

**Briefing on U.S. Policy of Inadmissibility of
HIV-Infected Noncitizens
Center for Strategic and International Studies and
Kaiser Family Foundation
April 12, 2007**

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J. STEPHEN MORRISON: I direct the CSIS task force on HIV/AIDS and the Africa program there and welcome to this gathering here today. I first want to thank Kaiser Family Foundation and Jen Kates in particular for allowing us to come and co-host this event here, which we've done a lot of partnership with Kaiser over the years and it's been one of the most enjoyable relationships that we've built up through the task force over the years and we're very grateful to Jen and to Dianne and others here at Kaiser for how far this has gone and the support that we've received in so many different ways. Jen was very integral intellectually and analytically in putting this and in conceptualizing this and moving this paper forward. I also want to single out Kate Hoffler from CSIS for her input on the paper and her input in helping us organize ourselves today.

The task force on HIV/AIDS is co-chaired by Senators Feingold and Frist. It's a broad effort that's been underway for over five and a half years. It has multiple parts to it and one very important component is a committee on prevention chaired by Jen Kates and Phil Nieburg. It's also engaged in lots of work and missions to China, Russia, India, Ethiopia and Nigeria. We've drawn extensively upon a broad network of expertise who've kindly donated time and interest and

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commitment to this effort and two of our speakers here today are among our most generous in that regard, Lou Sullivan and Helene Gayle, both of whom have contributed mightily over the years to different parts of our work and kindly have agreed to be with us here today, and in the case of Helene, is one of the co-authors of our paper.

In a way, this paper, looking at the inadmissibility policy of the U.S. is a continuation of work that we started in 2002. Phil and I wrote a short paper on this in 2002 because we thought at that time, gee this is an interesting issue. It's one that crosses different boundaries and has a heavy domestic dimension to it as well as an international dimension and this issue's not been given much attention or air time and it touches on U.S. national interests, it touches on public health expertise and policy and best practice and it touches on the way that we treat individuals in our country and whether we're treating them fairly and ethically or whether we're treating them in a manner is that inexcusable in different times and how might we begin to think about making our approach better. We issued that short paper and probably 10 or 12 people read it at that time. We still have a lot of spare copies if any of you are interested.

I think one of the events that stirred us to start thinking anew about this was Toronto and the international AIDS

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meeting, the IAS meeting in Toronto in August of last year. We'll hear more about that from Helene in her role as chair of IAS and host, co-host of that event. Many of us were there. Many of us were participating and observing and it just brought home in a very powerful and real way the one dimension of this inadmissibility policy, which has been that it is forbidden since 1990, the opportunity to have such a thing on U.S. soil and I think it got a lot of us thinking about why is that. That seems like a fairly large consequence. What are some of the other consequences as we look at this policy and how it is misaligned with current realities and evolving U.S. interests and when we did a debrief here with Jen and with Todd Summers and with Helene on the outcomes from Toronto, I think it was Todd Summers who first brought that issue up and said it's time to revisit all of this and we began a serious effort under the auspices of the prevention committee to start looking at this and doing the analysis, doing the research to put the paper together.

December one as we'll hear there was an announcement by the administration beginning to review waiver policies, and that I think gave us an additional development that raised the profile. So that's the genesis of this. We produce products that are intended to be analytic, fair minded, pragmatic in their recommendations and that can draw support from a range of

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different interests, that are not partisan, but are forward looking and what we want to see come out of this process really is today and Phil will talk in greater length about this, is we want to have a full discussion. We want to hear from you. We want to validate and be able to walk away and refine the approach, but we also want this to carry forward. We want this to help move forward a new discussion, a new broad dialogue around this policy and what can be done and to think creatively about who are the constituencies and the partners who need brought into that circle and made part of that process and what's the target in terms of trying to come up with refined options and market them to the right people who are going to be in the position to move at both the executive and Congressional level with this issue.

I'm very excited about this. I'm very grateful to the co-authors. I think this is a very good piece of work and I'm grateful to all of you today for coming to be with us, because we're going to need your help and your advice. Thank you very much.

JENNIFER KATES, M.A., M.P.A.: Good afternoon. I want to add my welcome to you to Steve's welcome and also thanks to CSIS and the task force, to Steve and to Kate in particular. The Kaiser Family Foundation has been involved with the task force since it was I think an idea and we've benefited from

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that collaboration for all these years as one of the key initiatives in D.C. that's providing dialogue opportunities on U.S. global AIDS policy and on complex issues and today's discussion, I get to be moderator today. Today's discussion is focused on one of those complex issues, the inadmissibility policy and one of the things that I think adds to the complexity of this policy, in addition to the politics of it, the public health implications, the international and domestic crossover, which is a very important dimension of this, it's complex in terms of how to go about looking at it and changing in terms of the laws and regulations in our country that it actually calls upon, so it's very complex from a bureaucratic perspective and administrative perspective, as well as public health. It's probably not so complex from a public health perspective, but the way that discussion has played out is complex. So what we're going to do today and we're very pleased to be able to have this kind of forum and just to add to Steve's discussion of the background leading up to this point, there were several other smaller briefings that were held on this topic, with some of you at those and in particular we really benefited from the input from the Wiltman Walker Clinic and Todd Hilcher [misspelled?] from Wiltman Walker is here from UNAIDS and I don't know if Dave Davids is there. People who have been working on this issue from different

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perspectives and global health council to add their input and expertise and help underscore the complexities as well as the different things that many stakeholders are involved in.

So today, what we'll go to in a moment is a presentation from Phil Nieburg of the key findings in the report and the issues and then we'll allow for a little Q&A with him if you have any questions about the presentation report, then we'll go right into a moderated discussion with our panelists, and then open it up to your questions. So I'm going to do a brief intro to our panelists and just let you know who we have here today and why we're so fortunate to have them with us for this discussion. First, very honored to able to introduce Dr. Louis Sullivan, who among his many accomplishments was the founding Dean and first President of Morehouse School of Medicine, where he continues to be integrally involved in that community today in many ways. Most importantly for our discussion today, Dr. Sullivan was the Secretary of HHS, appointed by George H. Bush in 1989, where he served until 1993 and this included the critical period of 1991, in which, and I think we'll hear about this later, in which the CDC did an expert consultation on this very question and recommended that HIV not be on the list of inadmissibility diseases and Dr. Sullivan at the time concurred with that recommendation from the public health experts, but it did not

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lead to a change in policy, so he was there at the time when much of this was being debated and discussed and we'll get to hear from his perspective today, how does he look back on that time and going forward, what's different about now or what's a different way to be considering this. We next will have with us Dr. Helene Gayle, who's currently the President and CEO of CARE, before that as you know was the director of the Bill and Melinda Gates foundation's HIV, TB and reproductive health program, but also most importantly for today, she served for more than 20 years with the U.S. Public Health Service, including as the Director of the National Center for HIV, SCD, and TB prevention in the mid 90s and through almost all of 2004, and was also present during many of these discussions and at the CDC when these reconsiderations were being discussed.

Also important for today's discussion, Helene was recently the President of the International AIDS Society and IAS has been, as Steve mentioned, a very critical stake holder here in this issue and just to preview for you one other thing that's coming up, on April 26th, Kaiser and CSIS are cohosting a briefing discussion with Craig McClure [misspelled?] who is the Executive Director of IAS, will be in Washington and one of the issues that we've asked Craig to discuss is the inadmissibility policy and how IAS relates to that policy and what it's seeing around the world in other countries, for

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example, when Canada made its recent change to accommodate the conference. So that's on April 26th and announcements will go out about that. And then finally, we have with us Phil Nieburg, who is a Senior Associate with CSIS but was with CDC for more than 20 years and brings public health and clinical expertise to this issue as well as being involved in these discussions and was the main report author so probably knows more about the history of this issue than anybody and he will be able to provide us with a good overview from the findings and so without further ado, I'm going to turn it over to Phil, and then we'll go to questions.

PHILLIP NIEBURG: Okay, thanks Jen. Good afternoon everyone. My job this afternoon is to summarize some of the highlights of the paper that will hopefully lead into useful areas of discussion. Before I start, I'd like to just acknowledge, in addition to the authors, acknowledge the support of a number of people. Jen mentioned a couple already, Todd Pelcher [misspelled?] and David Harris, but I'd also like to acknowledge the support and input from Genevieve [misspelled?] Grabman of the Global Health Council and Todd Summers of the Bill and Melinda Gates Foundation and Jennifer Cook, who is the Co-director of the Africa program with CSIS and who provided her usual, thoughtful support to production of this paper.

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Here's the current policy for screening of applicants for U.S. visas. Basically all applicants over 15 years of age are screened. For non-immigrant visas, applicants have to answer a screening question on the application that says what's up here. Do you have or have you ever had a disease of public health significance? HIV is not specified, neither is AIDS, but that's the question. Applicants for immigrant visas are screened not by that question, but by having a blood test for HIV and incidentally for syphilis. If HIV infected, visa applicants are considered inadmissible to the United States and the background and Immigration and Nationality Act is on the screen. Basically it says any alien determined to have a communicable disease of public health significance, which shall include infection with the etiologic agent for Acquired Immuno-deficiency Syndrome is in that inadmissibility category.

The italics in this last phrase are ours and refer to the change in law which is still current, in which Congress explicitly required that the Secretary of the Department of Health and Human Services include HIV on the list. Of the other seven diseases on the list which are on the bottom of the slide, five of those are primarily sexually transmitted infections. So that was the current policy and the two big picture questions that we're now facing are these; what should policy be for HIV screening of visa applicants and should those

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policies be differentiated in terms of the kind of visa that people are seeking and the rest of my presentation is a summary of the paper, which we think is a non-prescriptive approach, laying out some of the options for addressing the complex questions remaining.

Regarding the category of inadmissibility on entry visas, beyond people who have HIV and other health and disease problems, we're interested to look at the other groups who fall into that category and I'm not going to read all these, but it's interesting to look at this list. International child abduction, terrorist activity, participants in Nazi persecution, money laundering, people who've renounced citizenship for tax purposes. It's not an exhaustive list, but it gives you the flavor of who HIV infected people are lumped in with in the current law. Many of you know pieces of this already, but the question here is really where did the current policy come from and how did we get to this point.

In 1985 HIV was identified as the cause of AIDS and AIDS had been identified four years before that. In 1987, a year after an HIV test became commercially available, Congress passed the first HIV screening law. The rationale for that law was two fold. The public health rationale protects citizens from HIV infection risks and it is true that the data available then is very different than the data available now about the

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risk of casual spread and there was a lot of anxiety and fear in the public discussion. The second part of the rationale was a system burden concern, that is protecting the health and social service systems from care and cost burdens and because of the tone and the tenor of the public discussion, including items of Congressional record, there was an underlying message about stigma and bias. In 1989, a Dutch visitor to the United States was jailed when he landed in Minnesota and AZT was found in his luggage during a customs inspection. He spent five days in jail and a federal judge got him released, and that event precipitated a nearly successful boycott of the 1990 International AIDS Conference in San Francisco.

In 1991, as Jen alluded to, CDC recommended removing all diseases but TB from the list and Jim Mason who was the Assistant Secretary for Health and HHS Secretary Sullivan both concurred, but that effort failed. In 1992, the International AIDS Society, which is the sponsoring organization of the International AIDS Conferences moved the venue of the next meeting from Boston to Amsterdam, so as Steve pointed out we're in a situation where now, as of the Mexico City meeting in 2008, it will have been 18 years since the United States has been allowed to host an international AIDS conference. Most recently, or more recently actually, in 1993 under a new administration and a new Congress, another attempt was made by

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CDC and the Department of Health and Human Services to remove HIV from that list. That effort failed. Subsequently, a few months later, that new Congress passed a law requiring HIV to be on the list and that law was signed by the new President. So it's worth pointing out that HIV is the only disease singled out in this way by Congress.

For the next eight or 10 years, not much discussion of this visa occurred in the U.S. despite increasing certainty about the lack of casual spread. Beginning about 1998, there was a gradual but noticeable increase in U.S. interest in HIV/AIDS as a global leadership issue, culminating in first a large program in developing countries for prevention of mother to child transmission of HIV and in 2003 with PEPFAR, the President's Emergency Plan for AIDS Relief.

Finally, on this list in 2006, the White House announced a plan for a streamlined process for some short-term visa applicants and we'll talk more about that in a minute. So if HIV infection is found and documented in a visa applicant, what happens? People go into that inadmissibility category and the options for the next step, depend on what kind of visa they are looking for and applying for and who they are. For short-term visa applicants, that is non-immigrant, short-term visas, waivers are possible for stays of less than 30 days. If they are asymptomatic, not an obvious danger to the public health

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and have sufficient resources to cover their expenses in case of illness. For specific events, designated by the Department of Health and Human Services, blanket waivers are possible to allow HIV infected people to enter for the duration of that event. However, waivers are not possible for non-immigrant visa categories such as student visas and those wanting to come to accept existing job offers, even if there are sponsoring organizations involved.

For immigrant visa applicants, the process is more complicated. And it's certainly not simple or quick. A waiver requires a U.S. sponsor in a primary family relationship and those relationships are listed. It requires documentation of a low risk of disease spread, which in general means they must show evidence of having been counseled for HIV. They must document a low risk of becoming an economic burden, which means the sponsor signs a binding affidavit of support, which is actually signed by sponsors, whether people are HIV infected or not. And an HIV care provider must be identified. Other visa categories, that is those beyond people having primary family relationships are not eligible for waivers and those categories include such things as lottery winners, of the visa lottery, applicants for sponsored employee visas or business visas.

At this point, there's an emerging consensus that changes are needed and the public health rationale for the old

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system is clearly now invalid, that is there is no casual HIV spread and I'm sure we'll get a chance to talk about that. In fact, and I put this up as an example, the current policy is a disincentive to public health. There's a small study from the United Kingdom that showed that many HIV infected people in that country who come to the U.S. leave their medicines at home, don't take medicine for the duration of their visit, so in effect, put themselves at high risk for developing drug resistance. And for the second rationale, the health and social service burden issues are already addressed in immigration law in terms of the affidavit of support in the public charge test.

The current policy, as Steve alluded to, is out of sync with U.S. national interests. The lack of scientific and public health credibility make it appear that politics wins out over science, at least in this aspect of policy. The prior anti-gay stigma and commentary is a little bit ironic in the face of the global HIV pandemic, which is driven mostly by heterosexual transmission, and finally the issue of multiple missed opportunities since 1990 to educate U.S. constituencies, via the International AIDS Conferences, which might have been held here in other circumstances. On World AIDS Day last year, in a section of the White House facts sheet distributed on that day, entitled *The President is Dedicated to Ending*

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Discrimination Against People Living with HIV/AIDS, there was an announcement of the intent to initiate rule making to propose a categorical waiver, to allow HIV infected visitors to enter the U.S. through a streamlined process. That proposed rule making, and it's a little unclear what was intended or what is intended, but the proposed rule making presumably will require a public comment period. And what's happening in this process is not clear at the moment, but even if it's carried out exactly as hoped, we would not address the entire issue that we're talking about here today. Inadmissibility would still remain a public issue and the waiver, whatever it might be, would not address HIV issues for immigrant applicants.

So where does that leave us? Well the goals of policy change are probably three. To remove the stigma of inadmissibility, to simplify the visa and waiver process and to return public health decision making on HIV/AIDS to public health experts consistent with public health best practices. There's probably a fourth which is to bring the tenor of the visa discussion, HIV related visa discussion into harmony with the humanitarian position publicly championed by PEPFAR. And for Congress the options for Congress mean addressing HIV as an inadmissibility issue under the law, and returning the decision making authority to DHHS and those are probably overlapping issues. And it also would appear to be useful, we think it

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would be useful to require if those two other events happen, to require that Department of Health and Human Services review the list of diseases within a fixed period of time.

For the executive branch, the primary option is expanding and broadening the options available under the waiver system and I've listed them here and I'm not going to go through them, but basically it means making the waivers broader and lasting for longer periods and making some of them automatic. There is a question of what are the legal limits of the administrations, the executive branch's ability to expand waivers and it would still leave the inadmissibility issue to be addressed by Congress. There are in the paper that you have several additional issues, HIV screening issues, that could benefit from attention now, regardless of what the administration does and regardless of what Congress does, one is awareness of HIV sero status. The value of awareness in terms of preventing transmission, awareness of HIV status is clear for multiple studies and so it's probably not too early to start talking about making sure that awareness occurs, with respect for autonomy in any new policy. Second, is the issue of documenting or at least examining the adequacy of the counseling process that occurs, the HIV testing that's going on now for visa applicants. And finally, and this third one is actually not in our paper, although in retrospect it certainly

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should have been, is figuring out how to expedite the waiver process for the adoption of HIV infected orphans. Given all the home study that goes on for adoption processes in the U.S., it's difficult to imagine any benefit to anyone from dragging that process out and especially since the home study that's done which looks at financial resources, et cetera, is endorsed by U.S. CIS, Citizenship and Immigration Services. Finally, last slide, we return to the key question, many aspects of which are difficult and complex, even with that complexity, the U.S. appears now to be at the beginning of a promising new discussion of what constitutes the appropriate mix of policies and regulations concerning entry into the U.S. of noncitizens with HIV. A discussion that will hopefully move soon beyond an inadmissibility policy. Our intent in this paper was to set a context for the discussion and to begin laying out a menu of choices as well as to identify some immediate practical steps to ease the process for visa applicants and visa providers alike. It will be important in this effort that policy makers and administrators proceed carefully and thoughtfully to create a system that is both rational and human, that is at once based on public health principles, respectful of individual rights and is supportive of U.S. national interests.

Obviously more discourse will be needed after today.

More coalition building will be needed to carry the discussion

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forward. A bipartisan approach will clearly be needed so we welcome your feedback here in this session and your participation in the public discussion to come. Thanks.

[Applause]

JENNIFER KATES, M.A., M.P.A.: [Inaudible] this question is on the presentation and some of the points and then we'll go to -

PHILLIP NIEBURG: Yes? [Inaudible]

FEMALE SPEAKER: The question is a streamlined process. What is that referring to? Is that making each individual and taking them for who they are and processing them that way, regardless of HIV infection or does it entail addressing their ethnicity, their nationality, their economic status and all of that?

PHILLIP NIEBURG: At this point, I don't think any of us know the answer to that. It's not clear whether that statement is referring to making the process more automatic or to simplifying, reducing the number of hoops to be jumped through, but hopefully there will be a clarification of that soon.

FEMALE SPEAKER: Maybe there's someone here who can speak to that, but we do know that one of the issues that came up, the administration had reported [inaudible] is there a change made to the form, which currently doesn't say anything

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specific to HIV, but just says do you have one of these. Does the form then say except if you have HIV, you can come for 30 – It's complicated in a practical way how to implement this change for a specific category, so I think some of that is also part of what the exploration is. Is there anybody here who has more information on that discussion?

PHILLIP NIEBURG: Could you identify yourself please?

FEMALE SPEAKER: Sorry [inaudible] from the Global Health Counsel, Sara Friedman, also with the council and editor of [inaudible] and I have in the past couple weeks tried to contact both the State Department and Department of Homeland Security to ask them where they were on this process and we've gone through every avenue that we can think of, press office, trying to find the appropriate people and every answer that we can find is either that they are unaware of how this process is going or they're unaware of the process or they simply don't know what we're talking about or they have to talk with a supervisor but perhaps they'll get back with us, so it might indicate that a bit of clarification from those two agencies [inaudible] and with developing whatever process is then referred to. Some clarity could be brought to light on this and perhaps there's a representative of one of the agencies here that could help [inaudible].

[Laughter]

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TOM WALSH: Hi, I'm Tom Walsh, from the office of the U.S. Global AIDS Coordinator. The process is going on. I wish I had something I could tell you about at this point, but I can't. The process is underway as you gathered from the presentation. It is complex. It is a multi-agency reg and I wish there was more I could say at this point, but there isn't. But I do want you to know however, that people are working on it. It's - I know. I'm telling you. Thanks.

[Laughter]

MALE SPEAKER: Okay in back. Please identify yourself, also.

PEG WILLINGHAM: Hi, I'm Peg Willingham from the International AIDS Vaccine Initiative and I was wondering if the U.S. Government has documented the impact of this? In other words, was there a reporting requirement to Congress to say here's how this law has protected the United States, which I think most of us would say would be absurd, but has there been some way to document this is how by excluding these people, the U.S. has benefited in the following way or is there no reporting on that?

PHILLIP NIEBURG: There's no reporting requirement that we were able to find evidence of. In the annual report of U.S. CIS there is a table that documents how many people were refused entry because they were in that category, but it lumps

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all the health categories together, so we're not aware of any reports specific to this issue.

BOB ROW: I'm Bob Row [misspelled?] with the [inaudible] Reporter. This change is going to certainly require some effort on the part of Congress. Could you give us a sense of Congressional will, perhaps feedback from Senators Frist and Feingold and also often change requires a domestic constituency pushing for it. What would be a domestic constituency for this type of change?

PHILLIP NIEBURG: I'm aware and actually Steve may want to comment on this also, but I'm aware that there is interest on the part of a number of people in Congress on sort of clarifying the law. I'm not aware to the extent this is being planned, but I know there is more than one Congressional office that is looking into this as an issue to raise this session. Steve, do you have any?

[Inaudible]

PHILLIP NIEBURG: Yeah, okay.

FEMALE SPEAKER: It seems like we're there and that we have people on the panel [inaudible]. Thanks.

MALE SPEAKER: Steve, if you wanted to add anything to that or not.

J. STEPHEN MORRISON: We've been in discussions about doing a briefing of this kind on the hill. We've shared this

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paper with a number of offices that were involved in the vetting of the earlier paper, of the earlier drafts. Your question on the constituency I think is I'll leave for our panelists, because that's one of the most compelling questions as to what's the rationale or the hook for trying to get people to pick this up and move it, so if I can put that on the table for our panelists.

JENNIFER KATES, M.A., M.P.A.: I think I'm actually going to ask if Dr. Sullivan wants to share with us some of his thoughts, especially given that in 1991, when CDC came to you and made a public health recommendation, you supported that and the policy didn't change. Just give us some perspective on that time and –

LOUIS SULLIVAN: Well first of all, let me say this. This would not be the first time if this is the case that the White House or the President may not have gotten out in front of the agencies and I will refer specifically to the National Sickle Cell Program that President Nixon, in 1971 I think, announced. I happen to have been involved in a group of advisors who were put together at NIH about three weeks later and we were charged to figure out what a national sickle cell program would be. So we worked. The point is, we really ended up with the program that was effective, was quite significant and accomplished a lot. That's the first point I would make.

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The second point I would make is one that's obvious to everyone here. This is an issue that is always loaded with a lot of emotion or innuendo, et cetera. I would like to suggest that all sides, including those of you here today really try and be sure that that innuendo, emotion, et cetera, is implicit in the way questions are put forward, because it has been 1991, this is now 2007, I think the President has announced the intention to revise this and I would hope that he and his staff would be given time to really put this together. I think that in view of all of the emotion and I'll get to that in a little bit, that existed around the time that this all occurred, that for anyone to even approach this, I think requires some courage, so I would hope that courage is not then met with a fuselage of bullets because of that. Now, clearly we were caught in a very emotional issue. Jim Mason as you recall who was the Assistant Secretary for the Public Health Service when I was Secretary had been head of CDC and had been involved in this vetting process and I'm sure that Helene can shed more light on this. We looked at this from as objective a point as we could. This was a health issue. We felt that the data really were compelling, but it was not absolutely solid. You may remember at the time there was at least one, and perhaps two, cases of HIV infection which were claimed to have been obtained by just casual contact.

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We were in a time of what I considered almost a panic in some parts of our society about this issue, but we tried as professionals to say what is the right public health decision? What serves the interest of the American public? Because as health officials, your first charge is to protect the health of the public. The second is to try and see that health services are provided to individuals to the best of your ability and so this applied to immigrants as well as everyone else.

It's clearly as we approach the Congress with this concept, we were met with a lot of skepticism on the one hand, to outright hostility on the other, because again, this is mixed in. This is a disease that is mixed in with sexual activity. And whether you agree with it or not, there are segments of our society where unfortunately that really takes over the tone of the discussion. The issue of gay rights and of homosexuality, and so therefore, we were really trapped in our inability, certainly with some of the strong leadership in the Congress to have a rational discussion and as you know, this was really taken out of our hands. I would posit that there would probably not be any evidence that this policy has benefited the public, but I would be one to say that's not a question that I would want to put forward, because what I would want to do would be to encourage this process, which has – this goal, which has been announced, I wanted everything to

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encourage and support that goal, because all of us really want to have that objective met, so that would be my comment at the time. May I also point out one other thing? We at the time had a lot of suspicion from all segments of society and what was of particular concern to me was the fact that there were demonstrations on the campus of NIH with smoke bombs, protesting NIH researchers, the very people who were really lobbying me as hard as they could to change this policy, to get more resources and really were people I considered allies of those infected, but they were not treated that way by some advocacy groups. I was very much aware that a badge of honor among some of these groups seemed to be how much hell they could raise and be unpleasant to public officials. Certainly in the public square, know that you will be addressing people with various points of view and that's appropriate, but I think some of these things that happen were really a disservice to the goals that we're trying to achieve, because they really cause somewhat within Congress as well as within the administration, a backlash, so that the support that we wanted to get really eroded because of some of the actions that were taken.

JENNIFER KATES, M.A., M.P.A.: Thank you. It's great to get the historical perspective from you and I'm actually going to go right to Helene because we can continue this from

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the policy perspective at the time and the public health, what the CDC was thinking and how this came about from your perspective and what happened.

HELENE GAYLE: I'll just make a few comments and then I know we want to open it back up for discussion, and I'll just say a few things from the different perspectives that I bring, as you mentioned before, as somebody who's been involved as a public health official from my days at CDC and going through planning the Toronto conference and now as the present CEO of CARE international organization, and so just to talk about from the public health perspective and I think Phil laid out the issues very well, but clearly there has not been a strong rationale at the time, but as Dr. Sullivan said, at a time when there were more questions, one can understand that between the emotions and some of the unknowns, that a policy like that may have its supporters. Nevertheless, I think it's pretty clear today, knowing what we know now, that there's no real public health justification, for treating HIV, which is not a highly contagious disease as a cause for inadmissibility and really undermines our credibility that likes to pride itself on making policy decisions based on evidence, so I think it erodes our stance as an evidence based policy making country.

I think it also in many ways is one of these things in many ways is one of these things is what it was created really

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as a throwback in a way to an era where a lot of our decision making around AIDS really did have as much to do with emotion, with stigma and discrimination so I think it's a strong statement if we were to move away from something that's really a throwback to a time where our very way of thinking about HIV was not based on knowledge and compassion. I think we have moved from today, so I think for all those reasons, it's pretty clear that there's not a strong public health basis. Jen actually showed me this that kind of going back to the annals of history in 1991, and this is when we did have the CDC this expert consultation to bring people together to talk about this and I'll just read some of this verbatim.

HHS Assistant Secretary for Health, James Mason, who had some public health service endorsed the CDC conclusions and then forwarded them to the HHS Secretary, who also concurred and let me read you a quote from Dr. Sullivan back then. He said AIDS evokes an emotional response from many and that's understandable, but we have been virtually the only major country to try to bar HIV infected travelers. This policy, i.e., changing, the inadmissibility policy will bring us in line with the best medical thinking here and abroad. So I think that was a very strong statement that said we are out of line and we want to get in line with the best thinking and get in line with global thinking.

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I'll just read a little bit about what the expert consultation came up with and it said sexually transmitted diseases, including HIV infection are not spread by casual contact through the air or from food or water or other objects, nor will an infected person in a common public setting place another individual inadvertently or unwillingly at risk. HIV infection is transmitted adults in this country almost exclusively by two routes, sexual intercourse with an infected person and sharing of contaminated injection equipment by injection drug users. The risk of or protection from HIV comes not from the nationality of the infected person, but from the specific behaviors that are practiced.

The best defense against further spread of HIV infection, whether from a U.S. citizen or an alien I think is an educated population, so I think it goes on further to say basically our defense is not keeping people out of this country, but our defense is mounting a vigorous prevention campaign that will help those of us in the United States and anyone who comes into our borders, so I think it again reinforces the public health imperative and not the emotional or political, and just a couple point so about the international AIDS conferences, we were thrilled with the Toronto conference. We had 25,000 people. We had more than any other conference in the past, but I think we were all

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saddened this could not have been on United States soil and today with our policy in place, Toronto is about as close as any conference is going to be to the United States and as Secretary Sullivan said, I guess Phil said, it will be 18 years when we have the conference in Mexico since the last time we were able to have a conference here, so we think that from the standpoint of United States leadership, which has been so incredible on HIV between the resources that go to the global fund, PEPFAR, and all of the leadership that has continued to increase around the resources that the United States brings to bear against the global fight against HIV is just one more thing where we're out of line with what we're trying to be and finally I guess I would just add from my vantage point of now running a global organization, one of the concerns that people had was all of these aliens were going to come running to the United States for treatment and again, I think if we think about what we've done, we have now become the largest provider of treatment in the world and in fact, today, more than ever, the justification that people are going to flock here to get treatment, is again kind of in contrast to what we're doing, which is increasing global access, so that people can get treatment in their own homes, which is where people after all prefer to get treatment and flocking to the United States is just not a reality.

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The biggest impediment for people getting treatment is not their ability to get to the United States but it's their lack of awareness of their HIV status and so that's something that needs to change and as part of the program that we're involved in obviously trying to get people to have access to their HIV status so they can take advantage of the treatment programs that do exist and allow them to have safe treatment wherever they are in the world and so I think again, that justification, again, that kind of economic argument that this would be too expensive because we would have too many people coming here for treatment just doesn't hold with what we're doing on the other side to make treatment access available globally.

I guess I'll just end there and just say again thank for moving this issue forward and I think we want to do in this session is to figure out way we can keep this dialogue going and support action towards removing this policy and removing the restrictions. So thank you.

JENNIFER KATES, M.A., M.P.A.: I think we can go to questions, unless Phil or Steve. Yeah?

LOUIS SULLIVAN: I think this is really a propitious time to really try and move this, because the reality we have now is so different from 1990 or thereabouts. First of all, it was October of 1989 that as Secretary I approved federal

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reimbursement for AZT. That was the first drug and the only drug at that time that had show to be somewhat effective. Of course today, and people were really having compromised lifespan once they had the diagnosis of AIDS and today we have more than two dozen therapies and people really are living multiple years with their families, their working, et cetera, so I think we really have now a body of knowledge which we did not have then that really would lend the support to the change in policy and I do think that we have first of all more health professionals in the Congress who could help not only as physicians and nurses, but many others, and so the stigma that existed at that time, really has moderated significantly. We still have a problem without any question, but I do think that the environment is so different and we now have data that we can put before any member of Congress or the administration, so I would certainly think this is a very timely effort at this time, with the situation that we have now.

FEMALE SPEAKER: I just want to add one other thing and it is kind of to thank Dr. Sullivan for hanging in here with this issue. I always remember that San Francisco conference as the conference where I thought we lost Lou Sullivan to the cause. He kind of alluded to being in the public square and accepting your lumps not being so easy. It was a very difficult conference. He was confronted very aggressively by

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the activist community in ways that I think probably while I totally think that the expression has been one of the things in this epidemic that's been very important and has kept moving us along. On the other hand, as Secretary Sullivan said, I think we fight our best allies and I think in that case, that was the situation. Nonetheless, the next year, he really stood up for moving this policy forward, so I just again think from a historical perspective, that you played a really important role. You hung in there and the fact that you're here today still saying hang in there, I think is we shouldn't let that go unnoticed.

LOUIS SULLIVAN: Thank you for that generous comments. Basically I'm a physician and my role is to try to provide everything I can to improve the health of the people. The conference you refer to in Mosconisenna [misspelled?], two days before that conference I had had a meeting in the Oval Office with President Bush and really had a message that I was taking of conciliation and reaching out because we were very aware that the Bush administration and prior to that the Bush administration were looked upon as not being friendly or supportive of this issue. We were trying to set a new dialogue and a new tone and those of you who may remember that conferment was I guess the thing that bothered me most was it was obvious that there would be a demonstration and I thought

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there would be a two or three minute demonstration and it became obvious that the demonstrators were not going to stop. It was obvious that this was not simply a demonstration of position but really an effort to prevent me from making a statement and that's when I really took great offense at that, because everything that we were trying to do, that is you can't have a dialogue if someone doesn't listen, so from that standpoint it seemed that there was really no interest in listening, so that's the kind of thing I was referring to when I say that sometimes we may push people away who want to be allies, but by not the point we're trying to make, but the way it's being made.

MALE SPEAKER: The question or point that Lou made about that this is a propitious time and realities have changed, we've become as a nation deeply invested in international or in global HIV/AIDS on a bipartisan basis as a long-term enterprise and as a priority of United States foreign policy and national interests. We think of ourselves quite rightly with a considerable amount of pride in this achievement and in this step, which is an unprecedented step in U.S. foreign policy and commitments and it's an enlightened step as a nation to make this commitment. It's a bipartisan thing and that is a huge new reality and it's one that I think provides us the basis for making the case that we should not be denying

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ourselves the tool to educate and excite our own people. It's a bipartisan thing and that is a huge new reality and it's one that I think provides us the basis for making the case that we should not be denying ourselves the tool to educate and excite our own people by having the International AIDS conferences in the United States which have profound impacts on attitudes and opinions and knowledge levels and we'll hear from Greg McClure and what's happened in Canada and other countries that have hosted these conferences and why damage our own credibility internationally, as a humane and enlightened and committed nation because of this policy and why allow individuals to suffer unnecessarily in their desire to come to our nation in various fashions. It seems to me that those are the sort of broad themes that begin to get to the question that was raised at the front end about why should anybody care about this or pick this up.

It all has to do with where we are today and wanting to sustain that and wanting to sustain the interests and commitments around these issues. Thank you.

JENNIFER KATES, M.A., M.P.A.: I just want to give David Harris from UNAIDS if he's still here if he wanted to say anything from UNAIDS perspective, because David's been so helpful throughout this process and UNAIDS clearly has the

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global view as to how this plays out. But there's plenty other hands up.

MALE SPEAKER: I can just say something very briefly. I really appreciated working with Steve and Jen and Phil and everyone on this report. I think UNAIDS has been pushing this policy change for a long time. Back in '04 we had a report with the institute on migration, very much addressing this issue and I think all the arguments for why this needs to take place, be it from a public health, public charge perspective are certainly as valid as they've ever been. I think that Dr. Sullivan's comments are quite apt that now that we have all the evidence on our side and that there's no evidentiary basis for why this policy should be changed. We just have to smart and really strategic and that involves some strategic misalignment about how do we pursue this, how do we get the Congressional progress to move forward on that track to try and get to the end that we all want to achieve, so kudos for the effort.

JENNIFER KATES, M.A., M.P.A.: Thanks very much. Yes?

JUDITH: I'm Judith [inaudible] an independent consultant and I thank everybody for the effort and I couldn't agree more with what's been said, but I'm going to be a little contrary, because we also have a debate in this country right now on immigrating and I think that is highly relevant to any kind of effort on this issue. Also being somewhat contentious

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I think there's a strain in our foreign policy with we'll deal with problems elsewhere so these being somewhat contentious I think there's a strain in our foreign policy with we'll deal with problems elsewhere so the don't come to us and I will confess that when I was at the State Department, we tried to use that for avian flu. Dan Singer's here, let's do surveillance, let's stockpile drugs, let's help people so that we can stop an epidemic before it starts, but I'd just like to hear some thought on those other issues how they would play out and what the arguments are that since all politics is local to all Congressmen and Senators that would convince them to separate this from other issues that are even higher on the agenda and man Singer's here, let's do surveillance, let's stockpile drugs, let's help people so that we can stop an epidemic before it starts, but I'd just like to hear some thought on those other issues how they would play out and what the arguments are that since all politics is local to all Congressmen and Senators that would convince them to separate this from other issues that are even higher on the agenda and may play negatively.

MALE SPEAKER: Well, first of all thank you that comment. I would really think and recommend every effort to try and not have this subsumed in the immigration issue. That's to me a very different kind of issue and that my fear is

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that if that gets really entangled now, the opportunity we have to change this policy could be lost, because the immigration issue that you're referring to and this may happen, but I would certainly urge that this be seen as a public health issue, that there's no advantage to this current policy and as pointed out in Phil's paper, the fact that we really have this international leadership in terms of what this great PEPFAR program that has come forward, we have tremendous drugs now avail. We have shown that people who are under therapy are not a threat, so I would urge that if at all possible, this be seen as a separate issue. The immigration issue as you now know, that gets caught up into one part of Congress believes we shouldn't do anything to change the status because "these people have broken the law." And so you get caught up in other issues here so that would be my position, but I certainly understand your caution. I think we have to be aware of that, but I would certainly try and see this as a public health issue. There is no credible health public official believes this policy has any merit and really treat it in that way, as opposed to something related to immigrations. It's not really immigration at any rate. It's short term visitors and so forth.

FEMALE SPEAKER: And I've felt that I want to add one perspective that I gained in being involved in this process is

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that I learned a lot more about immigration law than I ever thought I would learn and one of the things is that there are a lot of the issues that have been going on in that debate and the issues used in the past about fear and changing inadmissibility policy are really things that have to do with other parts of immigration law that may or may not be discussed, but this is actually a thing that's not related to any of those other areas. For example, the public charge concern. We may have different ideas about how to address the public charge concern and should that be a concern for people coming into the country, should that be a policy issue and it's there and it's being addressed whether regardless of somebody has HIV or not.

So we struggled with that how to make all those connections, but in the end, I think what was really clear was that there was a whole range of things that were addressed. People may have different perspectives about how they're addressed and immigration law but they were not – This issue did not have anything to do with them really.

MALE SPEAKER: I just want to say probably the same thing in a slightly different way. What we're talking about here is an effort or goal or a need to clarify the HIV policy for people who are otherwise eligible for visas under the current system and the current guidelines so they're within the

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legal aspect of immigration. The paper does not suggest any changes in the categories eligible for immigration or the boundaries of those categories or the numbers, it doesn't suggest a loosening of the categories so in terms of the numbers of immigrants, there really would not be an effect and it does not address the issue of illegal immigrants. It does not call for it to legalize the status of illegal immigrants. So I think that at this moment are outside of the boundaries of that other debate, although the default position is to include as much as possible in that debate. It's a clear issue.

FEMALE SPEAKER: It looks like others wanted to say something about that.

FEMALE SPEAKER: Hi, my name is Gretchen [inaudible], I'm from Family Health International and I don't have a response to your particular question if that's what you were just debating, I just wanted to say quickly it would be helpful to get more clarification in terms of what you're proposing in terms of children, specifically orphans, because it's a very complex issue. While certainly we want all children to have a permanent home, if they do not have one a permanent family. The term orphan is very misunderstood in this country. Orphan internationally is a child who has lost one or both parents so much of the children who have been orphaned by AIDS have a living parent or grandparent who is taking care of them and we

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don't want to inadvertently push people towards thinking this is going to be a way to bring in a lot of AIDS orphans, most of whom are not infected.

Secondly, there is a complexity I believe in United States immigration law which I'm not an expert on which someone who has immigrated from sub-Saharan Africa or other places cannot adopt their own - they can only bring in immediate family, so if for example I have a colleague who is a physician, Ugandan physician, she cannot adopt her sibling's children. Now she has three siblings in Uganda who have died of AIDS and who have left children but she cannot adopt them under current regulations, so that would be another sort of thing to look into as the area of children explored.

[Inaudible]

FEMALE SPEAKER: It has to do with probably trying to discourage people bringing in extended family.

[Inaudible]

FEMALE SPEAKER: True, but because of HIV, more people would need to adopt children and bring them into the U.S.

MALE SPEAKER: I wanted to make sure that if we had questions or comments about what we were talking about. Mr. avian flu expert.

MALE SPEAKER: Don't tell people that. Since I'm not here in my official capacity, I'll just say I used to work for

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Judith Koffman [misspelled?]. Reconciliation of these policies is an executive branch issue and part is a legislative branch issue and with the ebb and flow it's hard to know where you're going to have the easiest fight or the best traction. The presentational we received at the beginning, kind of outlined the addressing this through the congressional mechanism and then addressing the seven other excludable diseases and the modifications of those, I'm just wondering might it also be useful to try to revise the list of seven excludable diseases, along the CDC recommendation of everything but tuberculosis, and although that wouldn't fix the requirement that HIV be excluded it at least highlights. One's TB and one's HIV and it would really put a lot more pressure on the congress to reexamine that clause that they inserted. What you guys think of that?

MALE SPEAKER: My comment as an ex CDC person and Helene might want to come on this too, is that that probably is a good idea but I'm guessing the CDC would be reluctant to take that on since there have been a couple of wrist slaps in the past and the other thing as that list showed, five of the other seven diseases are sexually transmitted diseases which carry their own emotional baggage.

FEMALE SPEAKER: [inaudible] while I think it would be an interesting strategy it would take more political capital to

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move something forward that doesn't ultimately answer the issue so I think you're right that it could but that in and of itself would take so much effort to move forward and then not still get to the final point and it just probably isn't a time efficient and energy efficient way of getting at the ultimate issue and waste a lot of capitol along the way.

MALE SPEAKER: I completely agree with that. I do think the forces are really more favorable at any time since I've been dealing with this issue. My concern is you would spend your capital and end up with a partial solution and I remind you there was the effort when President Clinton came in to reform healthcare, there was a lot of effort put into that and it failed. Now that was a decade ago and it's only now that we have this issue coming back is that if you really go for a half measure, I'm not sure that you can turn around and get that other, but I think you might be squandering what might be in your favor now.

JENNIFER KATES, M.A., M.P.A.: As moderation, I'm going to say some important issues are raised around adoption in children, but I think there are other people who work in that specific area.

FEMALE SPEAKER: Part of that question is why I asked to kind of differentiate what part has to do with HIV and what part I guess still has to do with as everyone else has said,

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let's keep this as clean as possible, specific to the issues of people with HIV and then if there are other issues like the fact that there are probably homes here that could take children who are orphaned back in home countries, let's deal with that but not heap that onto this and let's keep this issue as clean as possible based on the public health imperative and face the other one is whatever best for that particular issue.

ALAN MORE: I'm Alan More [misspelled?]; I'm a fellow at the global health council and also at CSIS. Let me just step back a minute and remind everybody what the administration was trying to do and because as Phil said, they are trying to fix the short-term issue. They are not touching the long-term issue, so strategically one of the issues that we have to wrestle with is that are we satisfied for the time being to leave them separate or do we want to join them, and let me expand on a couple of pieces here.

I think the reason that the work on the short-term admissibility issue, the short-term visa issue is invisible is because they're not ready to come out with something yet. They've got a law they're trying to get around and they've got smart lawyers working behind the scenes trying to figure out is there some way to fix this that in effect avoids a person having to disclose status, because disclosure, we haven't really talked about that is one of the most egregious aspects

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of current law. People if they do disclose may have it stamped into their passport and suddenly they're vulnerable to stigma persecution and so what the administration was trying to do was open the short-term door in a way that didn't require disclosure and didn't put people at risk. That doesn't begin to go far enough to fix the problem, but it goes a lot farther than old law did and they're still wrestling with that.

And then there's the question of broader immigration and the administration's view and my understanding is that their view is not withstanding the affidavit requirements that a sponsor has to show this is not going to become a ward of the state, the White House believes and I assume the ONB believes that a change in that part of the law would be very expensive.

Now, we don't know if it would be expensive and the best way to find out if it would be expensive would be to get a bill introduced that would lift that piece of the law, get CBO to look at it and if CBO says it's expensive then it's expensive for the purposes of the Congress. If CBO says the minimum number, then that argument goes out the window, but I just remind everybody that that's the environment that -

FEMALE SPEAKER: Can I ask you a question? Who is proposing that that part - one of the things that we were looking at and the report looks at is that piece of current law and showing that is not being discussed right now or on the

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table is changing. That would still be – so are you saying
that there –

MALE SPEAKER: No, I'm saying that not withstanding
that affidavit requirement, the White House believes it would
be an expensive change. I don't know what the analytical base
is, but what matters in the Congress is what CBO says so
Barbara Lee has talked about trying to lift everything if she
introduces a bill, CBO costs it, then that becomes the
determining factor of what the cost it. Not what somebody
claims but what CBO, in all its wisdom says. A couple of other
things, the question is how do we get Congress to act here and
I think that's really the challenge. There aren't that many
people that care about this stuff. We care, but most people
don't care and their risks in the Congress, I'm not convinced
that Congress is going to respond to the notion that the U.S.
is isolated, we should join the west, those are useful
arguments to have but I don't know that they become persuasive.
Having the AIDS conference here, we'd love to have the
conference here. Most people in Congress would say who cares
or why do we await to have a conference here where they're
going to shout down our secretaries, so I don't see that as
persuasive in the Congress.

I think we got to think beyond that. So how do we –
Assuming the administration is going to solve the visa problem,

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which maybe they can or can't do without a change in the law, the bigger question is in the long-term how do we do that? One, we have to show it doesn't cost very much and we talked about how that worked. I think we can make the case that there won't be some mass influx of people as has been discussed. I think the question is that forget we all think it's the right thing to do. I'm trying to thin how to persuade members of Congress. Is there some way to show that there are some public health risks to not doing this? That is not only the point of people who don't take medicine or people who conceal their status, but is there some other way, are there people who have immigrated here who are not getting tested, who are concealing their status, are there public health risks? I'm trying to think practically about how to persuade the Congress and ultimately what we need is leaders. We need thought leaders and we need members of Congress and ultimately we'll need the president on this one.

MALE SPEAKER: I think we also want to also sort of step back for a moment. It's important to get these consideration about how to motivate the administration and congress and what are the interests and what are the best arguments on the able for consideration and how we think about the consumption of this paper. We don't want to have a legislative session just now in this setting. That's not why

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we've convened that but it's not to discourage you from those comments. I think those are insightful.

MALE SPEAKER: I agree. We can't have a legislative session here but I do think we went through this when we were writing the paper and trying to come up with what really were the best arguments and at the end of the day the best arguments are this is the best interest of public health and I know that is not necessarily exciting to people in congress, but I think that trying to make other arguments that don't exist also backfires. So I think you're right. It would be great if there was some really compelling argument that said as a result of this we're doing bad things for public health. I don't think we can say that. There's probably small things you can point to and you can probably stretch some logic some, but I think our best argument has to be that if you get the years of people who care enough about this issue and care enough about doing the right thing and I think for the administration it is to a certain extent playing on the sense that there is some pride as being seen as a global leader on this issue, and if we want to be consistent with that sense of pride that here's one other thing that would help and so I think we struggled with that and at the end of the day we have to go back to what are the core reasons for doing it to begin with, but we can keep thinking about it.

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MALE SPEAKER: I don't think that this either in the Congressional or executive branch requires a major mobilization. I don't think the resistance to it is going to be significant. I don't think the complexity of coming forward with policies that would work is going to be all that complicated and its really a question of finding a champion in both domains who is prepared to cooperate and do the right thing and will be applauded for that and will not be a foreign policy triumph.

FEMALE SPEAKER: Its almost the fact that nobody does care will play in our favor. This is really not that big a deal and so maybe it can just move forward.

FEMALE SPEAKER: I think we were thinking the same thing. Because hearing a little more about this practical day to day, maybe that wasn't what you were going to say because Walker works with clients trying to navigate all of these complex policy issues but if that's not what you were going to talk about please go ahead.

MALE SPEAKER: That's what I talk about all the time and live and breath for the last 10 years. I appreciate your optimism Dr. Morse and I'm not as optimistic that we wont get a lot of resistance. I think that you're very convincing that the public issues here are a question – no doctor is going to be concerned that HIV positive foreign nationals present a

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danger to our health but I do think as Mr. More I believe said we're going to get a lot of debate on the public charge issue whether or not public born people with HIV are going to be expensive and whether or not the procedures in place of the affidavit are adequate to demonstrate that these folks are not going to put a burden our market. That will be very relevant to our debate or anybody's interest here.

I don't think we can demonstrate that public health is harmed by not allowing these folks in, but I think we can demonstrate that our public interest is harmed by not allowing people in by our credibility in our leader in HIV, but I can tell you in our day to day, so many of them have humanitarian reasons, why they should be here, why it's a great hardship why they can't stay here and a lot of them are well trained people and their companies need them here and many have been who sponsored for green cards by their employees. These are highly trained people. They do not qualify for the green card because they do not have the qualifying relative. It is a great hardship to the business when they can't proceed and follow through and if need be, that we find compelling people to testify to really present the human face on this, I can always get those people, because they're out there and I talk to them constantly.

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FEMALE SPEAKER: I was just going to add while you're giving the mic to the next person, Phil just showed me something that said the existing data suggests that people who immigrate legally, more of them get their HIV infection in this country than before they came in so I think it is one piece of evidence that adds to public charge and some of those kind of data then it does start at least building the case for some of the things that you're talking about Alan.

MALE SPEAKER: [Inaudible] with the Bay Area Reporter. The closest parallel that I can think of for this change you are trying to implement is the FDA policy on MS blood donations. We saw in that situation that attempts were made to change the policy on largely the same reasons. The situation had changed. Our knowledge had changed. The policy made no sense. There were domestic constituencies and bureaucratic constituencies that imposed a regulatory change as opposed to a legal change and yet we saw that effort fail. What lessons can you draw from that experience and why do you think the outcome will be different?

LOUIS SULLIVAN: Let me suggest a couple things which I think have already been said in a way. I think that this administration is in its twilight years. We have a president who's provided 15 billion dollars for an international AIDS program. He also provided I believe it's three billion dollars

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internationally for malaria programs, so those are significant dollars. More than any administration has ever done. I would think that since other things are not going so well here, that this would be an opportunity to try to appeal to the administration, that this would not only be in the public interest, but this would be consistent with what you're doing here with this issue, so at least I would think that would be worth that opportunity. We've had this statement from the President of the intention to change this, so I would really take him up on that and see if we could have a dialogue and see if we could work with them and be helpful and provide suggestions.

Might not be successful, but sometimes you're surprised with what does happen. So that at least that would be my suggestion.

LESLIE: Hi, my name is Leslie [inaudible]. I'm speaking partially on behalf of several other families are affected by visa's and the inadmissibility of noncitizens in relation to international adoption and that particular issue, while international adoption is not really an issue in this case, it does shine a light on this policy compared to many other situations.

If I were adopting child who had hepatitis or down syndrome or a heart defect or a number of other conditions,

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once I went through the program in my state, had background checks, had references everything under the sun and was approved by the United States Customs and Immigration Service and then was approved by the government of the country from which I was adopting a child who was deemed by them to be an orphan and by our U.S. Customs and Immigration to be an orphan, that child once adopted and recognized by my government and that other government as my child, could come into the United States as my child and as a citizen of the United States, however, because of this inadmissibility they're denied the visa, and this process creates an additional burden beyond what this already imposes and this does have a health impact on children and there are children who are legally the children of their parents of United States citizens and who are unable to come to the United States for the care and love of a family that they need and it shines really an example of how it does not make a lot of sense.

FEMALE SPEAKER: Can you explain because I think there's an additional burden because the question raised earlier was looking at maybe expediting that. Can you explain what the process is now when at that moment what happens?

FEMALE SPEAKER: What happens is that anyone who wants to adopt a child, they have to go through a lengthy process of home study and in your state and approval by the United States

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Customs and Immigration and then go through the process of the foreign government for the child to be deemed adoptable and also then by customs for that child to be deemed as an orphan who could adopted by a United States citizen and at point when the child then is eligible and has the ability to come to the United States, when the visa goes for the appointment they are denied because of their HIV status and in order for the child to come to the United States, because they are then declared an immediate relative of the United States citizen they have to go through a waiver process which was discussed before.

The parent has to in addition to everything else the parent has already done, again, many documents from doctor, from a public health official of the county and the state, and this has to go through the approval process of the CDC as well as the embassy of the foreign government again, and so it's not a quick and easy process. It can take up three to six months on top of what the already lengthy process is, so although it's a very small issue, it does shine a window on the burden and there are children who have become sicker during that point of time when they are going through the waiver process.

FEMALE SPEAKER: Thank you for clarifying that. For answering the questions on people's minds. Sorry.

FEMALE SPEAKER: Hi, my name is [inaudible] I'm with the International Community of Women Living with HIV and AIDS

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and thank you for the forum and thank to the participants who are working to change this policy but I want to communicate a public health disincentive for this policy, that this idea that people coming into the country to infect people living in the country with HIV sends a message to people without HIV that they bear no responsibility in protecting themselves and stopping the transmission of HIV and if we could measure that I think you would find that it does show a public health disincentive for maintaining this policy and another question I have is I'm wondering how many other countries have this policy and I know that Russia and China are and I have heard that China is taking measures to change this but the kinds of countries that have these laws, the kind of company we're kept in with this policy is I think a reflection on the United States.

FEMALE SPEAKER: If David wants to –

MALE SPEAKER: Let me comment briefly on that.

Regarding HIV screening or exclusion of short-term visitors, there are a number of countries that have laws like that, some of which are changing to become more liberal and China and Russia are both countries that do not allow entry for HIV infected people. A more complex issue is what happens with people who want to immigrate and the number of countries that require screening and for example, Belgium tests all of its

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long-term visitors or people who want immigrant visas. France is an example of a country that does not require testing but requires very high levels of health insurance for anyone who wants to immigrate. Canada does not have automatic inadmissibility, but they don't have a blanket exclusion, but everyone coming for at least six months or for permanent immigration, has to go through what's called an excessive demand concern.

It's not specific for HIV, it actually addresses other chronic illnesses as well and anyone coming from a number of countries that have high HIV prevalence and has to have an HIV test as well. So there's a whole mix and at least for long-term immigration, the testing requirement is present in a number of places. The short-term requirement is clearly out of line with that.

FEMALE SPEAKER: I think it's an important distinction that shows the complexity of this issue. One of the things I know Craig McClure will talk about from IAS when he's here in a couple weeks is how IAS looks at this and whether or not a conference can be held somewhere focused on that visitor piece. Not that they wouldn't have a position on the immigration law, but it's focused on the visitor piece, so Canada and Canada did have a visitor ban, but in association with the international AIDS society and others changed that in advance so the

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conference could be held there but they didn't make an underlying change in immigration law.

So it's a very complex realm and just like Phil said I believe there's a website that has a listing of the visitor immigration and what the status is. It's the one that has the most information in one place.

MALE SPEAKER: The reference for that is in the paper.

FEMALE SPEAKER: Just the first part of your comment I think goes back to this statement that I read early on, it just reinforces the last sentence that says the best defense against further spread of HIV whether from a U.S. citizen or an alien is an educated population. I think we need to remember that it is not people coming into our country causing our HIV spread. It is people within our own country not taking responsibility individually or Societally so I think we have to keep going back to talking about having an impact on HIV, this is not the issue. It is really looking at being much more vigorous in our prevention to being with.

FEMALE SPEAKER: Two things. One for clarification purposes is what Helene read from is actually an HHS press release from January of 1991, so it's archived on the web. We have some time, why don't we take a few questions and let the panelists respond to those and we'll give them the last work and then we'll close. So who has questions still? Unless we

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only have one question then we'll just take one. So there's two. So maybe three questions.

GUS: I'm Gus [inaudible] and I'll identify as part of the international family of those living with HIV/AIDS. I happen to be American. How many other people here are living with HIV/AIDS? I vary. That's great, but it also shows that those of us who are involved or concerned here are for the principle of involvement of people with HIV/AIDS. It was mentioned that Whitman Walker which does such good work, they're out there, well they're' also in here. I appreciate the pillars on which this report and your public health emphasis are based, so I wont reiteration them. In terms of question, can you imagine what it's like to be in a consular visa section of a U.S. embassy abroad, which is like being in the waiting room of a prison and have your name called over a loud speaker and everyone here, what did you mean by yes by checking off communicable diseases. I have friends that's happened to in countries where the stigma is greater than the United States but if you can just imagine what that experience is, but also if you're in that country where you make \$300 a year where you're invited to come to the U.S. and the visa application is \$100 but the waiver is \$250 dollars, at least that was true last year, what is that like? It's a part of the detriment, we've established the admission of people is not a

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threat to our public health and maybe the threat is to our
national reputations.

AIDS activists and those concerned about them around
the world have a loud voice and in many cases, I have been in
recently, they mistake their knowledge of the discrimination
policies as a rejection of the administration's very positive
AIDS policies. I appreciate so much this meeting being held in
your report.

JENNIFER KATES, M.A., M.P.A.: Other questions? Okay.
We can go home now? There seem to be a couple other questions.
Sorry.

[Inaudible] one of those American embassies in 1987
when the law came into effect and I don't think any of us
really thought twice about it. The public charge piece of it
seemed persuasive, but then one of my colleagues had to enforce
this. It was a man who had lived in the states of 20 years.
As people pointed out it was likely to happen here and my
friend said I'm sorry we cannot let you go back. And the guy
said I can't believe you're saying that, but my whole life is
there. He said we can't it's against the law. He said I will
go back, whether I have this visa or not, I will go home and my
friend said good luck and we cant do it for you and can we show
this really had any impact? I'm sure it hasn't because people
will come in and hide their medicine or get home through Mexico

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or do whatever, but I don't think it was effective for the purpose when it was intended and at a time when we do look bad international this would be an easy small win and it does sound like as Dr. Sullivan said the President is already thinking in that direction, I hate to say it, focus on the orphan issue which can be persuasive to people who don't care about other groups and just say here is an easy win at a time when we could use a few of those?

JENNIFER KATES, M.A., M.P.A.: Questions? David has a question in the back and so we'll do David, Todd and then Bob has another question and then we're really no more questions. Panelists get the last word.

MALE SPEAKER: Just a very quick comment from the perspective of UNAIDS and building off of the speaker in the front, one of the things we're underestimating the knowledge that most people on the hill have and that one still exists and one if they know it exists having any appreciation for the negative impact that it is having on individuals. And so, you know we found very persuasive and I'm not going to mention any names and bringing people before Congress who've gone through the experience that's Peg's describing of going to get a visa, even if they do declare themselves for a waiver, how discriminating that actually feels and how that's communicated to others on the hill and who have not experienced that and I

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do think it can be very persuasive in addition to the public health arguments that we're making and the issue that public charge issue is not otherwise dealt with and we're not pulling HIV out in a way that's exceptional.

We're basically saying that let's not treat HIV differently or add an additional bar for HIV that's not for other things and I think that basic level of knowledge on the hill in addition to having a couple of champions who might push this not to get into a legislative strategy discussion I think could really move it. I think there's a very, very low level of understanding among members of Congress that this exists, and if they do know that it exists, that there's not any appreciation for people in embassies or consular affair offices of coming to face with it. I would also encourage others in this room who have taught on the front from the Whitman Walker perspective, but thinking about ways as Dr. Sullivan was alluding to somewhat dispassionately of bringing those people into a dialogue and into the discussion so that we can really say sort of not throwing rocks at doors but let me bring you before a decision maker and let it show what this experience feels like and what it then does to the perceptions of United States leadership.

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JENNIFER KATES, M.A., M.P.A.: I think we are done with questions. So if anyone on the panel wants to have the last word?

FEMALE SPEAKER: I don't necessarily want to have the last word [interposing] but I think after several of the comments I do think that this is something we should actually think about is actually collecting case stories. I think like an epidemiologist, I think you have to have massive large data that has statistical value, but that's not really the way sadly sometimes unfortunately but that's not the way policy makers always think and I think it is these stories that bring real life situations home that can make the case persuasively about back to Alan's comment on the harm that's done, even if this is no large scale harm and the population based sense. So I think it may be something we may want to do, and I think that those who have stories that you suggested, if you actually can give those to us in a written form and I think it would be very powerful for us to collect those and put forth a case history and if you had data with names and situations, whatever you have. I think that would be very useful.

FEMALE SPEAKER: Certainly in our work at Kaiser on issues around Medicaid and low income populations, HIV and not HIV specific we've always found that providing real people and providing the complexities of their situations, it really means

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a lot more than the data that we crunch all the time too. So I think that's a great idea.

LOUIS SULLIVAN: I would certainly agree with Helene, but I would do both, because you want to really have as airtight a position as possible, because you know you're going to have people taking potshots at you. I agree that having personal stories in my experience, working with congress over the years, is that those stories do have an impact and sometimes much more than the epidemiologic study. The second point I would make is this is that if you were to find a champion in the congress who would also be on the appropriate committees, because in my opinion it's really a marginal effort that's on a committee that doesn't have anything to do with this issue, but failing that, I would be mindful that we are approaching an election year and this is a complex issue and you don't want to have an issue that takes 20 minutes to explain so if you have a champion here I would go with that.

Absent a champion, I would really find a way to communicate and work with the administration. That's the one game that's in town thus far. You may end up with less than a perfect solution. I would agree that the legislative solution would be the best, but starting from scratch without a champion in the congress at this particular time would not be the time I would try to mount that, because this is too complex an issue,

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but I would certainly try to take advantage of the President's announcement and work with his staff and come up with a resolution and I would hope and think that there would be a possibility here but clearly the only way you assure that nothing happens is if you don't do anything.

FEMALE SPEAKER: I just want to say words of wisdom and big thanks to our panelists and especially Dr. Sullivan. As Helene said, after all this time for still being committed to talking about HIV and the importance of addressing HIV and some of you for coming, for coming to these before and we really appreciate that and to others we look forward to continuing a dialogue. Thanks to CSIS.

[END RECORDING]