfusion recipients and hemophiliacs were at risk for AIDS.[56] And, indeed, when recommending that members of designated risk groups self-defer from donating blood, the CDC emphasized that "each [risk] group contains many persons who probably have little risk of acquiring AIDS."[57]

The Legacy of Language

While risk group terminology may have been based on competent epidemiology, it was not the basis for sound public policy. As Oppenheimer observes, "risk designation was, in effect, synonymous with carrier status, even among scientists, not to speak of the news media and among the general public."[58] Public health policy based on epidemiological categories suggested that "the disorder could be contained at the boundaries, among people who were 'different' from the majority but undifferentiated within each of the 'high-risk' groups."[59]

As part of a critique of using the biomedical model to conceptualize AIDS, Elizabeth Fee and Nancy Krieger note the grim irony of successfully applying risk group designations: risk group terminology does not simply reflect behavior; it reveals the historical, social, economic, and political relationships that have shaped the behavioral responses of a particular group. Thus, they argue, using risk group categories as the basis of public policy focuses on behavior out of context and reinforces stereotypes.[60] Accordingly, because race or nationality can imply particular behaviors, the exclusion of Haitians and Africans from the pool of blood donors based on risk group terminology reinforced the traditional sexual stereotype of the Black as the indolent indigent incapable of controlling a voracious sexual appetite, making him or her susceptible to venereal disease.[61] The stereotype of the Haitian was compounded by the exotic: a foreigner practicing voodoo, fantastic sexual rituals, or cannibalism, all of which intimate an unnatural exchange of blood.[62] Internationally, African nations banned from donating blood have borne a similar stigma, for Western nations have assumed them to be characterized by an erotic, bizarre, and promiscuous sexuality.[63]

Neither the introduction of the HIV antibody test in 1985, which federal officials feared would fail to screen out individuals in the window period before development of detectable antibodies, nor accumulating evidence discrediting the blood ban could compete with the persistent preoccupation with race and nationality. By 1988, World Health Organization data showed that Haiti had a lower rate of AIDS than the Bahamas, Bermuda, Guadeloupe, Trinidad, Tobago, and the United States.[64] In addition, Haiti had a higher or equivalent ratio of cases among men compared with women than the Bahamas, French Guiana, Honduras, and the Dominican Republic, demonstrating that Haiti did not have a remarkably high incidence of heterosexual transmission.[65] Yet while other regions, both within the United States and in Mexico and Puerto Rico, had shown increasing rates of heterosexual transmission of HIV,[66] none was included in the blood ban. Thus, those who opposed the FDA's ban on blood donors agreed that whatever justification existed in 1983, there remained no scientific basis for singling out Haitian blood donors.

Although the FDA dropped the ban in 1990, the epidemiological portrait of Haitians and the resulting public policy had already taken a toll. HIV was viewed as the fruit of promiscuity, and any group identified as being at risk for developing AIDS came to be perceived as promiscuous, irresponsible, reckless.[67] Discrimination against Haitian immigrants was widespread in New York and Miami,[68] and the repercussions reached beyond US borders. The epidemiological construction of Haiti as a diseased country dealt a ruinous blow to what was once Haiti's leading industry—tourism—and thereby contributed to the country's growing poverty.[69] Poverty, in turn, increased the extent and profitability of prostitution catering to North American gay tourists and added fuel to the epidemic's fire.[70]

Guantanamo Bay: From Cordon Politique *to* Cordon Sanitaire

Before 1992, the United States had pursued three strategies of Haitian containment: political, during the marine occupation from 1915 to 1934; economic, through repatriation of refugees during the Duvalier regimes; and public health, in the form of the FDA blood ban during the early years of the AIDS epidemic. Thus although immigrants from Third World countries, African countries, and the Caribbean have all informed perceptions of the risks and costs of HIV infection and helped to shape the US policy of excluding those infected with HIV, the story of Haitian immigrants gives coherence to the modern history of HIV exclusion, for Haitians connect the stories of the exclusion of blood and the exclusion of bodies, providing a more synthetic understanding of the US attempt to contain diseased nationalities.

Prior to the 1992 executive order to repatriate all Haitians intercepted at sea, the US Coast Guard had routinely intercepted Haitian boats bound for the United States. For each individual in those boats, the Coast Guard conducted preliminary shipboard screenings to assess the validity of the Haitians' requests for political asylum in the United States. Those seeming to qualify were taken to the US marine base at Guantanamo Bay, Cuba. As of November 22, 1991, the INS took over the procedures and began using a lenient "credible fear of return" standard in screening the intercepted Haitians. Those who passed this hearing were deemed eligible for political asylum and taken to the United States to file a formal application.[71]

US immigration law does not mandate HIV testing for asylum seekers who apply within the United States or at a US border as it does for individuals who apply for refugee status at a US embassy in their own country of residence. If individuals who reach the United States before applying are subsequently granted asylum, they are allowed to live in the United States for 1 year, after which those wishing to remain must test for HIV as part of the application for legal residence. But after Haitians accepted for asylum by Belize and Honduras tested positive for HIV, the United States began to test all Haitians previously classified as "screened in." Unwilling to admit any HIV-infected Haitians into this country, the INS established a second interview for all those who tested positive. During these interviews, it used a stricter qualification standard: the refugees now had to demonstrate a "well-founded fear" of return to Haiti. Notably, the INS refused to allow the Haitians legal counsel during these interviews, contrary to common practice in the United States. At that time, 115 of the HIV-positive Haitians were still deemed eligible for asylum and were segregated at Guantanamo's Camp Bulkeley. Much like prisoners, the confined Haitians wore bar-coded identification bracelets, were subjected to unannounced military sweeps by soldiers in riot gear, and were often incarcerated in the brig or smaller sections of the camp (Camp 7 or Camp Alpha) for breaking camp rules.[72]

While Haitian repatriation has roots in US political history, the Coast Guard patrol around Haiti and Guantanamo Bay transformed a *cordon politique* into a *cordon sanitaire.* By 1993, more than 200 HIV-positive refugees and their families had been detained in the overcrowded and unsanitary quarantine camp surrounded by razor barbed wire at Guantanamo Bay.[73] Some of the earliest arrivals had already been interned for more than 2 years. Those held at the base were well aware of their differential treatment and the fears that inspired it. "One thing I have noticed since the beginning of history," observed one woman held at the camp, "is that white people have been trying to create another planet where they can put us in order to separate us. . . . I think they are trying to create that planet now, and they are starting with the Haitians."[74] While this is not an unreasonable reaction from someone imprisoned in a quarantine camp, Guantanamo Bay represented something other than an attempt at racial separation; it represented protection from a nation perceived to carry the germ of physical dissolution and economic deterioration.

After the Haitians held in Guantanamo Bay resorted to a hunger strike, hoping to inspire immediate federal intervention, INS spokesman Duke Austin cast a dark shadow on the protest, warning, "Dissident behavior will not be rewarded."[75] Similarly, Perry Rivkind, also of the INS, equated the HIV threat posed by immigrants with broader forms of socially unsanctioned behavior and indicated that, "like any other people who have a communicable disease or any other kind of defect—a criminal offense, insanity, etc.—they [the infected immigrants] would be placed under deportation."[76]

In June 1993, a federal district court judge in Brooklyn ordered the federal government to release the Haitians detained at Guantanamo Bay. Judge Sterling Johnson ruled in part that the INS and US Department of Justice had improperly denied the Haitians legal counsel and adequate medical treatment in addition to imposing indefinite detention, violating their constitutional right to freedom of speech under the First Amendment and their right to due process under the Fifth Amendment. In addition, Johnson ruled that the INS and the attorney general violated administrative procedures of the Immigration and Nationality Act in screening the Haitian immigrants. In his ruling, the judge concluded that

> the detained Haitians are neither criminals nor national security risks. Some are pregnant mothers and others are children. Simply put, they are merely the unfortunate victims of a fatal disease. The Government has failed to demonstrate to this Court's satisfaction that the detainees' illness warrants the kind of indefinite detention usually reserved for spies and murderers.[77]

The Clinton administration, while reserving the right to appeal portions of the ruling, agreed to release the Haitian refugees to the United States.[78]

Meanwhile, the United States continued to pursue a political solution to Haiti's unresolved governmental crisis. To gain the military's participation in negotiations with the deposed President Aristide, the United States and United Nations invoked drastic economic sanctions against Haiti.[79] Such sanctions not only put pressure on the regime[80] but also deepened the economic and political woes of

an already impoverished nation.[81] Consistent with its commitment to eliminate the problem of fleeing Haitian refugees at its source, the Clinton administration maintained President Bush's policy of repatriating without a hearing all Haitian refugees intercepted on the high seas. A US Supreme Court decision of late June 1993 that upheld the administration's right to repatriate Haitian refugees[82] may have helped ensure that the federal government would erect no more HIV quarantine camps for Haitians; but, in addition to sustaining the US policy of "forcibly driving [Haitian refugees] back to detention, abuse and death,"[83] the decision reinforced what one advocate has termed a "Haitians-only [immigration] policy."[84] The Clinton administration began granting Haitians shipboard hearings again in June 1994 after violence in Haiti escalated.[85] Although Guantanamo Bay was also reopened, some have returned to Haiti in the wake of the US military intervention aimed at returning Aristide to power. We remain, however, no closer to a reasonable policy for Haitian refugees or HIV-infected immigrants.

HIV Exclusion: Containing Diseased Nationalities

Haiti has arguably experienced the extreme of US exclusionary policy, yet assumptions about many different nations and immigrants as a class have characterized the development and justification for HIV exclusion from the outset. In short, US policy was designed and has received broad sanction not as a "Haitians only" policy, but as an "immigrants only" policy.

The origins of the Guantanamo Bay episode date back to 1986, when the Public Health Service sought to add AIDS (and eventually HIV) to the list of diseases for which immigrants could be excluded,[86] contending that AIDS affected an individual's wage-earning capacity. The Public Health Service was preempted, however, by Sen Jesse Helms on June 11, 1987, when he successfully introduced legislation adding HIV to the list of "communicable diseases of public health significance."[87] Although the Government Accounting Office concluded in 1990 that the Secretary of Health and Human Services (HHS) retained the authority to remove HIV from the list of excludable diseases,[88] HHS Secretary Louis Sullivan did not act immediately.[89] Sullivan chose to wait for Congress to grant him explicit authority to review the list as a provision of the Immigration and Nationality Act of 1990. In 1991, Sullivan announced his intentions to designate only infectious tuberculosis as a "communicable disease of public health significance" for which immigrants, refugees, travelers, and visitors* to the United States could be banned.[90]

Congressional pressure from Rep William Dannemeyer and Sen Jesse Helms soon followed.[91] Within the Bush administration itself, the US Department of Justice, which must approve any changes in immigration policy, opposed HHS in lifting the ban on HIV.[92] The resulting political stalemate rekindled questions about whether the Helms amendment applied to travelers as well as to immigrants; in the minds of many, there was a substantive distinction between the two.[93] As indicated by congressional debate in 1987, HIV exclusion applied only to immigrants.[94] Although the INS subsequently applied the ban to travelers, its regulations allowed travelers to apply for waivers, but it made no exceptions for immigrants. Thus, in 1991, 15 Republican congressmen asked Sullivan to consider removing the ban for travelers only.[95] Ultimately, despite expectations that it would either drop HIV from the list of excludable diseases or compromise and drop the ban for travelers,[96] the Bush administration instead simplified the waiver requirements and process for travelers and allowed immigrants with a spouse, parent, or unmarried child living in the United States as a citizen or permanent resident to apply for waivers. The American consuls in foreign countries no longer asked travelers applying for visas whether they were infected with HIV but rather relied on the individual traveler to self-disclose infection. Immigrants, on the other hand, would be tested for HIV.

There are significant practical distinctions between travelers and immigrants. While travelers with HIV may pose a public health risk equal to that of infected immigrants, they are not likely to become a burden on the US health care system. And there are important cultural and political differences between them as well. Most travelers to the United States are Western European[97] or Japanese citizens[98] of "respectable" social class. In contrast, the majority of immigrants between 1971 and 1990 arrived from Third World countries, Latin America, and the Caribbean.[99] Assumptions about class and Western culture played into the US distinction between travelers and immigrants. Specifically, the political and cultural clout of those groups who were the first to challenge the ban on HIV ensured not only that their treatment would be substantially different from that of infected immigrants, but also that US immigration policy would become the focus of international criticism.[100] But while the criticism of Western nations called attention to US immigration policy, ultimately this rebuke worked only to force concessions for infected travelers, leaving the status of infected immigrants largely unchanged.

In a well-publicized incident, INS officials detained for 6 days a Dutch citizen en route to the 7th National AIDS Forum and 11th National Lesbian and Gay Health Conference in San Francisco after finding the antiretroviral drug azidothymidine (AZT) in his luggage. The agency denied Hans Paul Verhoef a waiver to travel after also finding in his belongings sex paraphernalia that "could be used in sexual activities involving single or multiple sexual partners."[101] Refusing to return home, Verhoef persisted in challenging US policy. While an immigration judge overturned the INS ruling, he also required the Dutch citizen to post $10 000 bond and promise to leave the United States within 3 weeks. Accepting Verhoef's stated intention not to have unsafe sex while in the United States, the judge noted that "he's a public official (in the Netherlands)." Verhoef's political and social standing as a credible public official undeniably secured his release. More significantly, until the Verhoef incident in 1989, the import of HIV exclusion remained largely unrealized.[102] Verhoef's case alerted the international AIDS community—many of whom were HIV infected—to the problems that US immigration policy would pose for them as they attempted to enter the country for future conferences.

The Sixth and Eighth International AIDS conferences planned for San Francisco and Boston, respectively, intensified international criticism of the exclusionary US immigration policy. In protest over the ban, nearly 100 organizations and countries boycotted the Sixth International Conference in San Francisco in 1990.[103] Significantly, while protests and threats of boycotts resulted in an executive order waiving the ban for all individuals attending that conference, conference organiz-

*Although US immigration law lists travelers and visitors as two categories of nonimmigrants, we use the term *travelers* here to mean both travelers and visitors.

ers attributed this success, in part, to limiting protest to the question of travel rather than immigration.[104] But compromises were not enough to save the 1992 International Conference. After the Bush administration failed to drop the ban on HIV in 1990, Harvard University was forced to move the conference from Boston to Amsterdam, for while the boycott had not devastated the 1990 conference, it was sure to do so in 1992.[105] Moreover, conference organizers felt they could not guarantee the safety and confidentiality of infected conference attendees as they entered the United States.[106] Again attention focused on the plight of travelers almost to the exclusion of immigrants.

The Clinton administration attempted to lift the ban on HIV in February 1993, when HHS Secretary Donna Shalala proposed dropping HIV from the list of excludable diseases.[107] This move touched off a reaction in the US Senate, which voted 76 to 23 in favor of an amendment to the National Institutes of Health (NIH) reauthorization bill codifying the ban on HIV-infected immigrants. As in 1987, the Senate debate maintained the distinction between travelers and immigrants. In the words of the amendment's sponsor, "there is a big difference" between the two groups.[108]

The Senate vote was promptly followed by similar action in the House of Representatives, which on March 11, 1993, voted by an overwhelming majority to instruct its conferee members to honor the Senate amendment. Both houses of Congress passed the NIH reauthorization bill after it came out of the conference committee, and President Clinton signed it into law in June.[109] Despite the optimism of some, such as Rep Henry Waxman from California, that the bill would exempt infected refugees, travelers, and immigrants already living in the United States,[110] the final legislation provided no such exemptions. Rather, as stated in the Conference Report, the legislation represented "a codification of current administrative practice."[111]

Medical and public health organizations almost uniformly agree that the exclusion of HIV-infected immigrants is an ill-advised public health policy.[112] But in the absence of a valid public health rationale, what has informed the current legislation? Rep Robert Dornan from California offers a clue:

> This is a pandemic of a venereal disease. Because AIDS is a politically protected disease, you never hear it referred to the way it was referred to on this floor in 1985, 1986, and 1987 when we called it a venereal disease. That is because whatever constructed our current politically correct language about AIDS kicked in drug users, innocent hemophiliacs, and people with blood transfusions, and since it is only 75 percent transmitted by hetero and homo sex, we do not refer to it as a venereal disease. But it is. Therefore, what we are talking about is letting people into this country in their young years—look at the profile of Haitians—in their young years, what liberals call raging hormone-sexually active years, into this country with a communicable venereal disease that is always fatal. I am not just isolating this disease or isolating Haitians. If they were all little redheads from Ireland I would still say: 'I am sorry, this is not the world's open hospital for people who cannot pay. That is an Irish problem.' It is a Haitian problem.... But we cannot let in people with a venereal disease that is communicable. That would kill Americans, and it is stupid.[113]

Rep Dornan may not have intended to isolate Haitians with the ban on HIV, but he clearly does conceive of Haitians as posing a threat to the health of Americans. Strikingly, Dornan—himself a redheaded Irishman—contrasts the implied sexual licentiousness of the Haitians with the stereotypical destitution of the Irish, whom he characterizes as viewing the United States as a source of free medical care. In Dornan's analysis, we must worry about the infected immigrant's inability to control his sexual behavior and expectation of free health care in the United States.

In an analysis of the Senate debates, the *New York Times* asserted that any prejudicial thinking on the part of our congressmembers cannot alter the legitimacy of their arguments: "Whatever their political motives, and whatever whiff of homophobia is in the air, Senate Republicans have raised serious cost and risk questions that need to be addressed."[114] Nevertheless, even a whiff of racism or homophobia can subtly, but substantially, alter the substance of economic and public health rationales.

According to Sen Orrin Hatch of Utah, exclusion of HIV-infected immigrants is purely "a question of the need to evaluate properly the economic impact of immigration and AIDS."[115] Similarly, the issue is quite straightforward to a representative of the American Medical Association, which endorsed the ban on immigrants but not on travelers, citing the potential economic burden that infected immigrants pose: "We simply cannot afford this policy.... We do not need any more AIDS patients."[116] But while the political imperative to consider the costs of immigration policy may in itself be impartial, the economic arguments employed to justify the exclusion of HIV-positive individuals have often rested on assumptions about the nature of immigrants infected with HIV.

Sen Don Nickles of Oklahoma, who introduced the ban into the Senate in 1993, was explicit about his assumption that infected immigrants are bound for destitution:

> If we change this policy we are going to have countless thousands of people who will want to emigrate to the United States, knowing we have quality health care and knowing we will take care of them. Uncle Sam will take care of them, the taxpayers will take care of them at enormous expense, ... [providing] health care for countless thousands who do not have health insurance, countless people who are right now struggling to pay their health care bills.[117]

In similar fashion, Rep Cliff Stearns of Florida asked, "Before we open the doors to just anyone, would it not be a matter of sound public policy to take care of our own citizens, afflicted with the HIV/AIDS virus, before adding infected immigrants to the public charge?"[118] Assumptions about the earning ability of immigrants were not limited to Congress; the CDC,[119] Justice Department,[120] HHS,[121] and members of Congress reportedly received more than 100 000 letters supporting the ban and questioning how the United States can afford to pay for the health care of HIV-infected immigrants.

Like others fearing the collapse of our health care system, the *New York Times* revealed hidden attitudes toward immigrants, assuming that the United States would have to pay for the health care costs of every infected immigrant: "At an average cost of $100 000 to treat an AIDS patient from infection to death, the admission of 700 infected immigrants each year would commit the nation to $70 million for their lifetime treatment."[122] No immigrant, the editorial implies, can be expected to pay for one cent of his or her medical expenses.

There Are No Islands: Immigration in an Era without Borders

The construction of dangerous nations or races and their systematic exclusion through the use of national borders may satisfy a psychological need, may

make us feel safe. Still, policymakers are compelled to evaluate not only the social implications and consequences of such policies, but also their efficacy and public health merit. While the Immigration Restriction Act of 1924 may have effectively cut off the flow of immigration until 1965, when the Celler Act reversed the immigration quotas,[123] it is illusory to believe that current immigration policy will accomplish a similar goal. A transportation and travel revolution has fundamentally changed the nature of national borders in the past 20 years.[124] Legal and illegal immigrants to the United States number in the millions each year, and international tourists number in the tens of millions. In 1992 alone, it is estimated that 44.5 million people visited the United States.[125] In the words of Austria's director of immigration, "There are no distances any longer in this world. There are no islands."[126]

AIDS cannot be contained with porous borders.[127] Thousands of HIV-infected illegal aliens already live in the United States. Estimates of the number of HIV-infected immigrants who come to this country vary. In 1989, out of 397 000 immigrants applying for permanent residency, 442 tested positive for HIV.[128] By 1991, the National Commission on AIDS estimated that between 300 and 600 individuals with HIV would immigrate to the United States each year[129]; other estimates range from 200 to 3500 infected immigrants annually.[130] Many other immigrants are infected after their arrival. And illegal immigration to this country will continue unabated. These individuals will not be tested for HIV unless they choose to apply for permanent residence. Otherwise, undocumented immigrants who believe themselves to be at risk for HIV infection will continue to be driven underground—away from public health care, HIV testing and counseling, and treatment programs—by a justified fear of deportation.[131]

A just and rational immigration policy regarding HIV-infected immigrants must consider practical public health and economic considerations. But it must also resist the stereotype of the diseased foreigner. Policymakers cannot deny that HIV/AIDS is expensive and often debilitating. Many of those infected will be unable to shoulder medical expenses alone throughout their entire illnesses. As discussed, economic arguments in both the Senate and House debates carried considerable weight in securing the passage of legislation restricting the HIV-infected immigrant. Nevertheless, only contradictory data exist on the overall burden that immigrants, whether infected or not, impose on the economy. The debate has centered around whether immigrants contribute more in taxes and spending than they extract in benefits such as education, health care, or welfare. Several recent studies suggest that immigrants are overrepresented on the welfare roles; that undocumented immigrants and their children pose an additional, unacceptable burden on American taxpayers; and that immigrants—legal and illegal—displace American workers.[132] Yet for each unfavorable report concerning immigrants, another favorable one can be found: immigrant taxes exceed immigrant welfare expenditures, only a small fraction of undocumented immigrants receive any welfare or social security entitlements, the employment rate of all immigrants exceeds that of the native population, and illegal immigrants avoid public services for fear of being detected.[133] Given the limited data with which to work, the many different variables that can be factored in or ignored,[134] and the assumptions researchers are willing to make, estimating the economic impact of immigration will remain difficult.[135]

While codifying the exclusion of immigrants with HIV, the Nickles amendment acknowledged the lack of evidence regarding the economic potential of HIV-infected individuals by calling for an "assessment of the anticipated costs of the admission to the United States of persons with HIV to public health care programs."[136] Given that individuals with HIV may offer more than 10 years of economic productivity,[137] the blanket assumption that every infected immigrant is doomed for destitution and will eventually turn to the government for financial support is at present unfounded. Indeed, since the inception of the Immigration and Nationality Act of 1990, of the 173 infected immigrants who had applied for a waiver as of February 1993, only 3 had been denied on the grounds that they were likely to become a public charge.[138] If US immigration policy excluding HIV-infected immigrants is based on the threat of an overburdened health care system, the failure to erect equal barriers against people with other expensive chronic ailments such as heart disease, diabetes, or end-stage renal disease, as was noted by both senators and representatives opposing HIV exclusion, calls the objectivity of economic rationales into question. Senator Nickles claims that the difference between HIV and cancer or heart disease is communicability: "[HIV] is a communicable disease—it is spread."[139] Yet as Sen Edward Kennedy points out, such a rationale is inconsistent with Sen Nickles' leniency toward visitors: "If you believe that HIV is a health risk, then they [visitors] endanger the public health of the American people every bit as much as immigrants."[140]

Immigration law has allowed the exclusion of individuals "likely to become a public charge" since 1882. And since 1891, immigration law has restricted the entry of those with "loathsome or ... dangerous contagious disease[s]." Unlike tuberculosis, which is acquired passively by breathing (something individuals can hardly avoid), HIV is not readily transmissible.[141] HIV illness is undeniably expensive, and no one can say what economic toll infected immigrants might exact. Yet Congress has opted to designate HIV as a "communicable disease of public health significance" rather than attempt to exclude HIV-positive individuals using the public charge criterion.[2] Clearly, the conceptual boundary distinguishing HIV as a public health threat from HIV as an economic threat has lost its meaning.[142] Its dissolution has been precipitated by the stereotypical image of the infected immigrant as both sexually uncontrolled and financially dependent. □

Acknowledgments

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References

1. Quarantine—one of the oldest methods of forestalling epidemic disease dating back to the 14th century—erected broad barriers against disease and was not intended to screen out individual, infected immigrants or travelers. In the United States, the quarantine functions of the Public Health Service remained distinct from medical examination of individual immigrants for infectious disease after 1891. R.C. Williams, *The United States Public Health Service, 1798–1950* (Washington, D.C.: U.S. Government Printing Office, 1951), 63–69, 79–81, 84–85, 100–112.
2. Chap. 376, 22 Stat. 214 (47th Cong., 1st sess.; 1882).
3. Public, no. 162, Chap. 1012, 32 Stat. 1213 (57th Cong., 2nd sess.; 1903).
4. E. Yew, "Medical Inspection of Immigrants at Ellis Island, 1891–1924," *Bulletin of the New York Academy of Medicine* 56 (June 1980): 488–510.
5. Chap. 551, 26 Stat. 1084 (51st Cong., 2nd

sess.; 1891). "Loathsome" diseases included "those whose presence excites abhorrence in others, and which are essentially chronic, such as favus, ringworm of the scalp, parasitic fungus diseases, Madura foot, leprosy and venereal disease. Dangerous contagious diseases are such as trachoma, filariasis, hookworm infection, amoebic dysentery, and endemic hematuria." A.C. Reed, "The Medical Side of Immigration," *Popular Science Monthly* 80 (1912): 388.

6. Williams, *Public Health Service.* Although the Public Health Service was responsible for the medical inspection of immigrants at many ports of entry, the practice has been well documented only for Ellis Island, the nation's largest port of entry.
7. At Ellis Island, first-class passengers were not inspected or were given a cursory inspection aboard ship; second-class passengers were not inspected until 1898. Steerage passengers were inspected in a procedure called "the line." While the inspection procedure varied slightly over time and among individuals, the general pattern was that as immigrants entered the main building, often carrying heavy baggage, they formed two lines leading to the stairs where physicians assessed their general condition, facial expressions, posture, and gait as they approached. At the head of the lines, physicians turned back the eyelids of each immigrant with a buttonhook to check for trachoma and then inspected the scalp for favus. Physicians also quickly checked for physical deformities and assessed eyesight, mental condition, and intelligence, placing a chalk mark on the clothing of the immigrants to designate any suspected "defect." These "marked" immigrants were then held for more extensive medical examinations. A confirmed diagnosis was certified as either class A (loathsome or dangerous contagious diseases legally requiring exclusion), class B (diseases likely to interfere with an immigrant's ability to earn a living), or class C (conditions less serious than either class A or B, such as pregnancy, which nonetheless required a record). Primary source descriptions of inspection procedures include S.B. Grubbs, *By Order of the Surgeon General* (Greenfield, Ind.: Mitchell, 1943); Reed, "Medical Side." Secondary source descriptions include A.M. Kraut, "Silent Travelers: Germs, Genes, and American Efficiency, 1890–1924," *Social Science History* 12 (Winter 1988): 377–394; Yew, "Medical Inspection"; F. Mullan, *Plagues and Politics: The Story of the United States Public Health Service* (New York, N.Y.: Basic Books, 1989); and R.T. Solis-Cohen, "The Exclusion of Aliens from the United States for Physical Defects," *Bulletin of the History of Medicine* 21 (1947): 33–50.
8. Historian Alan Kraut notes that at Ellis Island, the percentage of immigrants debarred for medical reasons rose from under 2% in 1898 to nearly 70% by 1916, reflecting not only improvements in diagnostic techniques but also a growing medical imperative to restrict immigration. Kraut, "Silent Travelers," and A. Kraut, "Silent Strangers: Germs, Genes and Nativism in John Higham's *Strangers in the Land," American Jewish History* 76 (1986): 142–158.
9. A.M. Kraut, *Silent Travelers: Germs, Genes, and the "Immigrant Menace"* (New York, N.Y.: Basic Books, 1994). There is evidence that examinations to identify "feebleminded" or insane immigrants resulted in the disproportionate exclusion of Jews, Hungarians, Italians, and Russians at Ellis Island during the second decade of the 20th century. Notably, exclusion on the basis of mental status did not have roots in bacteriology but rather in psychology and eugenics. S.J. Gould, *Hen's Teeth and Horse's Toes* (New York, N.Y.: W.W. Norton & Company, 1983).
10. Yew, "Medical Inspection." In addition, both Yew and Kraut indicate that Public Health Service physicians at Ellis Island were singularly reluctant either to sit on the Board of Special Inquiry, which made final decisions regarding exclusion, or to determine whether medical conditions might cause immigrants to become a public charge.
11. Nevertheless, even at Galveston, the proportion of deported Jews did not exceed the overall proportion of deported immigrants until 1914. B. Marinbach, *Galveston: Ellis Island of the West* (Albany, N.Y.: State University of New York Press, 1983). Among Jews at Ellis Island, the proportion of exclusions based on medical certification for either favus or trachoma was quite low at 0.003%. Kraut, "Silent Strangers," and Kraut "Silent Travelers."
12. As one Public Health Service surgeon stationed at Ellis Island stated, "Immigration should be restricted absolutely to such races as will amalgamate, without lowering the standard of our own national life.... In general, immigrants from the Mediterranean countries should be excluded, especially those from Greece, South Italy and Syria, as well as most Hebrews, Magyars, Armenians and Turks." Reed, "Medical Side," 391. The Public Health Service was increasingly charged to act as an agent of exclusion. Kraut argues that in 1903 and in 1907, physicians were given increased imperative to exclude those likely to become public charges, despite protests that such determinations went beyond the scope of medical judgment. Kraut, "Silent Strangers," 147–148.
13. Yew, "Medical Inspection"; Kraut "Silent Strangers."
14. J. Higham, *Strangers in the Land: Patterns of American Nativism 1860 to 1925* (New York, N.Y.: Atheneum, 1967).
15. R. Hofstadter, *The Age of Reform* (New York, N.Y.: Vintage Books, 1955).
16. D.H. Bennett, *The Party of Fear: From Nativist Movements to the New Right in American History* (New York, N.Y.: Vintage Books, 1990).
17. The term *eugenics* was coined by Francis Galton, cousin of Charles Darwin, in 1883. As historian Nancy Leys Stepan argues, for some eugenicists better breeding involved not only improving the genetic quality of the human race by encouraging the reproduction of the "fit" and discouraging that of the "unfit," but also preserving the genetic purity of "superior" races. N.L. Stepan, *In the Hour of Eugenics: Race, Gender, and Nation in Latin America* (Ithaca, N.Y.: Cornell University Press, 1991).
18. D.J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (Berkeley, Calif.: University of California Press, 1985); K. Ludmerer, *Genetics and American Society: A Historical Appraisal* (Baltimore, Md.: The Johns Hopkins University Press, 1972).
19. *Immigration Restriction Act of 1924,* Public, no. 139, chap. 190, 43 Stat. 153 (68th Cong., 1st sess.; 1924).
20. D. Holstrom, "The New Americans," *Christian Science Monitor,* June 17, 1992, 9, 12.
21. J. Dillin, "Migration to US Expected to Break Record in '90s," *Christian Science Monitor,* November 21, 1991, 8.
22. P. Brimelow, "Time to Rethink Immigration?" *National Review,* June 22, 1992, 30–32, 33–42, 44–46; U.S. House Committee on Ways and Means, *Use of Social Security Number as a National Identifier: Hearing before the Subcommittee on Social Security of the Committee on Ways and Means,* 102nd Cong., 1st sess., February 27, 1991, 148.
23. J. Dillin, "The U.S. Welcome Mat Showing Wear," *Christian Science Monitor,* May 20, 1992, 8; J. Benson, "The Melting Pot in the 1990s: The Glue of Shared Values Still Holds," *Christian Science Monitor,* March 27, 1992, 11; M.J. Mandel, "The Immigrants," *Business Week,* July 13, 1992, 114–118, 120, 122; "The U.S. a Welfare Magnet," *FAIR Immigration Report,* November 1990, 4; "Immigrants Swell the Welfare Roles," *FAIR Immigration Report,* May 1990, 4.
24. "Tough Talk on Aliens," *New York Newsday,* August 10, 1993, 22.
25. "Alien-Bashing, Albany Style," *New York Newsday,* January 24, 1994, 34. Wilson proposes to deny health care, education, and other benefits to illegal immigrants, while Padavan's recommendations include a temporary moratorium on immigration and rescission of laws banning discrimination against aliens.
26. J. Friedman, "Deportation $," *New York Newsday,* February 4, 1994, 3; J. Friedman, "Clinton Getting Tough on Asylum," *New York Newsday,* January 25, 1994, 8.
27. A. Lewis, "The Politics of Nativism," *New York Times,* January 14, 1994, A29.
28. "Penalizing Immigrants," *New York Newsday,* August 23, 1993, 18.
29. Mandel, "Immigrants"; "The New Americans: Yes, They'll Fit In Too," *Economist,* May 11, 1991, 17–18, 20; A. Brinkley et al., eds., *American History: A Survey.* Volume 2: *Since 1865,* 8th ed. (New York, N.Y.: McGraw-Hill Inc., 1991); Holstrom, "New Americans"; Brimelow, "Rethink Immigration?"
30. M. Crichton, *Rising Sun* (New York, N.Y.: Knopf, 1992); J. Anderson, "How America Sees Japan, and Vice Versa," *New York Newsday,* January 14, 1993. See also J.W. Dower, *War without Mercy: Race and Power in the Pacific War* (New York, N.Y.: Pantheon Books, 1986), for an excellent

discussion of the American military perception of Japanese soldiers during World War II.

31. A. DePalma, "Mexican Official Rebukes U.S. on Chinese Aliens," *New York Times,* August 7, 1993, A14; D.J. Schemo, "Refugees Blocked from Getting Legal Help," *New York Times,* June 10, 1993, B4.
32. *Immigration and Nationality Act of 1990,* Public Law 101-649, Sec. 601(a)(i)(1990).
33. For in-depth accounts of U.S. involvement in Haiti, see M.-R. Trouillot, *Haiti, State against Nation: The Origins and Legacy of Duvalierism* (New York, N.Y.: Monthly Review Press, 1990), and P. Farmer, *AIDS and Accusation: Haiti and the Geography of Blame* (Berkeley, Calif.: University of California Press, 1992), 151–190.
34. Even after Haitian independence, the peasant farmers of the plantation system continued to provide financial support for the state in an exploitative system. Yet peasants had no political voice. Thus, as Trouillot argues, Haitian history is characterized by an increasing gap between civil and political society. Trouillot, *Haiti, State against Nation,* 16–17.
35. The nature of Haitian economic dependency on the United States is related to a reliance on a monocrop export (coffee) and a substantial trade deficit. While the United States was the major importer to Haiti, it in turn bought only a small percentage of Haitian exports. Trouillot, *Haiti, State against Nation,* 103–104.
36. N. Glick-Schiller and G. Fournon, "Everywhere We Go, We Are in Danger: Ti Manno and the Emergence of a Haitian Transnational Identity," *American Ethnologist* 17 (1990): 329–347.
37. Farmer, *AIDS and Accusation;* Glick-Schiller and Fouron, "Everywhere We Go."
38. The INS defines an asylee as an individual in the United States or at a U.S. port of entry who is unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution. U.S. Immigration and Naturalization Service, *Statistical Yearbook of the Immigration and Naturalization Service, 1991* (Washington, D.C.: U.S. Government Printing Office, 1992).
39. Duvalier's repudiation of communism in the early 1960s and subsequent repression of a nascent communist movement helped assure the United States of the necessity of totalitarianism as a protection against communism. It also secured U.S. economic, political, and military support—after a period of only lukewarm tolerance by the Kennedy administration during the Cold War—over the course of the two Duvalier regimes and beyond. Thus, a U.S. welcome for Haitian asylum seekers would have been inconsistent with public support for Haitian military governments. Asylum seekers and refugees from communist nations have apparently enjoyed the most leniency under U.S. immigration law although some question the accuracy of INS statistics, which cannot account for the number of potential applicants discouraged or otherwise prevented from filing an application. Personal communication, Committee to Aid Ethiopian Refugees, Inc., August 1993. In this paper, we have limited comparisons to Cuba, a communist country, and Nicaragua, a country portrayed as communist beginning with the Reagan administration; like Haiti, both are relatively close to the United States.
40. Unlike an asylee, a person seeking refugee status is outside of the United States. In some circumstances, the president may grant individuals residing within their country of nationality the ability to apply for refugee status. There has rarely been consensus regarding whether individuals fleeing Haiti should be considered asylees or refugees, especially once they are picked up by the U.S. Coast Guard or Navy or taken to a U.S. military base, such as the one at Guantanamo Bay. For the purposes of our discussion, we compare asylee data with refugee data when it makes conceptual sense to do so. While the distinction between asylees and refugees can be confusing when comparing data, it is not a distinction that should be overlooked, for classification as either has important ramifications for HIV testing.
41. In 1993, 2726 (83%) Cuban applicants and 5 (26%) Nicaraguan applicants were granted refugee status, compared with 1260 (16%) Haitian applicants. At the end of 1993, no refugee-status applications for Haitians were pending. Nevertheless, only about half of the 10 000 Haitians allowed to enter the United States since 1992 have applied for asylum. Asylum seekers are normally paroled into the United States for 1 year, during which time they must file an application. Because the agencies helping the Haitians file for asylum are dealing with an unusually large number of applicants, the INS has allowed them more time to file. More meaningful conclusions can be drawn once these asylum applications have been processed. U.S. Immigration and Naturalization Service, *Statistical Yearbook of the Immigration and Naturalization Service, 1989–1992* (Washington, D.C.: U.S. Government Printing Office, 1992). Unpublished data and information for 1993 was received from the Immigration and Naturalization Service, Statistics Division/COSTA, July 18, 1994. Notably, the numbers of Haitian refugee-status applicants do not include Haitian refugees interdicted at sea and returned to Haiti based on the INS prescreening procedure discussed in the text. Roughly 70% of some 35 500 Haitians interdicted at sea by the U.S. Coast Guard were returned to Haiti. *Haitian Centers Council v. Sale,* 823 F. Supp. 1028 (E.D.N.Y. 1993).
42. J. Dreyfuss, "The Invisible Immigrants," *New York Times Magazine,* May 23, 1993, 20–21, 80–82.
43. H.W. French, "Despite Plans, U.S. Refugee Process in Haiti is Said to Lag," *New York Times,* March 2, 1993, A13.
44. H.W. French, "Few Haitians Test U.S. Sea Barricade," *New York Times,* January 21, 1993, A8.
45. U.S. Dept of Health and Human Services, Public Health Service, Centers for Disease Control, *Reports on AIDS Published in the Morbidity and Mortality Weekly Report, June 1981 through February 1986* (Springfield, Va.: National Technical Information Services, 1986), 1–2.
46. Centers for Disease Control and Prevention, "Opportunistic Infections and Kaposi's Sarcoma among Haitians in the United States," *Morbidity and Mortality Weekly Report* 31 (1982): 353–361.
47. Centers for Disease Control and Prevention, "Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-agency Recommendations," *Morbidity and Mortality Weekly Report* 32 (1983): 101–103. For an analysis of the response of the gay community to the blood ban, see R. Bayer, *Private Acts, Social Consequences: AIDS and the Politics of Public Health* (New Brunswick, N.J.: Rutgers University Press, 1991).
48. Office of Biologics, National Center for Drugs and Biologics, *Memorandum to All Establishments Collecting Blood for Transfusions,* March 24, 1983.
49. In 1985 the CDC eliminated the designation of Haitians as a separate risk category, classifying Haiti instead as a "pattern 2" country characterized by heterosexual transmission of AIDS. No change was made in the FDA policy of banning Haitians from blood donation, despite the adoption of pattern 2 terminology and the development of a diagnostic test for HIV in 1985. Rather, the designation of pattern 2 was used to draw more countries under the ban. At the level of nations, such classification has served as an epidemiological summary of the predominant modes of HIV transmission: pattern 1 countries are characterized by homosexual transmission and pattern 2 countries, by heterosexual transmission. On an individual level, however, classification as pattern 2 may accomplish little more than masking a desire to differentiate the risk of heterosexually transmitted HIV in African and Third World countries from that in the Western world: "This difference between Patterns One and Two thus helps white, Euro-American heterosexuals evade the idea that they might themselves be vulnerable since African (and African-American) heterosexuality is so evidently different than Euro-American. Euro-American heterosexuality is 'not at risk' as long as . . . heterosexual AIDS remains distant." C. Patton, "From Nation to Family: Containing African AIDS," in *Nationalisms and Sexualities,* ed. A. Parker, et al. (New York, N.Y.: Routledge, 1992), 222. Thus it could be argued that designating *cases* as pattern 2, rather than as simply heterosexual, served to entrench social and sexual stigma by disguising stereotypes in the ostensibly neutral language of epidemiology. Notably, pattern 2 terminology was dropped from the CDC's reporting of AIDS cases by risk factor in March 1994. Centers for Disease Control and Prevention, "Heterosexually Acquired AIDS—United States, 1993," *Morbidity and Mortality Weekly Report* 43(1994):159.
50. C. Baillou, "Outraged Haitians Challenge FDA's AIDS Blood Test-Stigma," *NY Amsterdam News,* April 28, 1990, 8.
51. Oppenheimer has offered the most exhaustive analysis of the CDC and the

early epidemiological construction of AIDS. As he argues in response to previous criticism that the CDC had been too quick to look to biological agents as the cause of new diseases (specifically, Legionnaires' disease in 1976), CDC epidemiologists adopted a "lifestyle" model in tracing the origins of the new immune deficiency syndrome. Because AIDS was first identified among gay men, the CDC examined what it considered to be the unique features of gay lifestyle: a combination of multiple sexual partners ("promiscuity") and inhalation of amyl nitrite ("poppers"). Wedded to the lifestyle model, the CDC focused investigations of AIDS on gay men rather than on women, heterosexuals, or intravenous drug users. As a result, studies of AIDS among women and heterosexuals, which would have lent support for the existence of a transmissible agent, were underrepresented in the medical literature until after 1984. The CDC was not convinced that AIDS was caused by a specific agent until cases among hemophiliacs and blood transfusion recipients appeared. G. Oppenheimer, "Causes, Cases, and Cohorts: The Role of Epidemiology in the Historical Construction of AIDS," in *AIDS: The Making of a Chronic Disease,* ed. E. Fee and D.M. Fox (Berkeley, Calif.: University of California Press, 1992), 49–83.

52. CDC, "Prevention of AIDS," 101.
53. Food and Drug Administration Blood Products Advisory Committee, Position Statement, April 20, 1990.
54. Farmer, *AIDS and Accusation.*
55. Ibid.
56. Centers for Disease Control and Prevention, "Possible Transfusion-Associated Acquired Immune Deficiency Syndrome (AIDS)—California," *Morbidity and Mortality Weekly Report* 31 (1982): 652–654.
57. CDC, "Prevention of AIDS," 102.
58. Oppenheimer, "Causes, Cases," 61.
59. Ibid., 62.
60. E. Fee and N. Krieger, "Understanding AIDS: Historical Interpretations and the Limits of Biomedical Individualism," *American Journal of Public Health* 83 (October 1993): 1477–1486.
61. A.M. Brandt, "Racism and Research: the Case of the Tuskegee Syphilis Study," *Hastings Center Report* 18 (1978): 21–29; S. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness* (Ithaca, N.Y.: Cornell University Press, 1985).
62. R. Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic* (New York, N.Y.: Penguin Books, 1987).
63. Patton, "From Nation to Family."
64. New York State Department of Health, AIDS Institute, *Memorandum to Members of the AIDS Advisory Council re: FDA Guidelines on Deferral of Persons Born in Haiti from Donation of Blood and Blood Products,* July 9, 1990.
65. T.C. Quinn, F.R.K. Zacarias, and R.K. St. John, "HIV and HTLV-1 Infections in the Americas: a Regional Perspective," *Medicine* 68 (1989): 189–209; J.M. Shultz et al., "Heterosexual Transmission of HIV in the USA: Male-to-Female Ratios among Immigrants from Pattern II Countries Compared with American-Born Heterosexual Cases," *AIDS* 4 (1990): 1298–1299.
66. New York State Department of Health, Bureau of Communicable Disease Control, *AIDS Surveillance Monthly Update: For Cases Reported through April 1990;* New York City Department of Health, AIDS Surveillance Unit, *AIDS Surveillance Update,* May 30, 1990.
67. Oppenheimer, "Causes, Cases."
68. Shilts, *And the Band Played On,* 322.
69. "AIDS and the Workplace," *World AIDS Day Features,* December 1, 1991; M. Whitaker, "The Devil Has Fallen," *Newsweek,* February 17, 1986, 44–46; R. Evans, "Epidemics and Revolutions: Cholera in Nineteenth Century Europe," *Past and Present* 120 (1988): 123–146; Farmer, *AIDS and Accusation.*
70. Farmer, *AIDS and Accusation.*
71. *Haitian Centers Council v. Sale.*
72. Ibid.
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