2008

Moving Forward: Recommendations on U.S. HIV Immigration Policy (Haiti)

Georgetown University Law Center, Human Rights Institute

AUTHORS

Katherine Buckel
Casie Copeland
Lydia Desmond
Astrid Dorélien
John Nader

RESEARCHERS

Kelechi Acholonu
Lindsay Baldwin
Hugh Carlson
Stacey Fernandez
Charles Gillig
Niloufar Khonsari
Erika Pinheiro
Luke Polcyn
Cassandre Theano

FACULTY ADVISORS

Andrew Schoenholtz
Deputy Director, Institute for the Study of International Migration
Georgetown University

Ben Berkman
Former Deputy Director, O'Neil Institute for National and Global Health Law
Georgetown Law

SUPPORT PROVIDED BY

Georgetown Law, Office of Dean Alexander Aleinikoff
Georgetown Human Rights Institute

ACKNOWLEDGEMENT

Georgetown Human Rights Action acknowledges the support of innumerable people without whom this project would not have been possible.

The support of the administration and faculty of Georgetown Law has been indispensable to this project. The group particularly thanks Dean Alexander Aleinikoff, Georgetown Human Rights Institute's Deputy Director Rachel Taylor, and Dean Everett Bellamy who have remained dedicated to the project's mission to use law in the service of positive policy change.

Community health and advocacy groups in the cities of New York, Miami, and Port-au-Prince, Haiti provided critical local support. The groups are too numerous to list individually, but every contact with whom we met should know that their help was invaluable.

Most importantly, the group is grateful to the HIV-positive individuals who entrusted us with their deeply personal stories in the hope that they might contribute to improving the lives of others who share in their struggle.

Prologue

Since 1987, individuals with HIV have effectively been barred from entering the United States.[1] In that year, the U.S. Department of Health and Human Services (HHS) added HIV to the Center for Disease Control and Prevention's list of "dangerous contagious diseases" (CDC list).[2] As mandated by the Immigration and Nationality Act (INA), individuals infected with diseases on this list are inadmissible to the United States.[3] In 1991, HHS sought to remove HIV from the CDC list based on a greater understanding of HIV and its transmission.[4] But in the climate of misunderstanding and fear that characterized discussions of HIV in the early 1990s, Congress declared HIV an exceptional threat to the country and mandated its continued inclusion on the CDC list.[5] With this act, HIV became the only medical condition explicitly named by Congress as grounds for inadmissibility to the United States.[6]

This report focuses on HIV-positive spouses, children, parents, and siblings of U.S. citizens or Lawful Permanent Residents (LPRs) affected by the "HIV bar". These individuals are only able to

[1] 52 Fed. Reg. 32,540-03, 32,540-03 (Aug. 28, 1987) (to be codified at 42 C.F.R pt. 34); s*ee also* Act of July 11, 1987, Pub. L. No. 100-71, 101 Stat. 391 (1987) (requiring the President to add HIV to the list before August 31, 1987); s*ee generally* PHILLIP NIEBURG ET AL., MOVING BEYOND THE U.S. GOVERNMENT POLICY OF INADMISSIBILITY FOR HIV-INFECTED NONCITIZENS: A REPORT OF THE CSIS TASK FORCE ON HIV/AIDS 1 (2007) (available at: http://www.csis.org/media/csis/pubs/movingbeyondinadmissibility.pdf).

[2] *Id*. Congress changed the language "dangerous contagious diseases" to "communicable diseases of public health significance" in the Immigration Act of 1990, Pub. L. No. 101-649, § 601, 104 Stat. 4978, 5067 (1990) (amending 8 U.S.C. § 1182(a)(1)(A)(i)). In this report, the term "CDC list" refers to this list before and after 1990. The CDC is under the jurisdiction of HHS. For a list of diseases on the list, *see* 42 C.F.R. § 34.2(b) (2008). Medical Examination of Aliens (AIDS), 52 Fed. Reg. 21607-01 (1987); s*ee generally* MOVING BEYOND THE U.S. GOVERNMENT POLICY OF INADMISSIBILITY FOR HIV-INFECTED NONCITIZENS, *supra* note 1 at 2.

[3] 8 U.S.C. § 1182(a)(1)(A)(i) (2008).

[4] *See* Press Release, U.S. Department of Health and Human Services, Communicable Diseases and Foreign Visitors (January 15, 1991) *available at* http://www.hhs.gov/news/press/pre1995pres/910125.txt.

[5] Immigration and Nationality Act § 212(a)(1)(A)(i) (1993) (stating that "any alien…who is determined (in accordance with the regulations prescribed by the Secretary of the Department of Health and Human Services) to have a communicable disease of public health significance, which shall include infection with the etiologic agent of acquired immune deficiency syndrome . . ." is ineligible to receive a visa to be admitted to the U.S.) (current version at 8 U.S.C. § 1182(a)(1)(A)(i) (2008)).; *see generally* MOVING BEYOND THE U.S. GOVERNMENT POLICY OF INADMISSIBILITY FOR HIV-INFECTED NONCITIZENS, *supra* note 1 at 2.

[6] MOVING BEYOND THE U.S. GOVERNMENT POLICY OF INADMISSIBILITY FOR HIV-INFECTED NONCITIZENS, *supra* note 1 at 2.

immigrate or change their status by obtaining a special waiver, the I-601 waiver.[7] This report also considers the additional difficulties presented by the I-601 waiver for CAA, NACARA, and HRIFA immigration applicants.[8] Qualifying for this waiver is a monumental task for many individuals, even those who seem to fulfill its stringent requirements.[9]

To receive an I-601 HIV waiver, an applicant must fulfill three discreet criteria.[10] First, a qualifying family member – a spouse, child, or parent – must sponsor the applicant.[11] Second, she must prove that the danger to public health and the possibility of spread of infection posed by her condition is minimal.[12] Finally, she must demonstrate how she will pay for medical services in the United States at no cost to U.S. government health care providers without their prior consent.[13] It is difficult for many HIV-positive individuals to meet the various waiver criteria.[14] Even if these criteria are met, USCIS and State Department officials grant I-601 waivers on a discretionary basis.[15]

In February and March of 2008, members of Georgetown Human Rights Action traveled to New York, Miami and Port-au-Prince, Haiti to research the effects of this policy on HIV-positive foreign nationals applying to immigrate for family reunification. The group interviewed U.S. and foreign government officials, immigration attorneys and advocates, and HIV-positive immigration applicants. In July 2008, Congress, recognizing that the HIV bar is discriminatory and does not

[7] For immigration purposes, two types of waivers were instituted: the I-601 waiver, for all intending immigrants except refugees and asylees, and the I-602 waiver, specifically for refugees and asylees. These waivers are authorized by INA 212(g) and INA 209(c), respectively. *See* United States Citizenship and Immigration Service, I-601, Application for Waiver of Grounds of Inadmissibility (available at: http://www.uscis.gov/files/form/I-601.pdf); United States Citizenship and Immigration Service, "I-602, Application by Refugee for Waiver of Grounds of Excludability" (available at: http://www.uscis.gov/files/form/I-602.pdf).

[8] These Acts are the Cuban Adjustment Act, the Nicaraguan Adjustment and Central American Relief Act, and the Haitian Relief and Immigration Fairness Act.

[9] MOVING BEYOND THE U.S. GOVERNMENT POLICY OF INADMISSIBILITY FOR HIV-INFECTED NONCITIZENS *supra* note 1.

[10] "Immigrant Waivers for Aliens Found Excludable under Section 212(a)(1)(A)(i) of the Immigration and Nationality Act due to HIV Infection," Memorandum HQ 212.3-P, Alexander Aleinikoff, Executive Associate Commissioner (Sept. 6,1995).

[11] *Id.*

[12] *Id*.

[13] *Id*.

[14] MOVING BEYOND THE U.S. GOVERNMENT POLICY OF INADMISSIBILITY FOR HIV-INFECTED NONCITIZENS, *supra* note 1.

[15] Immigrant Waivers for Aliens Found Excludable under Section 212(a)(1)(A)(i), *supra* note 10.

address public health concerns,[16] removed the statutory requirement that HIV be included on the CDC list.[17] President George W. Bush signed the Act into law on July 30, 2008.[18] However, the Act only removed the Congressional mandate for HIV's inclusion on the CDC list and returned discretion to the agency; HHS must promulgate a regulation to actually remove HIV from the CDC list.[19] While HHS has stated that it intends to remove HIV, it remains on the CDC list today.[20]

In light of the change to the law, Georgetown Human Rights Action continued to investigate U.S. HIV immigration policy through the end of 2008 and into 2009. This body of research, along with the results of the fact-finding missions, indicates that even if HIV is removed from the CDC list of communicable diseases, additional policy changes are required to provide fair and non-discriminatory immigration procedures for HIV-positive individuals. This report makes recommendations to that effect.

[16] *See e.g.*, 154 CONG. REC. S6820, 6838 (daily ed. Jul. 16, 2008) (statement of Sen. Durbin, noting the HIV bar "does not further any public health goals ...We will take an important step towards ending discrimination against people with HIV by lifting this travel ban and treating persons with HIV the same way we treat those with other medical conditions. That is consistent with the goals of PEPFAR and the U.S. leadership role in fighting discrimination against people with HIV around the world.").

[17] The Tom Lantos and Henry J. Hyde United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008. Pub. L. No. 110-293, § 305, 122 Stat. 2918, 2963 (2008). This act is also known the Reauthorization of the President's Emergency Plan for AIDS Relief or the Reauthorization of PEPFAR.

[18] This was a provision of the Tom Lantos and Henry J. Hyde United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008, *supra* note 17. Section 305 of the Act amends §212(a)(1)(A)(i) of the Immigration and Nationality Act (8 U.S.C. 1182) by striking "which shall include infection with the etiologic agent for acquired immune deficiency syndrome" from the statute. HHS is now authorized to make a determination about HIV/AIDS' inclusion on the list, as it does with all other diseases. *See* Tom Lantos and Henry J. Hyde United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act, Pub. L. No. 110-293, §305, 122 Stat. 2918 (2008).

[19] 8 U.S.C. 1182 §212(a)(1)(A)(i).

[20] *See* "Discussion of Comments," Federal Register Vol. 73, No. 194, pg. 58025 at the final paragraph of § 3(A) (Oct. 6, 2008).

Table of Contents

"Jean's" Story

In December 2006, my three children and I went to a doctor in Port-au-Prince as part of the U.S. visa application process. My children and I hoped to join my father who was living in the United States. The doctor said he would deliver the results of my examination to the Embassy because "there was a little problem." I had no idea what this problem could be.

I reported to the Embassy for my scheduled meeting, but an official told me my medical report had not yet arrived. Later, I returned to the Embassy and another official told me that my medical report had a "problem," and that I couldn't leave the country. The official said the problem was that I was HIV-positive and because I had HIV I would need extra papers before I could continue with my application process. I was shocked. No one told me anything about the disease and I thought I was going to die soon.

After I found out I was HIV-positive, I didn't want to eat or do anything. I cried all the time. I couldn't think of anything but death. Even though I knew little about HIV, I was scared to talk to anyone about it. Still, I tried to submit my paperwork for an HIV waiver. I returned to the Embassy with information from three different doctors in the United States who had agreed to treat me when I arrived there, but the Embassy refused each one. They didn't give a reason. Finally, I found a doctor the Embassy approved.

After some time I heard about an HIV advocacy organization called ASON.[21] *They referred me to GHESKIO,*[22] *a clinic in Port-au-Prince that receives funding from the United States. At GHESKIO I began HIV treatment and counseling. For the first time I saw people living with HIV and leading productive lives. I learned that although having HIV is difficult, I could still live a full life. It was very different than how I felt after visiting the Embassy. Why would Americans, after giving so much money for HIV medicines and programs like GHESKIO, not let people with HIV or AIDS come to the United States?*

Jean continues to wait for word from the Embassy about his waiver. When he began the process he had a lawyer, but he can no longer afford to retain the lawyer's services. While Jean is glad he got tested for HIV through the visa process, he believes the waiver process in its current form is complicated, inefficient, and an affront to people's dignity. As Jean said, "It is bad enough that there is discrimination against HIV-positive people in Haiti – it shouldn't be the case that, at the U.S. Embassy, people with HIV are treated like they're already dead."

[21] Association de Solidarité Nationale des Personnes Infectées et Affectées par le VIH/SIDA (National Solidarity Association for People Infected and Affected by HIV/AIDS).

[22] Groupe Haitien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections).

Executive Summary

This report highlights the difficulties that HIV-positive immigration applicants encounter under current U.S. law and recommends how U.S. policy should be improved to provide non-discriminatory treatment in the wake of Congress's removal of the statutory HIV bar. The report uses Haitian immigrants as a case study, in part because they are a group disproportionately affected by the current policy.

Georgetown Human Rights Action's (GHRA) findings reveal that, in addition to problematic immigration laws, HIV-positive individuals experience discrimination throughout the visa and waiver application process. Specific problems include the discriminatory and, at times, illegal treatment of HIV-positive individuals by (1) civil surgeons and panel physicians performing mandatory medical examinations and (2) U.S. immigration officials.

Current U.S. regulations require immigration applicants to undergo a standard medical examination that includes an HIV test. HHS requires that civil surgeons and panel physicians who perform the medical examinations[23] provide basic pre-test counseling to all patients, and post-test counseling to those who test positive.[24] However, GHRA's findings indicate that many individuals, particularly those receiving examinations outside of the United States, do not receive pre- or post-test counseling.[25] Many individuals are not even informed they are being given an HIV test, while others

[23] The required medical examinations are performed by civil surgeons and panel physicians. The DOS approves panel physicians who perform the medical examinations abroad. The USCIS approves civil surgeons who perform medical examinations in the United States. *See* Centers for Disease Control and Prevention, "Medical Examination for Immigration Frequently Asked Questions" (Oct. 7, 2008) (available at: http://www.cdc.gov/Ncidod/Dq/refugee/faq/faq_aliens.htm#_Toc98743969) (stating "Civil Surgeons are designated by the District Director of the U.S. Citizenship and Immigration Services (USCIS)" and "Panel Physicians are selected by U.S. Department of State (DOS) embassies and consulates.").

[24] Although HHS promulgates separate regulations for panel physicians and civil surgeons, the pre- and post-test requirements are the same. *See* Technical Instructions for Panel Physicians, (available at: www.cdc.gov/ncidod/dq/pdf/ti/alien.pdf); *see also* Technical Instructions for Civil Surgeons (available at: http://www.cdc.gov/ncidod/dq/pdf/ti-civil.pdf).

[25] *See* Interview with Association de Solidarité Nationale des Personnes Infectées et Affectées par le VIH/SIDA (National Solidarity Association for People Infected and Affected by HIV/AIDS), in Port-au-Prince, Haiti (Mar. 7, 2008) (on file with authors).

are not informed of their HIV status until their visa interviews at the U.S. Embassy.[26] These findings indicate there is insufficient oversight to ensure the enforcement of HHS regulations. In addition to the regulations, human rights and public health standards require that doctors inform HIV-positive individuals of their status and provide information and counseling.

GHRA also uncovered systemic discrimination in the treatment of HIV-positive individuals by immigration officials. GHRA's interviews revealed a troubling number of instances in which patient confidentiality was breached, HIV waivers were denied and supporting documents rejected without explanation, and USCIS adjudicators and Department of State (DOS) consular officials disclosed applicants' HIV status in non-confidential settings.[27] The U.S Embassy in Port-au-Prince, Haiti required HIV-positive individuals to report to the Embassy on specific days and stand in separate lines, thereby exposing their HIV status to the public.[28] These findings raise concerns that, even following the removal of HIV as an immigration barrier, HIV-positive applicants will continue to experience improper treatment.[29] GHRA recommends standardizing the processing of HIV-positive applicants both in the United States and abroad. Greater oversight and training should be provided at U.S. consulates to end discriminatory treatment of individuals with HIV.

In addition to improving the processing of HIV-positive applicants, additional policy changes are required to rectify the effects of past discrimination. Once HHS removes HIV from the CDC list, USCIS should allow for the reopening of previously denied family reunification applications that included an I-601 HIV waiver, without fees. Pending HHS action, USCIS should immediately and automatically reopen any cases denied after July 30, 2008 that included an I-601 waiver and put them

[26] *Id.*

[27] *Id. See also* Interview with Randolph P. McGrorty, Chief Executive Officer, Catholic Charities in Miami, Fla. (Feb. 15, 2008) (on file with authors).

[28] *See* Interview with Association de Solidarité Nationale des Personnes Infectées et Affectées par le VIH/SIDA (National Solidarity Association for People Infected and Affected by HIV/AIDS), in Port-au-Prince, Haiti (Mar. 7, 2008) (on file with authors).

[29] Even if HIV is removed from the CDC list, testing may still occur. If testing does not occur, there are a number of other ways an applicants HIV status may become known to immigration officials. *See* 42 C.F.R. § 34.3(a)(4).

on hold. USCIS should continue processing I-601 waivers but applications that would be denied should be placed on hold until new regulations are promulgated. These policy changes would mitigate the discrimination faced by HIV-positive individuals under current law, fulfill Congressional intent to remove HIV as a barrier to immigration, and follow established agency and judicial precedent.

Additionally, once HHS promulgates new regulations, individuals whose applications under the Cuban Adjustment Act (CAA), the Nicaraguan and Central American Relief Act (NACARA), and the Haitian Refugee and Immigration Fairness Act (HRIFA) were denied because they were unable to meet the demanding requirements of an HIV waiver should be allowed to reopen their cases without fees. Congress should amend NACARA and HRIFA by extending the filing deadlines for those individuals who met the original provisions of the statutes but were disqualified by their HIV status. These amendments would give individuals who have been residing in the United States for nearly two decades the opportunity to obtain legal status.

The following recommendations should be implemented to ensure that HIV-positive immigrants are treated fairly under U.S. immigration laws and policies.

Recommendations

- HIV should be removed from the CDC list of communicable diseases of public health significance.
- USCIS and DOS should immediately ensure that panel physicians and civil surgeons provide pre- and post-test counseling as required by current U.S. regulations.
- USCIS and DOS should immediately develop regulations to improve oversight of panel physicians and civil surgeons, such as effective violation-reporting mechanisms.
- USCIS and DOS should immediately implement staff training programs and modify practices to ensure equal treatment and confidentiality of HIV-positive applicants at immigration processing centers in the United States and abroad.
- Pending HHS action, USCIS should allow family reunification applicants who submitted an I-601 waiver and whose applications were denied to request a no-fee reopening and hold on their cases and, once new regulations are promulgated, a *de novo* review.
- Pending HHS action, USCIS should immediately and automatically reopen any cases denied after July 30, 2008 that included an I-601 waiver and put them on hold.
- USCIS should continue processing I-601 waivers, but applications that would be denied should be placed on hold until new regulations are promulgated.
- Once HHS promulgates new regulations, USCIS should allow HIV-positive CAA, NACARA, and HRIFA applicants whose applications were denied to request a reopening of their cases and *de novo* review without fee.
- Once HHS promulgates new regulations, Congress should extend the filing deadlines for HIV-positive individuals who met the original qualifications of NACARA and HRIFA but could not apply because they did not meet the requirements of an I-601 HIV waiver.

"Katiana's" Story

I am Haitian, and my brothers, mother, and stepfather are all in the U.S. I first submitted my visa application in 1993 with the help of my mother. I didn't know anything about HIV until I was forced to get tested as part of the visa application process. When I found out I had HIV, I was afraid to tell my family. I felt so depressed and embarrassed, I terminated my visa application.

My mother was so distraught that I wouldn't be joining her in the United States and I finally confessed it was because I had HIV. Fortunately, my mother was very supportive of me. She flew to Haiti and took me to the GHESKIO[30] clinic for treatment. Through GHESKIO I found out about ASON[31] and the HIV waiver, and in December 1998 I went back to the U.S. Embassy.

At first the Embassy officials thought that they had lost my file. Eventually they found it but had a hard time believing it was mine. They said, "This can't be you; you should already be dead by now." Officials at the Embassy are rude to people with HIV, and anybody who works at the Embassy knows that you have HIV/AIDS because there are only certain days people with health problems can come to the Embassy. Even on those days, there are special lines inside the Embassy for people with HIV/AIDS. I feel I have lost ten years of my life going through the waiver process. I am lucky because my mother has agreed to continue to sponsor me, but I am embarrassed because I am an adult and my mother still has to support me. If I were in the U.S., I could support myself and my mother wouldn't have to send money to Haiti. This system is not right.

[30] Groupe Haitien d'Etude du Sarcome de Kaposi et des Infections Opportunistes (Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections).

[31] Association de Solidarité Nationale des Personnes Infectées et Affectées par le VIH/SIDA (National Solidarity Association for People Infected and Affected by HIV/AIDS)..

I. USCIS and DOS should act immediately to ensure that panel physicians and civil surgeons provide pre- and post-test counseling as required by U.S. regulations, that confidentiality is maintained at immigration processing centers, and that there is stringent oversight of immigration processing of HIV-positive individuals.

A. Medical Exams and HIV-Positive Immigration Processes in the United States: The Example of Miami

Current U.S. regulations require immigration applicants to undergo a standard medical examination that includes an HIV test. HHS civil surgeon regulations require pre-test counseling for all patients, and post-test counseling for those who test positive.[32] GHRA's research in Miami indicates that civil surgeons approved by USCIS consistently fail to comply with this requirement.[33] In fact, some individuals do not even know they are receiving an HIV test during their medical examination. Further, some individuals who test positive are not informed of their HIV status by their civil surgeon, rendering the required post-test counseling impossible.[34] Worse yet, individuals are sometimes denied a copy of their medical examination results and informed of their HIV status by immigration officials in non-confidential settings, rather than by trained health professionals as per regulation.[35] USCIS officials have also referenced applicants' HIV status in other non-confidential settings, including in front of applicants' children. In one example, a USCIS official disclosed to an elderly Cuban LPR applicant's daughter that her father was HIV-positive; the daughter no longer speaks to her father.[36] Unfortunately, these violations are not rare and were prominent concerns in discussions with immigration attorneys, community health workers, and the HIV-positive immigrants themselves.

---

[32] *See* Technical Instructions for Panel Physicians (available at: www.cdc.gov/ncidod/dq/pdf/ti/alien.pdf); *see also* Technical Instructions for Civil Surgeons (available at: http://www.cdc.gov/ncidod/dq/pdf/ti-civil.pdf).

[33] Interview with JoNel Newman, Director, University of Miami Health Rights Clinic, in Miami, Fla. (Feb. 18, 2008) (on file with authors).

[34] *Id. See also* Interview with Dr. Eddy Génécé, Directeur Exécutif, Promoteurs Objectif Zerosida in Port-au-Prince, Haiti (Mar. 3, 2008) (on file with authors).

[35] Interview with Randolph P. McGrorty, Chief Executive Officer, Catholic Charities in Miami, Fla. (Feb. 15, 2008) (on file with authors).

[36] *Id.*

B. Medical Exams and HIV-Positive Immigration Processes Abroad: The Example of Haiti

The problems reported in Miami and New York – including lack of pre- and post-test counseling, denial of access to medical examination results, immigration officials informing individuals of their HIV status, and breaches of confidentiality – were prominent in GHRA's interviews in Haiti.[37] But additional problems with HIV immigrant processing, not seen in the United States, were identified in Haiti.

In some cases, individuals were *never* affirmatively informed of their HIV status, neither by panel physicians nor consular officials in subsequent meetings.[38] Instead, consular officials ended visa interviews by telling HIV-positive applicants that they were required to submit additional paperwork, without any explanation of the HIV waiver process.[39] Applicants were left to deduce their HIV-positive status based on the paperwork they received. Some applicants who learned of their HIV status in this manner reported suffering severe depression and experiencing extended suicidal periods.[40]

One of the more difficult aspects of immigration for HIV-positive Haitians is the procedure at the U.S. Embassy in Port-au-Prince. Consular officials only meet with HIV-positive visa applicants on certain days of the week.[41] On these days HIV-positive applicants must stand in separate lines while they wait for their interviews.[42] This process is well known and, for these applicants, predicates their ability to receive a visa on their willingness to expose a personal medical condition to the general public. This is especially problematic in Haiti where discrimination, stigmatization, and violence against HIV-positive individuals are all too common. Applicants found this process unnecessary,

[37] *See* Interview with Dr. Eddy Génécé, Directeur Exécutif, Promoteurs Objectif Zerosida in Port-au-Prince, Haiti (Mar. 3, 2008). *See also* Interview with Association de Solidarité Nationale des Personnes Infectées et Affectées par le VIH/SIDA (National Solidarity Association for People Infected and Affected by HIV/AIDS), in Port-au-Prince, Haiti (Mar. 7, 2008) (on file with authors).

[38] Interview with Association de Solidarité Nationale des Personnes Infectées et Affectées par le VIH/SIDA (National Solidarity Association for People Infected and Affected by HIV/AIDS), in Port-au-Prince, Haiti (Mar. 7, 2008) (on file with authors).

[39] *Id.*

[40] *Id.*

[41] *Id*.

[42] *Id*.

humiliating, and terrifying.

C. Recommendations for Policy and Practice

The findings about HIV testing and counseling expose a significant discrepancy between the regulations promulgated by HHS and the practice of many panel physicians and civil surgeons. These regulatory violations go unreported because there is not an effective mechanism to report violations by panel physicians or civil surgeons.[43] This lack of a generally available and effective feedback mechanism allows continued violations of federal regulations[44] and the use of medical examiners who violate the Hippocratic Oath.[45] This disconnect between policy and practice has immediate and lifelong repercussions for HIV-positive immigrants.

If HHS continues to require HIV testing as part of the required medical examination, USCIS and DOS should develop regulations to improve oversight of panel physicians and civil surgeons, such as effective violation-reporting mechanisms.[46] USCIS and DOS should develop an optional and anonymous feedback mechanism to protect individuals from fear of retribution for complaints. Once a complaint has been made, it should be investigated immediately and the resulting comments should be made a part of the panel physician's or civil surgeon's employment file. USCIS and DOS should promulgate regulations related to the process by which complaints will be addressed and panel physicians and civil surgeons may be removed from their positions. USCIS, DOS, and HHS should collaborate to ensure panel physicians and civil surgeons are being effectively monitored and operate

[43] 9 FAM 42.66(N4) (CT; VISA-1067) (stating that "USPHS/CDC Division of Global Migration and Quarantine oversees and monitors panel physician activity in collaboration with the Bureau of Consular Affairs." Although this Division and Bureau have oversight and monitoring authority, there is no institutionalized mechanism for potential immigrants to report violations of the law and their rights to either the Division or Bureau.).

[44] *See* Technical Instructions for Panel Physicians (available at: www.cdc.gov/ncidod/dq/pdf/ti/alien.pdf); *see also* Technical Instructions for Civil Surgeons (available at: http://www.cdc.gov/ncidod/dq/pdf/ti-civil.pdf).

[45] Interview with Randolph P. McGrorty, Chief Executive Officer, Catholic Charities in Miami, Fla. (Feb. 15, 2008) (on file with authors).

[46] 42 U.S.C. 252 (1998) (stating "The Surgeon General [functions transferred to the Secretary of HHS] shall provide for making, at places within the United States or in other countries, such physical and mental examinations of aliens as are required by the immigration laws, subject to administrative regulations prescribed by the Attorney General and medical regulations prescribed by the Surgeon General [Secretary of HHS] with the approval of the Secretary.").

under clear monitoring guidelines.

Moreover, USCIS and DOS should implement staff training programs and additional oversight to ensure the equal treatment and confidentiality of HIV-positive applicants at processing centers. USCIS and DOS officials should never be the first to inform individuals of their HIV status. Before an official discusses the details of an applicant's HIV status with her, the official should confirm that the applicant has received a copy of her medical examination, is aware of her HIV status, and has had the opportunity to discuss the issue with a trained health professional. If the applicant is unaware of her status, the officer should refer the applicant to a medical professional for post-test counseling services and be obligated to report the physician.[47] Discussions about an applicant's HIV status or HIV-related immigration procedures should always be confidential. Applicants should be asked privately if they want family members or others who have accompanied them to the processing center to be a part of the discussion.

DOS should take immediate steps to end the requirement that HIV-positive individuals stand in separate lines at the U.S. Embassy. DOS should also require all U.S. Embassies and Consulates to review their procedures for processing HIV-positive travel and immigration visa applicants to ensure they are treated with the "dignity and respect" DOS promises all applicants.[48]

[47] Applicants pay a fee for a medical examination that includes pre- and post-test counseling for HIV. If a panel physician has not provided post-test counseling they have deprived the applicant of a service they paid for.

[48] Customer Service Statement to Visa Applicants, U.S. Department of State (available at: http://travel.state.gov/visa/visa_2796.html).

"Françoise's" Story

I am a Haitian citizen, and I began the visa application process in 1994. I hoped to join my mother, my husband, and my eight siblings in the United States. My mother was the first to go to the United States. She sponsored all of my brothers and sisters to come to the U.S.; my husband is a U.S. resident so he sponsored me.

In order to get my visa, I went to get the required medical exam. After the exam, the doctor told me that I should go straight to the Embassy for the results. When I did, they gave me some papers and told me I needed to return to the doctor. When I got home I looked at the paperwork from the Embassy. It said that I had HIV. That's how I found out that I was HIV-positive, alone in my house.

I was shocked and terrified. I immediately called my husband in the U.S. He said he was leaving me. I have not heard from him since.

I was afraid to tell my family that I was HIV-positive. I thought they would be scared to be around me, but now, more than ever, I felt that I needed them. After my husband left me, the only way I could join my family in the U.S. was to ask my mother to sponsor an application and HIV waiver for me. When I did, she refused because I had HIV. I was now completely alone in Haiti, and I had no choice but to terminate my application.

II. USCIS should allow family reunification applicants who submitted an I-601 waiver and whose applications were denied to request a reopening and hold on their cases and, when new regulations are promulgated, a *de novo* review without fee. USCIS should also automatically reopen and put on hold any cases denied after July 30, 2008 that included an I-601 waiver. USCIS should continue processing I-601 waivers but applications that would be denied should be placed on hold until new regulations are promulgated.

USCIS should allow family reunification applicants who submitted an I-601 waiver and whose applications were denied to request a reopening and hold for their cases and, when new regulations are promulgated, a *de novo* review without fee. Pending HHS action, USCIS should immediately and automatically reopen any cases denied after July 30, 2008 that included an I-601 waiver and put them on hold.[49] USCIS should continue processing I-601 waivers but applications that would be denied should be placed on hold until new regulations are promulgated. These applications should only remain on hold until HHS removes HIV from the CDC list; HHS has stated its intent to do so.[50]

A *de novo* review of such applications would ensure that qualified applicants who were denied due to the I-601 waiver are granted legal status; status should not be granted to applicants who do not qualify for adjustment of status for reasons unrelated to the I-601 waiver. This reopening would comply with Congress' intent to remove HIV as a barrier to obtaining legal status in the United States and is consistent with judicial and agency precedent.

A. These Actions Fulfill Congressional Intent

When Congress reauthorized PEPFAR it recognized that overturning the bar is an important step in ending discrimination against HIV-positive foreign nationals. It noted that the bar "does not further any public health goals" and cited a disparity between the United States' role as a global leader in the fight against HIV and its policy of discrimination against HIV-positive individuals traveling and

[49] July 30, 2008 is the effective date of the Reauthorization of PEPFAR.
[50] *See* Letter from Michael O. Leavitt, Secretary of HHS, to Sen. Gordon Smith (Sept. 30, 2008) (on file with author); Letter from Michael O. Leavitt, Secretary of HHS, to Sen. John Kerry (Sept. 30, 2008) (on file with author).

immigrating to the United States.[51] Congress described the waiver process as "cumbersome, restrictive, and ineffective" [52] and as a practice by which HIV-positive individuals worldwide are made aware they are "unwelcome in our country – period."[53]

The record demonstrates that Congress recognized that HIV-positive individuals suffer needless discrimination under the HIV bar. Refusing these individuals the opportunity to reopen their cases after the bar is overturned, requiring that they pay to reopen their cases, or denying applications filed after the effective date of the legislation would all be contrary to the spirit of the new legislation and would exacerbate the very discrimination Congress sought to end. Allowing individuals to reopen previously denied applications and putting on hold pending cases that would be denied under current regulations would mitigate that discrimination and fulfill Congress's intent.

B. These Actions Follow Judicial Precedent

Judicial precedent supports the reopening of HIV-positive applicants' cases without fee. In *American Baptist Churches v. Thornburg*, Guatemalan and Salvadorian nationals, as a class, alleged that their asylum claims were systematically adjudicated in a discriminatory manner and a federal court approved a settlement that provided automatic *de novo* adjudications without fee.[54] Any Guatemalan or Salvadorian who applied for asylum during the specified period was considered a class member and eligible for *de novo* review.[55] Under the terms of the settlement (ABC settlement), the INS would retry as many as 150,000 Guatemalan and Salvadoran asylum claims and grant temporary status to 500,000 Guatemalans and Salvadorans who lacked legal status at that time.[56] Furthermore, class members were

[51] 154 CONG. REC. S6820 (daily ed. Jul. 16, 2008) (statement of Sen. Durbin).
[52] 154 CONG. REC. S6820, 6838 (daily ed. Jul. 16, 2008) (statement of Sen. Gordon Smith).
[53] *Id*.
[54] *American Baptist Churches v. Thornburgh*, 760 F. Supp. 796 (N.D. Cal. 1991).
[55] *See Chaly-Garcia v. U.S.*, 508 F.3d 1201 (9th Cir. 2007).
[56] *See* Robert M. Cannon, Comment, *A Reevaluation of the Relationship of the Administrative Procedure Act to Asylum Hearings: The Ramifications of the American Baptist Churches' Settlement*, 5 AM. U. ADMIN. L.J. 713, (1991) (citing Jay Mathews, *500,000 Immigrants Granted Legal Status*, Wash. Post, Dec. 20, 1990, at 1, col. 1).

also granted a number of important benefits under the settlement agreement, including the adjudication of reopened cases under 1990 asylum regulations that were more favorable to asylum applicants and restrictions on USCIS's authority to detain eligible class members.[57] The United States had systematically discriminated against Guatemalan and Salvadoran asylum applicants, their cases had not truly been heard, and the ABC settlement was an effort to mitigate that discrimination.

Although the discrimination in the ABC settlement case was illegal and discrimination against HIV-positive individuals is statutorily sanctioned, the ABC settlement case is instructive. Guatemalan and Salvadoran nationals were systematically denied asylum for discriminatory reasons - just as HIV-positive individuals are systematically denied adjustment of status for discriminatory reasons.[58] Like the ABC class members, the cases of many HIV-positive individuals denied under the HIV bar have never been truly heard. HIV-positive individuals, as a class have experienced discriminatory treatment and it should be rectified by allowing their cases a *de novo* review. Allowing these cases to be heard would be much less burdensome than under the ABC settlement because the numbers of individuals affected are much smaller.[59] HIV-positive family reunification applications denied under the HIV bar,

[57] *Id*., *see* United States Citizenship and Immigration Services, American Baptist Churches v. Thornburgh (ABC) Settlement Agreement (Oct. 28, 2008) (available at: http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=86d796981298d010VgnVCM10000048f3d6a1RCRD&vgnextchannel=828807b03d92b010VgnVCM10000045f3d6a1RCRD). The ABC settlement agreement allowed for adjudication of reopened cases under the 1990 asylum regulations, which require a notice sent to an applicant explaining the reasons for the decision if the applicant was determined to be ineligible. The applicant was then provided with time to respond before a final decision on her case – a benefit not available under the post-1990 asylum rules. The agreement also restricts USCIS's detention authority over eligible class members and class members who registered for the ABC program or TPS could apply for suspension of deportation or cancellation of removal under more favorable rules than those that applied to other applicants. Also, dependents that would no longer qualify as a derivative beneficiary on a principle's asylum application were still eligible for ABC Program benefits, as long as the dependent was a registered class member listed on the principal class member's original asylum application.

[58] *See, generally,* Sheryl Zounes, Note, *Positive Movement: Revisiting the HIV Exclusion to Legal Immigration*, 22 GEO. IMMIGR. L.J. 529 (2008) (discussing the fact that in 1993 Congress should have heeded the recommendation of HHS in removing the HIV bar, but declined to do so for discriminatory reasons, not based on public health, economic, or scientific rationale).

[59] The Gay Men's Health crisis estimates that the HIV bar prevents about 500 HIV-positive immigrants from entering the U.S. each year and notes that the Congressional Research Service (CRS) approximates that between 200 to 300 HIV-infected persons seek immigration to the United States each year (without noting how many are denied are admitted). DANIEL M. BERNSTEIN ET AL., GAY MEN'S HEALTH CRISIS, HIV AND LAWFUL PERMANENT RESIDENCY: AN ANALYSIS OF THE HIV BAR, WAIVERS, AND PROSPECTS FOR CHANGE 11 (2007), (available at: http://www.gmhc.org/policy/

like ABC class members, should be reopened and reviewed without fee to rectify the effects of discriminatory practices.

C. These Actions Follow Agency Precedent

Agency precedent also supports reopening the cases of HIV-positive applicants denied under the HIV bar and putting recently denied, currently open, and new cases involving an I-601 waiver on hold. In the Consolidated Appropriations Act that took effect on December 26, 2007, Congress expanded the discretionary authority of the Secretary of Homeland Security to exempt certain material support grounds for inadmissibility, including some that excluded applicants who had only provided support under duress.[60] The Secretary did not exercise this discretion until March 26, 2008 when he ordered USCIS to review all cases denied on or after December 26, 2007.[61] Any cases denied on the basis of one of the newly-exempted grounds were to be reopened on USCIS motion and put on hold.[62] Applicants whose cases were reopened were to receive notice of the action.[63] USCIS officials were ordered to withhold adjudication of any open or new cases that would have been denied under the newly-exempted grounds.[64] Importantly, the Secretary also ordered that anyone whose case had been denied *at any time* under the newly-exempted inadmissibility grounds could request the reopening and reconsideration of their case, and that their motion and any request for a fee waiver should receive favorable consideration.[65]

The situation the Secretary faced after Congress expanded his discretionary authority but before

---

federal/immigration_papers08.pdf). The U.S. State Department indicates that in 2008, 832 individuals with *any* type of communicable disease were denied immigration visas and 437 communicable-disease waivers were approved. *See* U.S. Deparment of State: Visa Statistics (available at: http://travel.state.gov/visa/frvi/statistics/statistics_1476.html). State Department statistics do not identify how many such waivers were for HIV. *See id.*

[60] Consolidated Appropriations Act of 2008, Pub. L. No. 110-161, 121 Stat. 1844 (2007).

[61] Memorandum from Jonathan Scharfen, Deputy Dir. of U.S. Citizenship and Immigration Servs. to Assoc. Dirs., Chief, Office of Admin. Appeals, and Chief Counsel (Mar. 26, 2008) (on file with author).

[62] *Id*.

[63] *Id*.

[64] *Id.*

[65] *Id*.

new agency regulations were promulgated is analogous to USCIS's position in the wake of Congress's removal of the statutory HIV ban. Having provided material support to a terrorist group even under duress was an automatic barrier to entry under the material support bar, as is being HIV-positive under the HIV bar. Congress's Consolidated Appropriations Act set the stage for USCIS action that would provide relief for adjustment of status applicants excluded under the material support bar. Similarly, Congress's PEPFAR reauthorization anticipates HHS action removing HIV from the CDC list, granting HIV-positive applicants relief from the HIV bar.[66] In the period between Congressional and agency action on the material support bar, the Secretary acted to ameliorate the situation of adjustment of status applicants whose cases stood to benefit from new regulations. Thus, it would be consistent with USCIS precedent if, in the period between PEPFAR's reauthorization and the removal of HIV from the CDC list, USCIS takes similar measures to ameliorate the situation of HIV-positive applicants.

III. USCIS should allow HIV-positive CAA, NACARA, and HRIFA applicants whose applications were denied to request a reopening and hold on their cases and, once new regulations are promulgated, a *de novo* review without fee. Additionally, once new regulations are promulgated, Congress should extend the filing deadlines for HIV-positive individuals who met the original qualifications of NACARA and HRIFA but could not apply because they did not meet the requirements of an I-601 HIV waiver.

USCIS should allow HIV-positive CAA, NACARA, and HRIFA applicants whose applications were denied to request a reopening and hold on their cases and, once new regulations are promulgated, a *de novo* review without fee. Once new regulations are promulgated, Congress should pass amendments to NACARA and HRIFA to extend the filing deadlines for otherwise qualifying HIV-positive individuals. The CAA, NACARA, and HRIFA were passed as humanitarian measures in response to crisis following political unrest and civil wars in Central America, Haiti, and Cuba.[67] The

[66] Anticipation that HHS would remove HIV from the CDC list, the Act included an increase in visa fees to offset anticipated costs of lifting the HIV ban.

[67] Austin T. Fragomen Jr. & Stephen C. Bell, Immigration Fundamentals: A Guide to Law and Practice, Practicing Law Institute, 4 ed. (2004).

Acts grant legal status to immigrants who fled their home countries and maintained a continuous presence in the United States by a specified date (the dates and specific requirements differ by statute).[68] These individuals did not have to qualify for any other type of visa, have family members in the United States, or demonstrate that they would not become a public charge (even on health-related grounds); they simply had to prove their nationality, length of residence in the United States, and show that they were not inadmissible under certain provisions in the INA.[69]

CAA, NACARA, and HRIFA applicants are required to submit the I-601 HIV waiver rather than the I-602 HIV waiver refugees and asylees submit.[70] To receive an I-601 HIV waiver, an applicant must fulfill three discreet criteria.[71] First, a qualifying family member – a spouse, child, or parent – must sponsor the applicant.[72] Second, she must prove that the danger to public health and the possibility of spread of infection posed by her condition is minimal.[73] Finally, she must demonstrate how she will pay for medical services in the United States at no cost to U.S. government health care providers without their prior consent.[74] The I-602 waiver requires that the applicant demonstrate a minimal danger to public health and risk of spread of infection within the United States but does not require a qualifying family member.[75] Applicants under the CAA, NACARA, and HRIFA, like refugee and asylum applicants, were not required to show that they would not become a public charge or that they had family members in the United States.[76] Despite the Acts' humanitarian intentions, the I-601 waiver requires applicants to fulfill criteria the CAA, NACARA, and HRIFA were designed to avoid.[77]

---

[68] The Cuban Adjustment Act of 1966, Pub. L. 89-732 (1966); Nicaraguan Adjustment and Central American Relief Act of 1997, Pub.L. 105-100, § 202(a) (1997); Haitian Refugee and Immigration Fairness Act of 1998 Pub. L. 105-277 (1998).
[69] *Id*.
[70] Immigrant Waivers for Aliens Found Excludable under Section 212(a)(1)(A)(i), *supra* note 10.
[71] *Id.*
[72] *Id.*
[73] *Id*.
[74] *Id*.
[75] *Id*.
[76] The Cuban Adjustment Act of 1966, Pub. L. 89-732 (1966); Nicaraguan Adjustment and Central American Relief Act of 1997, Pub.L. 105-100, § 202(a) (1997); Haitian Refugee and Immigration Fairness Act of 1998 Pub. L. 105-277 (1998).
[77] *See generally* Rebecca Kidder, *Administrative discretion gone awry: the reintroduction of the public charge exclusion for*

Interviews with immigration attorneys and community health workers demonstrated that many otherwise qualifying HIV-positive CAA, NACARA, and HRIFA applicants could not meet the waiver requirements.[78] The biggest obstacle for these applicants was finding a qualifying family member through whom they could apply for an HIV waiver. The interviews further indicated that the requirements of the I-601 waiver led many otherwise qualifying applicants not to apply for LPR status and that many who did apply were denied.[79]

Once HIV is removed from the CDC list, Congress should amend NACARA and HRIFA to extend the filing deadlines for HIV-positive applicants. These applicants will have resided in the United States for nearly twenty years and should be able to apply for legal status under NACARA and HRIFA. HIV-positive CAA, NACARA, or HRIFA applicants whose applications were denied should be allowed to request that their application be reopened for *de novo* review without fee. These actions should be taken as soon as HIV is removed from the CDC list to ensure that qualifying individuals are able to apply for and enjoy legal status in the United States.

HIV-positive refugees and asylees, 106 YALE L. J. 389 (1996).

[78] Interview with Shannon Laguerre and Kelleen Corrigan, Florida Immigrant Advocacy Center in Miami, Fla. (Feb. 20, 2008); Interview with Steve Forrester, Miami, Fl. (Feb. 19, 2008) (on file with authors).

[79] *Id*.

Conclusion

The congressional removal of the statutory HIV bar from the INA was a significant step in ending discrimination against HIV-positive immigrants. However, HIV will remain on the CDC list until HHS amends its regulations, and action must be taken to rectify past discrimination and to end ongoing discrimination against HIV-positive intending immigrants.

HHS must promulgate a regulation removing HIV from the CDC list. Once HIV is no longer a barrier to entry, cases previously denied under the HIV bar should be reopened. USCIS should continue processing I-601 waivers but applications that would be denied should be placed on hold until new regulations are promulgated. HIV-positive CAA, NACARA, and HRIFA applicants should be able to legalize their status in the United States and enjoy the benefits of legal residency as Congress intended. HIV testing and processing procedures should be streamlined to eliminate discriminatory practices and give HIV-positive intending immigrants whose rights are violated a mechanism to report such violations. Congress, USCIS, DOS, and HHS are all involved in the processing of HIV-positive immigrants and each body or agency has much to contribute. GHRA hopes individuals, agencies, and Congress will act to rectify problems indentified in this report and continue the United States' leadership in the field of HIV/AIDS policy.

Persons Interviewed for this Report:

Alternative Chances, Haiti
Michelle Karshan, Executive Director
"Harry," deportee
"Junior," deportee

Archdiocese of Port au Prince, Haiti
"Robert," Catholic Priest

Association for National Solidarity (ASON), Haiti
Jean Saurel Beaujour, Executive Director
Jaccine Inocan, Director
"Danielle," member
"Fransique," member
"Jean," member
"Katiana," member
"Rachel," member
"Pierre," member

Bureax des Avocats Internationaux, Haiti
Mario Joseph, Founder and Director

Catholic Charities, Miami, FL
Randy McGorary, Executive Director
Georges Francis, Attorney

Catholic Relief Services, Haiti
Anne Toussiant, Protection Project Manager

Center for Haitian Studies, Miami, FL
Dr. Laurinus Pierre, Executive Director

Cite Soleil Clinic, Haiti
Dr. Joey Proctor, Executive Director
Mimi Dominique, Assistant Director
"Laura," patient
"Pierre," patient
"Rachel," patient

Coalition to Lift the Bar

St. Damien Pediatric Hospital, Haiti
Father Rick Frechette, M.D., Director

Diaspora Community Services, New York, NY
Suzanna Depalo, Director of Case Management

Gay Men's Health Crisis, New York, NY
Krishna Stone, Director of Community Relations
Vishal Trivedi, Immigration Project Manager

Haitian Center's Council, New York, NY
Dr. Marie Pierre-Louis, HIV/AIDS Program Director

Haitian Women of Miami (FANM), Miami
Marleine Bastien, Executive Director

Florida Immigrant Advocacy Center (FIAC), Miami, FL
Shannon Laguerre, Attorney

Thomas Griffin, Partner at Morley Surin & Griffin, P.C., Philadelphia, PA

Haitian Group for the Study of Kaposis Sarcoma & Opportunistic Infections (GHESKIO), Haiti
Dr. Serena Koeing

Haitian Consulate, New York, NY
Yolaine Milfort
Judith Bertrand, Cultural & Community Liaison

Haitian Lawyers Association, Miami, FL
Jeff Cazeau, President

Haiti Democracy Project, Washington, DC
James Morrell, Executive Director

Immigration Equality, New York, NY
Victoria Neilson, Legal Director

Institute for Justice and Democracy in Haiti, Portland, OR
Brian Concannon, Director

Inter-American Dialogue, Washington, DC
Dan Erikson, Senior Associate for US Policy and Director of Caribbean Programs

Ministry of Foreign Affairs, Haiti
Kendley Pierre-Toussaint

Office of the Governor, New York, NY
Jocelyn Mayas, Immigration Liaison

Office of National Migration, Haiti

Office of Senator John F. Kerry (D-MA), Washington, DC
Alexandra Nunez, Aide to Senator Kerry

Peace Corps Haiti
Jennifer McCormic, Returned Peace Corps Volunteer

Program Nasyonal du Lut Kont VIH/SIDA, Haiti
Joel Dars, Director

Promoteurs Objectif Zerosida (POZ), Haiti
Dr. Eddy Genece, Executive Director

Sant La Haitian Neighborhood Center, Miami, FL
Gepsie Mettalus, Executive Director

South Florida AIDS Network (SFAN), Miami, FL
Sergio Lindarte, Manager
Kathy Pierre Toussaint
Edgard Resto, Health Educator
"Louis," patient

Trinity College
Bob Maguire, Professor

United States Citizenship and Immigration Services
Anonymous Officials

United States Congress Immigration Subcommittee, Washington, DC
David Shahoulian, Counsel

United States Embassy in Port-au-Prince, Haiti
Anonymous Officials

University of Miami Health Rights Clinic, Miami, FL
Jonel Newman, Director
Leah Stautkus, Law Student

Whitman Walker Legal Clinic
Todd Pilcher, Senior Managing Attorney