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"Loathsome and Dangerous": Time to Remove Syphilis and Gonorrhea as Grounds for Inadmissibility

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ABSTRACT

In this Comment, I examine the ways the United States has managed its borders and population through health-based exclusions that often serve as a proxy for race-based exclusions. I look specifically at how two sexually-transmitted infections (STIs)—syphilis and gonorrhea—became and remain grounds for inadmissibility. Since 1891, certain noncitizens entering the U.S. must be screened for these two STIs, yet both infections are detectable, treatable, and prevalent in the United States. Through analysis of the laws and policies that govern inadmissibility, I show how mandatory screening for STIs is a product of fear-based disease narratives and racist calculations of risk, with origins in more explicitly racist forms of health control, particularly sexual health control, at the U.S. border. I investigate how the premise of border health security relies on racial, gendered, and geographic othering, where sexual health in particular becomes a site of intervention for the U.S. government to manage threats to whiteness. Ultimately, after overviewing the impacts of mandatory STI screening, I conclude that STIs must be removed from inadmissibility grounds.

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INTRODUCTION

During the COVID-19 pandemic, the Trump administration seized the chance to enact bold, sweeping border closures. President Donald Trump declared a public health emergency and used those emergency powers to block the entry of (some) migrants. The government quickly instated COVID-19 travel bans for certain countries,[1] beginning with China and Iran.[2] Under the cover of the pandemic, the Trump administration even suspended the entry of immigrants who it claimed might jeopardize U.S. economic recovery.[3] The longest closure was the invocation of Section 265 of Title 42, a little-used provision in the Public Health Service Act that authorizes the director of the U.S. Centers for Disease Control and Prevention (CDC) to block the entry of individuals when there is a "serious communicable disease threat."[4] Trump enacted Title 42 at the Mexico and

1. *See Travel Restrictions Issued by States in Response to the Coronavirus (COVID-19) Pandemic, 2020–2022*, BALLOTPEDIA, https://ballotpedia.org/Travel_restrictions_issued_by_states_in_response_to_the_coronavirus_(COVID-19)_pandemic,_2020-2022 [https://perma.cc/W2AP-34LH]. Most countries enacted similar restrictions as an immediate response to the pandemic. *See COVID-19 Related Travel Restrictions*, UN WORLD TOURISM ORG. https://www.unwto.org/covid-19-travel-restrictions [https://perma.cc/PQF4-ULF3]. *See also* Erika Lee, Maddalena Marinari & Ibrahim Hirsi, *How the U.S. Weaponized COVID Against Migrants*, PUB. BOOKS (Aug. 2, 2021), https://www.publicbooks.org/how-the-us-weaponized-covid-against-migrants [https://perma.cc/X7Z3-MRQX] ("The initial travel restrictions, for example, targeted the same immigrant groups subject to previous immigration provisions and echoed earlier racist rhetoric about the pending arrival of thousands of people from Muslim and predominantly African nations.").
2. The United States did not enact a travel ban against Europe until nearly a year after the pandemic began, even though Italy was one of the first countries with a high caseload. *See* Suspension of Entry as Immigrants and Nonimmigrants of Persons Who Pose a Risk of Transmitting 2019 Novel Coronavirus and Other Appropriate Measures to Address This Risk, 85 Fed. Reg. 6709 (Jan. 31, 2020); Suspension of Entry as Immigrants and Nonimmigrants of Persons Who Pose a Risk of Transmitting 2019 Novel Coronavirus and Other Appropriate Measures To Address This Risk, 85 Fed. Reg. 12855 (Feb. 29, 2020).
3. *Proclamation Suspending Entry of Immigrants Who Present Risk to the U.S. Labor Market During the Economic Recovery Following the COVID-19 Outbreak*, THE WHITE HOUSE (Apr. 22, 2020), https://trumpwhitehouse.archives.gov/presidential-actions/proclamation-suspending-entry-immigrants-present-risk-u-s-labor-market-economic-recovery-following-covid-19-outbreak [https://perma.cc/TDW9-F4K6]. The United States was the only country to issue such a ban during the pandemic.
4. John Gramlich, *Key Facts About Title 42, the Pandemic Policy That Has Reshaped Immigration Enforcement at U.S.-Mexico Border*, PEW RSCH. CTR. (Apr. 27, 2022), https://www.pewresearch.org/short-reads/2022/04/27/key-facts-about-title-42-the-pandemic-policy-that-has-reshaped-immigration-enforcement-at-u-s-mexico-border [https://perma.cc/Y6A8-35WN].

Canadian borders, but nearly all expulsions were at the southern border.[5] The invocation of Title 42 was clearly a transparent ploy to curb migration, under the guise of a health emergency.[6]

When President Joseph Biden took office less than a year later, his administration enacted a similar travel restriction.[7] Biden also initially kept Title 42 in place, over protests that the policy was plainly racist.[8] A federal judge blocked enforcement of Title 42 as an "arbitrary and capricious" invocation of the Public Health Service Act, because of the tenuous connection between migration and the pandemic, and the policy's devastating impact on migrants.[9] A few months later, Biden tried to end Title 42—over a year after its implementation—but then a different federal judge blocked the order because of the "irreparable harm" it would cause states to provide healthcare for migrants.[10] The Title 42 restriction finally expired in May 2023, over three years later, with the end of the declared public health emergency. By its end, the policy authorized 2.7 million expulsions at the Mexico border alone, while other points of entry remained relatively open.[11]

5. *A Guide to Title 42 Expulsions at the Border*, AM. IMMIGR. COUNCIL (May 25, 2022), https://www.americanimmigrationcouncil.org/research/guide-title-42-expulsions-border [https://perma.cc/9UZ7-9XST].
6. *See* Prashasti Bhatnagar, *Public Health as Pretext: The Evisceration of Asylum Law and Protections During a Pandemic*, 35 GEO. IMMIGR. L.J. 317 (2020); Azadeh Erfani, *Closing the Border Was an Illegal, Racist Distraction From a Failed Covid-19 Response. Then, It Became Indefinite*, NAT'L IMMIGR. JUST. CTR. (June 22, 2020), https://immigrantjustice.org/staff/blog/closing-border-was-illegal-racist-distraction-failed-covid-19-response-then-it-became [https://perma.cc/6Y5F-CGAU].
7. Suspension of Entry as Immigrants and Nonimmigrants of Certain Additional Persons Who Pose a Risk of Transmitting Coronavirus Disease 2019, 86 Fed. Reg. 7467 (Jan. 25, 2021).
8. Priscilla Alvarez, *ACLU Files Lawsuit Against Border Coronavirus Restrictions*, CNN (June 10, 2020), https://www.cnn.com/2020/06/10/politics/aclu-lawsuit-border-restriction-coronavirus/index.html [https://perma.cc/WLS3-CB2N]. CGRS and Oxfam America joined the suit. *Id.*; *Public Health Experts Urge U.S. Officials to Withdraw Order Enabling Mass Expulsion of Asylum Seekers*, COLUM. MAILMAN SCH. PUB. HEALTH (May 18, 2020), https://www.publichealth.columbia.edu/news/public-health-experts-urge-u-s-officials-withdraw-order-enabling-mass-expulsion-asylum-seekers [https://perma.cc/YGD3-HR9A].
9. Huisha-Huisha v. Mayorkas, 642 F. Supp 3d 1, 20, 27, 39 (D.D.C. 2022). The opinion also noted that millions of other travelers crossed the border under less restrictive measures. *Id.* at 42. This varying permeability of the border, depending on the identity of the person crossing, further underscored the pretextual nature of the government's public health claim.
10. Uriel J. Garcia, *Judge Blocks Biden Administration From Lifting Public Health Order Used to Quickly Expel Migrants*, TEX. TRIB. (May 20, 2022), https://www.texastribune.org/2022/05/20/title-42-border-judge-ruling-migrants [https://perma.cc/N9ED-XW9E].
11. *See id.*; Camilo Montoya-Galvez, *What Is Title 42, the COVID Border Policy Used to Expel Migrants?*, CBS NEWS (Jan. 2, 2023), https://www.cbsnews.com/news/title-42-immigration-border-biden-covid-19-cdc/ [https://perma.cc/YE4Q-38VM]; Camilo Montoya-Galvez, *How Title 42's Expiration Reshapes Immigration Policy at the U.S.-Mexico*

This invocation of Title 42 was a clear example of the U.S. government using bad-faith public health arguments to enact discriminatory border restrictions. The advocacy and outcry brought popular attention to the intersection of health policy and immigration, particularly the way the government can use the two to achieve racist exclusions.

The weaponization of health authority to selectively exclude migrants is not new. The United States has long managed its borders and population through health-based exclusions that serve as proxies for race. The use of security logic to shape health policy is called "health security."[12] In the United States, national security and health security often work in tandem, as the U.S. government frequently invokes concerns over public health during national security crises.[13]

Border, CBS NEWS (May 12, 2023), https://www.cbsnews.com/news/what-is-title-42-policy-immigration-what-happens-ending-expiration [https://perma.cc/4R6W-ZUQL].

12. Health security in this framing has a specific relationship within U.S. military imperialism and a xenophobic fear of outsiders. The idea of being health secure could have radical potential—for example, available and affordable medical care security, food security, or housing security. The concept of health security I refer to here, however, is used by the U.S. government to justify exclusionary practices in tandem with the national security apparatus. Steve Hinchliffe and Nick Bingham elaborate on this narrow and nativist view of security, describing nation-state security (as conceptualized by Western states) as "premised on a bipolar world of friend and enemy, its spatialization into territorial units, and a militarization of various borders." Steve Hinchliffe & Nick Bingham, *Securing Life: The Emerging Practices of Biosecurity*, 40 ENV'T & PLAN.: ECON. & SPACE 1534 (2008); *see, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905) (affirming that "self-defense" principles authorize a society's "right to protect itself against an epidemic of disease which threatens the safety of its members"). The U.S. government deems certain bodies health threats to its members, and it attempts to sort members from threats through border enforcement as a health security project.

13. For example, eleven days after the September 11th attacks, the Bush administration created the Office of Homeland Security (formalized as the U.S. Department of Homeland Security (DHS) in 2002). President George W. Bush, in describing the functions of the new DHS, included "stockpil[ing] more medicines to defend against bioterrorism." George Bush, *The Department of Homeland Security*, DHS 1, 1 (2002), https://www.dhs.gov/sites/default/files/publications/book_0.pdf [https://perma.cc/5UFU-SAPZ]. Today, DHS has multiple projects to develop medicine to defend against bioterrorism, and the military is one of the dominant investors in prosthetics and leads research to combat infectious diseases domestically and globally. *See, e.g.*, Lena Sun & Juliet Eilperin, *Obama: U.S. Military to Provide Equipment, Resources to Battle Ebola Epidemic in Africa*, WASH. POST (Sept. 7, 2014), https://www.washingtonpost.com/world/national-security/obama-us-military-to-provide-equipment-resources-to-battle-ebola-epidemic-in-africa/2014/09/07/e0d8dc26-369a-11e4-9c9f-ebb47272e40e_story.html [https://perma.cc/RE5C-8KYY]. Many scholars have noted that September 11 set in motion a new project of expansive securitization against bioterrorism. *See, e.g.*, PATRICIA NOXOLO & JEF HUYSMANS, COMMUNITY, CITIZENSHIP, AND THE "WAR ON TERROR" (2009); Wendy Larner, *Neo-*

That is, public health initiatives often work within national security frameworks and adopt or mirror many of the same rhetorical tactics, such as the concept of preempting health (much like security) threats.[14] For example, health security mimics national security in the reasoning that individuals must relinquish certain rights due to policies to remove security risks.[15] Thus, health security describes the U.S. government's investments in defensive measures against internal and external health threats.

The specific health security projects in this Comment occur on the border, where the U.S. government justifies exclusions as protections against external health threats.[16] This spatial strategy relies on the assumption that diseases can be

Liberalism: Policy, Ideology, Governmentality, 63 STUD. POL. ECON. 5 (2000); REECE JONES, BORDER WALLS: SECURITY AND THE WAR ON TERROR IN THE UNITED STATES, INDIA, AND ISRAEL (2012); Melinda Cooper, *Pre-empting Emergence: The Biological Turn in the War on Terror*, 23 THEORY, CULTURE & SOC'Y 113, 113–14 (2006) (observing the U.S. government's divestment from public health to biodefense against a "generic microbiological threat"). However, the development of DHS is situated in a longer history of similar protective reflexes. During World War II and the Cold War, the United States also prioritized health as a security agenda item. *See, e.g.*, Colin McInnes & Kelley Lee, *Health, Security and Foreign Policy*, 32 REV. INT'L STUD. 5 (2006); JENNIFER TERRY, ATTACHMENTS TO WAR: BIOMEDICAL LOGICS AND VIOLENCE IN TWENTY-FIRST-CENTURY AMERICA (2017).

14. *See* Nicholas B. King, *Security, Disease, Commerce: Ideologies of Postcolonial Global Health*, 32 SOC. STUD. SCI. 763, 763 (2002) ("Although often characterized as [a] humanitarian activity, modern public health as practi[c]ed in the United States and other Western industrialized nations has long been closely associated with the needs of national security and international commerce"); *see, e.g.*, *Mission, Role, and Pledge*, CDC (Apr. 29, 2022), https://www.cdc.gov/about/organization/mission.htm [https://perma.cc/UFU9-759H]. Centers for Disease Control and Prevention (CDC) describes part of its mission as "[f]ighting diseases before they reach our borders—detecting and confronting new germs and diseases around the globe to increase our national security." *Id.* The U.S. government conceives of these threats narrowly. It does not address the root causes of terrorist attacks, nor does it address structural health inequalities that make individuals from certain countries more likely to have certain health conditions. The security policies are instead focused on exclusion.

15. Much like national security efforts—such as airport body scans—health security initiatives often justify similar individual sacrifices of privacy—such as COVID-19 contact tracing—for the so-called safety of the country.

16. *See Considerations for Health Screening at Points of Entry*, CDC (Aug. 26, 2022), https://www.cdc.gov/immigrantrefugeehealth/considerations-border-health-screening.html [https://perma.cc/SMX6-QRV2]; CDC, *Travel Restrictions to Prevent the Spread of Disease*, CDC (Oct. 5, 2022), https://www.cdc.gov/quarantine/travel-restrictions.html [https://perma.cc/8YL5-C8UY]; *see also* King, *supra* note 14, at 764 ("One of the key functions of public health has been to protect its citizens against threats perceived as having an external origin, particularly infectious diseases carried across national borders."). This focus leads to disproportionate attention at the border, while other health factors, like food quality or environmental health, receive too few resources.

restricted through policy at political borders.[17] Though recent outbreaks, including SARS, swine flu, Ebola, and Zika, highlighted the futility of trying to confine communicable diseases into state boundaries, national and international efforts still focus on containing disease by managing the movement of people across borders.[18] Polly Price recognized how "[t]he fear of the global spread of pandemic diseases . . . compels governments to emphasize national security at their borders."[19] Written before the COVID-19 pandemic, Price's words have only become truer as many countries, including the United States, initiated travel bans, ceased visa admissions, and implemented widespread vaccination requirements to manage the early stages of the pandemic.[20]

In this Comment, I clarify that health cannot be achieved by individual—or population—based border policing. To do so I develop a critique of what I term *border health security*: the efforts, policies, and rhetoric focused on ensuring national health through the management of bodies at the border.[21] Border health security refers to the way health policy is instrumentalized to implement a series of narrow and nativist protective measures, such as the exclusion, examination, or incarceration of individuals at the border.[22] While health security encompasses

17. *See, e.g.*, Robbie J. Totten, *Epidemics, National Security, and US Immigration Policy*, 31 DEF. & SEC. ANALYSIS 199 (2015).

18. *See, e.g.*, Nicole Errett et al., *An Integrative Review of the Limited Evidence on International Travel Bans as an Emerging Infectious Disease Disaster Control Measure*, 18 J. EMERGENCY MGMT. 7 (2020); *U.S. Port Health Stations*, CDC (Apr. 21, 2022), https://www.cdc.gov/quarantine/quarantine-stations-us.html [https://perma.cc/5U7B-5NHC] ("[In] 2004–2007 [the n]umber of quarantine stations increased to 20 because of concerns about bioterrorism after World Trade Center attack in 2001 and worldwide spread of disease after SARS outbreak in 2003.") [https://perma.cc/5RVJ-U7AT].

19. Polly J. Price, *Sovereignty, Citizenship, and Public Health in the United States*, 17 N.Y.U. J. LEGIS. & PUB. POL'Y 919, 920 (2014).

20. *See supra* Introduction (describing the Trump and Biden administration response to the COVID-19 pandemic).

21. The U.S. House of Representatives introduced a bill titled "Border Health Security," which seeks to "keep all Americans safe from threats to our biosecurity" through the increase of information-sharing and surveillance of infectious diseases at the U.S. border. Border Health Security Act of 2021, H.R. 4812, 117th Congress (2021). This bill was introduced after I began writing, so it did not inform my choosing of the term, but it provides a pertinent example of the phenomenon I describe.

22. Title 42, the detention of Human Immunodeficiency Virus (HIV) positive Haitians in Guantánamo, and the incarceration of Panamanian women suspected of sex work are all reflective of U.S. use of carceral tactics under the guise of health. *See generally* NEEL AHUJA, BIOINSECURITIES 71 (2016); A. Naomi Paik, *Carceral Quarantine at Guantánamo: Legacies of US Imprisonment of Haitian Refugees, 1991–1994*, 115 RADICAL HIST. REV. 142 (2013). The U.S. government and certain health officials often characterize these measures as necessary to

the variety of the ways a state engages in health defense, border health security specifically concerns government efforts taken in pursuit of the fiction that health risks can be stopped at state lines. The policing of health risks at the border reinforces U.S. government efforts to make the border a real barrier between the United States and the outside world.[23] The policing of these health risks is incomplete and inconsistent, where the border is permeable for individuals considered less risky (like citizens or European tourists). In that sense, the border becomes a greater boundary for certain groups of people perceived as posing certain risks (like refugees). When the U.S. government selects people for increased scrutiny or requirements because they belong to a risk group or come from a particular place, the government fortifies the boundaries of who gets to be part of the United States.

My approach to the concept of border health security is informed by geography. Disease geography scholars have long pointed to the discriminatory and dangerous implications of popular rhetoric that locates disease in certain places or in people from those places.[24] The United States portrays its border as a barrier to unhealthy or risky places, and it uses border health security interventions like medical examinations as a way to prevent unhealthy or risky bodies from infecting the state. The United States classifies certain groups as more dangerous to its health security, much like it does in national security projects.[25] Border health security relies on seemingly medically objective calculations of risk as a basis to

achieve health, but I argue that health is being used to justify these movement restrictions and security measures, which are the ends, not the means.

23. For further discussion of the paradox of the border, *see* WENDY BROWN, WALLED STATES, WANING SOVEREIGNTY 38–39, 80–82 (2010) (describing how the U.S. government's efforts to fortify its barriers via border wall are ineffective protections against perceived threats, instead the efforts serve as a symbolic divider between the U.S. and the Global South that requires constant policing).

24. *See, e.g.*, Nicholas B. King, *The Scale Politics of Emerging Diseases*, 19 OSIRIS 62 (2004); Nicholas B. King, *Immigration, Race, and Geographies of Difference in the Tuberculosis Pandemic*, *in* RETURN OF THE WHITE PLAGUE: GLOBAL POVERTY AND THE "NEW" TUBERCULOSIS 39 (2003) [hereinafter *Tuberculosis*] ; PAUL FARMER, AIDS AND ACCUSATION: HAITI AND THE GEOGRAPHY OF BLAME (1992); S. HARRIS ALI & ROGER KEIL, NETWORKED DISEASE (2008); AHUJA, *supra* note 22; Patricia J. Lopez & Abigail H. Neely, *Fundamentally Uncaring: The Differential Multi-Scalar Impacts of COVID-19 in the U.S.*, 272 SOC. SCI. & MED. 1 (2021); Bruce Braun, *Biopolitics and the Molecularization of Life*, 14 CULTURAL GEOGRAPHIES 6 (2007); Tim Brown, Susan Craddock & Alan Ingram, *Critical Interventions in Global Health: Governmentality, Risk, and Assemblage*, 102 ANNALS ASS'N AM. GEOGRAPHERS 1182 (2012); STEVE HINCHLIFFE, NICK BINGHAM, JOHN ALLEN & SIMON CARTER, PATHOLOGICAL LIVES: DISEASE, SPACE AND BIOPOLITICS (2016).

25. That is, both border health security and national security enforcement often rely on identity-based assessments of risk that are based in little more than stereotypes or scapegoating, such as the targeting of Muslim or Middle Eastern men as terrorism risks.

manage, screen, exclude, and incarcerate certain groups at the border, which creates (by design or effect) discriminatory racial impacts. From early immigration health screening to current COVID-19 restrictions, the United States has a long history of implementing racist, xenophobic health policies at the border. However, despite occasional outcries over discriminatory measures like Title 42,[26] one of the most widespread programs—the mandatory medical examinations of migrants—has received little challenge.

In this Comment, I focus on mandatory medical examinations, specifically the screening for syphilis and gonorrhea, two sexually transmitted infections (STIs).[27] The premise of border health security relies on racial, gendered, and geographic othering, which becomes clear by analyzing mandatory STI screening, one of the United States's most enduring border health security measures. Despite being common and treatable infections, syphilis and gonorrhea are the only STIs that render certain noncitizens inadmissible for entry into the United States.[28] This might be surprising: there are many other STIs, so it is perhaps unclear why these two are the only inadmissible ones or why noncitizens can be excluded for having an STI that is prevalent in the United States. Granted, this policy rarely results in exclusions.[29] Nevertheless, it merits study for three reasons. First, as exemplified by Title 42, legal authorities that lay dormant for extended periods remain available to the federal government as sources of power in unpredictable

26. For other examples of infamous border health security measures, *see also* Michael Ratner, *How We Closed the Guantanamo Camp: The Intersection of Politics and Litigation*, 11 HARV. HUMAN RIGHTS J. 187 (1998) (detailing the litigation efforts to release HIV-positive Haitian migrants detained in Guantánamo); Kenichi Serino, *Travel Bans Punish Countries for Doing Necessary Work to End The Pandemic, South Africa Epidemiologist Says*, PBS NEWS HOUR (Dec. 2, 2021), https://www.pbs.org/newshour/health/outrageous-and-an-overreaction-south-africas-top-epidemiologist-responds-to-omicron-travel-ban [https://perma.cc/M7QA-TNCY] (condemning the U.S. decision to issue a travel ban to South Africa after its discovery of the Omicron COVID-19 variant).

27. Syphilis is a bacterial infection caused by *Treponema pallidum*. It is the only STI of the several infections that cause human treponemal diseases, which also include yaws, endemic syphilis (bejel), and pinta. Treponemal diseases are characterized as polymorphous, presenting changing symptoms that result in frequent misdiagnosis in early years, though they first present with lesions. *See* William Eamon, *Cannibalism and Contagion: Framing Syphilis in Counter-Reformation Italy*, 3 EARLY SCI. & MED. 1 (1998); Solomon M. Marks, Anthony W. Solomon & David C. Mabey, *Endemic Treponemal Diseases*, 108 TRANS. REP. SOC. TROPICAL MED. HYGIENE 601 (2014). Gonorrhea is also a bacterial infection that first presents with pain and discharge. *Gonorrhea*, MAYO CLINIC (Apr. 14, 2023), https://www.mayoclinic.org/diseases-conditions/gonorrhea/symptoms-causes/syc-20351774 [https://perma.cc/VR9J-KQZC].

28. 42 C.F.R. § 34.2. Inadmissibility grounds only apply to noncitizens seeking admission, which includes individuals with any immigrant visa application, refugee application, adjustment of status application, and certain nonimmigrant visa applications.

29. *See infra* Part I.C.3 (discussing the available data on Class A inadmissibility findings).

moments. Second, the government's uneven approach to syphilis and gonorrhea on the border has no scientific justification. Third, this selective STI screening requirement is the product of longstanding eugenic and racist discourses around sexual health, sexual immorality, desirability, and population control. I interrogate STI screening to reveal the medical examination as a nonsensical and discriminatory immigration policy.

In Part I, I look at the current STI screening requirement to show how the current system has burdensome effects on migrants and how the policy is not grounded in legitimate public health understandings. I describe the status of Class A and B conditions in immigration regulation as of 2023. Next, I look at the impact of a Class A or B notification, as well as the impact of the examinations in general, on applicants. Finally, I assess the prevalence of syphilis and gonorrhea Class A and B notifications, the consequences of such diagnoses, and the ways STI screening affects all applicants.

In Part II, I discuss the origins of U.S. government management of health within immigration policy, particularly sexual health, to explain how this screening requirement originated. I show how health-based exclusions developed alongside race-based exclusions in immigration policy, as well as how the eugenic movement influenced both immigration law and sexual health management in ways that can still be seen in STI screening. I highlight the history of the authority for medical examinations for inadmissibility grounds, looking at how this public health mandate has been used to implement violent and discriminatory sexual health interventions at and across the border. I argue that the history demonstrates that mandatory STI screening is a legacy of xenophobic immigration policies and racist eugenic policies, in which STI-based exclusions serve joint functions of population selection.

In Part III, I recommend removing STI screening from the immigration process. I provide a brief theoretical framework to clarify how present screening practices are inextricable from their roots in eugenics. I conclude that contemporary STI screening works only as a tool of racist border health security policies, perpetuating xenophobic logics entrenched in the U.S. immigration system.

I. RETAINING SYPHILIS AND GONORRHEA AS CLASS A AND B CONDITIONS DOES NOT PROTECT PUBLIC HEALTH

In Part I, I argue that, given the current prevalence and management of syphilis and gonorrhea in the United States, screening and excluding individuals with these STIs has minimal impact on public health, but a very negative impact

on noncitizens. In Part I.A, I provide an overview of the current U.S. caseload of syphilis and gonorrhea, as well as CDC efforts to reduce the spread domestically. In Part I.B I compare this reality to the present immigration law and regulations governing mandatory STI testing of applicants. Lastly, in Part I.C I discuss the consequences of an STI Class A or B notification on both caseload and applicants.

A. Domestic Prevalence of Syphilis and Gonorrhea Today

Before describing the STI screening system on the border and its legal structure, I first explain how the syphilis and gonorrhea caseload is handled in the United States, to show how these domestic practices differ from practices at the border.

Both syphilis and gonorrhea are relatively common in the United States. A recent outbreak of syphilis in 2015 led to renewed public health concern.[30] According to CDC, there were 133,945 new diagnoses of syphilis in 2020.[31] Gonorrhea is even more prevalent in the United States. According to CDC, gonorrhea is "very common, especially among young people."[32] The United States sees 1.6 million new infections a year, and it is the second most reported bacterial STI in the country.[33] Today, both infections are readily treatable, only leading to serious health problems if left untreated.[34] Given that both infections are common

30. Jan Hoffman, *Hunting a Killer: Sex, Drugs and the Return of Syphilis*, N.Y. TIMES, (Aug. 24, 2017), https://www.nytimes.com/2017/08/24/health/syphilis-std-united-states.html [https://perma.cc/AQZ7-LAG8]; *Syphilis Strikes Back*, CDC (Apr. 12, 2019), https://web.archive.org/web/20201018043630/https://npin.cdc.gov/campaign/syphilis-strikes-back [https://perma.cc/H4Y3-73ZR]; Caroline Chen, *Syphilis Is Resurging in the U.S., a Sign of Public Health's Funding Crisis*, NPR (Nov. 1, 2021), https://www.npr.org/sections/health-shots/2021/11/01/1050568646/syphilis-std-public-health-funding [https://perma.cc/RVC6-6UJD]; Tara Law, *Why Syphilis Is Rising in the U.S. and What Symptoms Are*, TIME (Sept. 27, 2022), https://time.com/6217556/syphilis-symptoms-treatment-cases [https://perma.cc/M64C-T8EP].

31. *Detailed STD Facts – Syphilis*, CDC (Apr. 11, 2023), https://www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm [https://perma.cc/T7LX-PCRX].

32. *Gonorrhea – CDC Basic Fact Sheet*, CDC (Apr. 11, 2023), https://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea.htm [https://perma.cc/CLJ2-FD4B].

33. *Id.*

34. Syphilis is treated with a single injection of benzathine penicillin if it is in the primary, secondary, or early latent stages. *Detailed STD Facts – Syphilis*, *supra* note 31. Gonorrhea is treated by a dual therapy strategy: a single dose of intramuscular ceftriaxone and oral azithromycin. *Gonorrhea – CDC Detailed Fact Sheet*, *supra* note 32. Neither of these treatments pose significant risks of further health complications, though there is concern that gonorrhea will become increasingly resistant to these strategies. *Drug-Resistant Gonorrhea: A Public Health Threat*, CDC (July 20, 2022), https://www.cdc.gov/std/gonorrhea/arg/public-health-threat/public-health-threat-text-only.htm [https://

and treatable, syphilis and gonorrhea do not pose an inordinate public health risk relative to other STIs or infections.

Current CDC campaigns primarily focus on the risk STIs pose to procreation. In recent years, CDC has focused on identifying and treating syphilis in pregnant people. Syphilis can be passed from parent to fetus,[35] causing miscarriage, still births, and early infant death.[36] For this reason, CDC urges people to avoid and treat syphilis in order to protect their potential unborn children. Additionally, CDC identifies risk groups for routine testing: sexually active men who have sex with men, sexually active people with Human Immunodeficiency Virus (HIV), and those who are taking PrEP.[37] CDC uses sexual identity as a way of selecting for testing, where CDC assigns different levels of risk to different sexual identities. CDC identifies slightly different risk groups for gonorrhea: "sexually active teenagers, young adults, and African

perma.cc/T2C8-CGJP]. As with all treponemal diseases, syphilis first presents with small, painless sores, meaning an infection can remain undetected for considerable time. If left untreated, syphilis can cause infertility and organ damage. *Detailed STD Facts – Syphilis, supra* note 31. Untreated syphilis can also lead to dementia, which has led to the popular association that syphilis makes a person "insane." *See* William Goldsmith, *Syphilis and Insanity*, 113 BOS. MED. & SURGICAL J. 433 (1885); Willis E. Ford, *Clinical Cases—Syphilitic Insanity*, J. INSANITY 74 (1874).

35. *STD Facts - Congenital Syphilis*, CDC (Apr. 11, 2023), https://www.cdc.gov/std/syphilis/stdfact-congenital-syphilis.htm [https://perma.cc/52PY-MQ9N].

36. CDC recommends that, because of these potential risks, all pregnant people should be tested, presuming that the individual will stay pregnant. The Trump administration used different language:

> Because untreated syphilis in a pregnant woman can infect and possibly kill her developing baby, every pregnant woman should have a blood test for syphilis. All women should be screened at their first prenatal visit. For patients who belong to communities and populations with high prevalence of syphilis and for patients at high risk, blood tests should also be performed during the third trimester (at 28–32 weeks) and at delivery.

Sexually Transmitted Diseases (STDs): Detailed Version, CDC (Jan. 30, 2017), https://web.archive.org/web/20190212070546/https://www.cdc.gov/std/syphilis/STDFact-Syphilis-detailed.htm [https://perma.cc/6V6H-HL8X]. Today, the page reads:

> When a pregnant person has syphilis, the infection can spread to their unborn baby. All pregnant people should receive testing for syphilis at the first prenatal visit. . . .
>
> . . . .
>
> Depending on how long a pregnant person has had syphilis, they may be at high risk of having a stillbirth. The baby could also die shortly after birth. Untreated syphilis in pregnant people results in infant death in up to 40 percent of cases.

Detailed STD Facts – Syphilis, *supra* note 31. Although the Biden administration's CDC page is more inclusive and less accusatory, the recommendations are the same. In both cases, CDC frame these risks and suggestions in terms of the health of the child, who must be protected through heightened screening of the pregnant person's body. *Id.*

37. *Id.*

Americans" as being at the greatest risk for gonorrhea.[38] However, CDC only recommends routine screening for sexually active women under twenty-five and older women with risk factors such as new or multiple sex partners.[39] Because gonorrhea can similarly lead to infertility and pregnancy complications if untreated,[40] CDC also recommends testing before and during pregnancy, much like syphilis. Thus, only certain people in the United States are selected for routine testing, and others only test for these STIs based on an individualized need.

In terms of prevention, CDC largely focuses on encouraging individual behavioral changes—particularly sexual behavioral changes. For preventing both infections, CDC recommends condoms, abstinence, or longterm monogamy.[41] By emphasizing monogamy or abstinence as prevention, rather than other forms of safe sex, CDC constructs the idea of a healthy sexual relationship to be a monogamous one that pursues intentional pregnancy. CDC labels people as at-risk for STIs if they deviate from this idealized sexual relationship.[42] Otherwise, CDC has not implemented other preventative measures.

B. Current Laws and Regulations Governing STI Screening in Medical Examinations

Having briefly outlined the domestic practices for reducing syphilis and gonorrhea infections, I now turn to the practices that govern syphilis and gonorrhea testing at the border.

The U.S. government imposes certain conditions on different categories of individuals trying to enter the border, some of whom are considered to be seeking

38. *Gonorrhea – CDC Detailed Fact Sheet*, *supra* note 33.

39. *Id.* As of the Biden administration, CDC no longer recommends routine gonorrhea testing for queer men. During the Trump administration, the guidance read: "If you are a sexually active man who is gay, bisexual, or who has sex with men, you should be tested for gonorrhea every year. If you are a sexually active woman younger than 25 years or an older woman with risk factors such as new or multiple sex partners, or a sex partner who has a sexually transmitted infection, you should be tested for gonorrhea every year." *Id.*

40. *Id.* If untreated, gonorrhea can lead to epididymitis, which can lead to infertility, or pelvic inflammatory disease, which also results in infertility, ectopic pregnancy, or other pregnancy complications. Like syphilis, gonorrhea can be transmitted to a fetus during pregnancy.

41. *Detailed STD Facts – Syphilis*, *supra* note 31; *Gonorrhea – CDC Detailed Fact Sheet*, *supra* note 33; *STD Prevention*, CDC (Feb. 22, 2023), https://www.cdc.gov/std/prevention/default.htm [https://perma.cc/ZL6U-J52G].

42. This echoes earlier eugenic thinking about optimal procreation. *See infra* Part II (describing eugenic policies to promote or discourage different types of sexual relationships).

admission.[43] Anyone seeking admission is subject to inadmissibility grounds. These include, for example, security-related inadmissibility grounds, public-charge inadmissibility grounds, and health-related inadmissibility grounds. Individuals who have any of these inadmissibility grounds are not allowed entry, unless they seek a waiver or can prove an exemption applies to them.

I consider health-related inadmissibility to be part of border health security, as these grounds are a form of health-based exclusions. These exclusions are designated at different scalar levels, from specific individuals to at-risk groups, and all the way to country-level exclusion.

At the primary level, the United States screens individuals for health-related inadmissibility grounds. As many infectious diseases, particularly STIs, can lie dormant or undetected in the carrier, the U.S. government treats any person not proven healthy as a risk at the border. Attributing a disease outbreak to the entry or actions of an individual becomes an incredibly dangerous scapegoat,[44] yet this tracking of individuals and their movements became increasingly normalized during the COVID-19 pandemic.[45] At the next level, the United States tries to find these potential unknown carriers by defining risk groups,[46] which are used to better determine when and whether a health intervention is necessary. In this way, every individual in a high-risk group becomes subject to health intervention,

43. Anyone applying for an immigrant visa, refugee status, adjustment of status, and certain nonimmigrant visas. This means that an individual already within the United States might be required to test for syphilis and gonorrhea if, for example, they are applying for adjustment of status.

44. *See* AHUJA, *supra* note 22, at 12; PRISCILLA WALD, CONTAGIOUS: CULTURES, CARRIERS, AND THE OUTBREAK NARRATIVE 68, 213 (2008); ALAN KRAUT, SILENT TRAVELERS: GERMS, GENES AND THE "IMMIGRANT MENACE" 79 (1994) (blaming Chick Gin for the start of the bubonic plague in California). The United States has often blamed outbreaks on individuals with "outsider" identities: Chick Gin was a Chinese-American immigrant, Typhoid Mary was an Irish immigrant. *Id.* at 79. Gaëtan Dugas, the so-called Patient Zero of the Acquired Immunodeficiency Syndrome (AIDS) epidemic, was a Canadian living in New York and a gay man. Brian D. Johnson, *How a Typo Created a Scapegoat for the AIDS Epidemic*, MACLEAN'S (Apr. 17, 2019), https://www.macleans.ca/culture/movies/how-a-typo-created-a-scapegoat-for-the-aids-epidemic [https://perma.cc/SZ7L-4EDU].

45. *See, e.g.*, Farah Stockman, *Told to Stay Home, Suspected Coronavirus Patient Attended Event With Dartmouth Students*, N.Y. TIMES (Mar. 4, 2020), https://www.nytimes.com/2020/03/04/us/coronavirus-new-hampshire-dartmouth.html [https://perma.cc/H57S-L6BF]; *Where Americans Gathered, the Virus Followed*, N.Y. TIMES (Aug. 28, 2020), *https://www.nytimes.com/interactive/2020/08/28/us/covid-virus-cluster.html* [https://perma.cc/FE9G-82XG]; Rich DeMuro, *Yes, Coronavirus Tracking Was Installed on Your Phone. No, It's not Doing Anything (Just Yet)*, KTLA (July 3, 2020), https://ktla.com/morning-news/technology/covid-tracking-iphone-android-update [https://perma.cc/8J28-QTG6].

46. *See Tuberculosis*, *supra* note 24; Totten, *supra* note 17.

regardless of their individual risk. Finally, the United States extends this thinking about risk to define healthy and unhealthy, or sanitary and unsanitary, places.[47]

When noncitizens seek admission to the United States, they face every level of scalar exclusion. As an individual, they are screened for inadmissible health conditions. As a member of a particular risk group, they face heightened scrutiny. And as someone coming from a particular country, they face additional scrutiny or outright denial.

The health-related grounds of inadmissibility are set out in 8 U.S.C. Section 1182, or the Immigration and Naturalization Act (INA) Section 212(a)(1)(A). These include conditions like drug addiction, mental disorders associated with harmful behavior, or having a communicable disease.[48] According to the U.S.C., a noncitizen is inadmissible if they have a "communicable disease of public health significance . . . in accordance with regulations prescribed by the Secretary of Health and Human Services."[49] The U.S.C. does not identify particular communicable diseases of public health significance. Instead, the U.S. Department of Health and Human Services (HHS) has the authority to determine which diseases qualify. HHS has delegated this power to the U.S. Public Health Service (PHS) and its agency the Centers for Disease Control and Prevention (CDC) to determine the inadmissible communicable diseases.[50]

PHS and CDC issue regulations categorizing these diseases and other 212(a)(1)(A) health-based inadmissibility grounds into Class A or B conditions. The classes correspond to the consequences for having that condition, where individuals with Class A conditions are rendered inadmissible and individuals with Class B conditions are subject to discretion. Anyone seeking admission—including any immigrant visa, refugee status, adjustment of status, and certain nonimmigrant visas—must complete a medical examination to determine whether they have a Class A or B condition.

47. *See* Brown, Craddock & Ingram, *supra* note 24; FARMER, *supra* note 24. Places as reservoirs of disease. *See, e.g.*, RICHARD PRESTON, THE HOT ZONE (1994); DAVID QUAMMEN, SPILLOVER: ANIMAL INFECTIONS AND THE NEXT HUMAN PANDEMIC (2012).

48. Immigration & Naturalization Act § 212 (A)(1)(a).

49. § 212 (A)(1)(a)(i).

50. 42 C.F.R. § 34.2–4 (derived from Section 361(b) of the Public Health Service Act (PHSA)). Authorized by the Public Health Service Act, together CDC, U.S. Public Health Services (PHS), and U.S. Citizenship and Immigration Services (USCIS) govern health at the border. The U.S. Department of State certifies the panel physicians who conduct the examinations abroad, and USCIS does the same for civil surgeons domestically.

CDC most recently updated the regulations defining Class A and B conditions in 2016. Prior to this regulation, CDC specifically considered removing syphilis and gonorrhea from the list. In its notice of proposed rulemaking, CDC sought comments on whether syphilis and gonorrhea should be removed from Class A and B conditions.[51] The syphilis and gonorrhea exclusions are thus not artifacts of earlier legislation—CDC intentionally and consistently retains these STIs as inadmissible conditions.

According to the new regulation, Class A medical conditions, which render an applicant inadmissible today, include:

> [C]ommunicable diseases of public health significance, a lack of certain vaccinations, and 'a current physical or mental disorder and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of the [individual] or others;' 'a history of a physical or mental disorder and behavior associated with the disorder, which behavior has posed a threat to the property, safety, or welfare of the [individual] or others and which behavior is likely to recur or lead to other harmful behavior;' or 'drug abuse or addiction.'[52]

The Class A definition continues to equate health conditions with "threats," emphasizing the border health security rationale for these exclusions, casting individual health issues—even those that are not communicable—as risky or undesirable to allow into the United States. By excluding noncitizens with these conditions, CDC implicitly signals that it considers individuals within its border with those conditions similarly undesirable to the U.S. population.

CDC limited the list of Class A communicable diseases of public health significance to include four enumerated diseases: syphilis, gonorrhea, Hansen's disease, and tuberculosis.[53] CDC removed three STIs from Class A and B designation but retained syphilis and gonorrhea,[54] observing that no public comments had recommended removing syphilis and gonorrhea. Despite the continued revision of the regulations, four now-treatable diseases have remained Class A conditions since the inception of classifications.

51. Medical Examination of Aliens-Revisions to Medical Screening Process, 80 Fed. Reg. 35899 (June 23, 2015) (amending 42 C.F.R. 34). This notice received six public comments, which advocate for keeping STIs in the medical screenings and exclusions, even requesting HIV be reinstated as an exclusion. CDC also proposed changing the language from "syphilis, infectious stage" to "syphilis, infectious" in keeping with current medical discourse. *Id.*
52. 42 C.F.R. § 34.2.
53. Medical Examination of Aliens-Revisions to Medical Screening Process, 80 Fed. Reg. at 35899; 42 C.F.R. § 34.2.
54. Medical Examination of Aliens-Revisions to Medical Screening Process, 80 Fed. Reg. at 35899.

The Notice of Proposed Rulemaking for this new regulation included CDC's justifications for retaining syphilis and gonorrhea. The stated justifications reveal the assumptions, fears, and stigmas guiding the CDC's decisions. CDC explained:

> Continued screening for these . . . diseases during the medical examination provides an opportunity to identify and treat disease in alien populations and thus provide a measure of public health protection to the general U.S. population.[55]

In the same notice, CDC proposed removing three other STIs because they were geographically contained in "tropical settings"[56] and thus do not pose a serious threat to the U.S. population. Here, CDC relied on border health security rhetoric: "protecting" the health of the "general U.S. population" from disease threats in "alien populations," where the most threatening diseases are the ones that could cross the border.[57]

In the 2016 regulation, CDC also introduced two new discretionary categories for Class A conditions that only apply to applicants from abroad: communicable diseases declared by Presidential Executive Order[58] and communicable diseases that "may pose a public health emergency of international concern."[59] This allows for greater executive discretion in declaring a disease

55. *Id.*

56. Chancroids, granuloma inguinale, and lymphogranuloma venereum. In particular, granuloma inguinale and lymphogranuloma venereum "typically occur in tropical and impoverished settings (i.e., with limited access to water, hygiene); and both conditions are increasingly uncommon over time." *Id.* CDC added, "As mentioned, these primarily tropical infections can be prevented through improved personal hygiene; protected sex (use of a condom); and treatment of sexual partners." *Id.* CDC locates these STIs as too distant to be threatening, while blaming individuals for unhealthy sexual hygiene.

57. *Id.*

58. Presently, communicable diseases set by Presidential Executive Order include cholera, diphtheria, plague, smallpox, yellow fever, viral hemorrhagic fevers, SARS, measles, and flus that "can cause a pandemic." *What Diseases Are Subject to Federal Isolation and Quarantine Law?*, U.S. DEP'T OF HEALTH & HUM. SERVS. (July 21, 2022), https://www.hhs.gov/answers/public-health-and-safety/what-diseases-are-subject-to-federal-isolation-and-quarantine-law/index.html [https://perma.cc/L5LU-AGKE].

59. 42 C.F.R. § 34.2 (following recommendation by the director of CDC and provided that one of the factors listed in Section 34.3 are met). The factors listed in 42 C.F.R. § 34.3 include:

> (i)The seriousness of the disease's public health impact; (ii) Whether the emergence of the disease was unusual or unexpected; (iii) The risk of the spread of the disease in the United States; (iv) The transmissibility and virulence of the disease; (v) The impact of the disease at the geographic location of medical screening; and (vi) Other specific pathogenic factors that would bear on a disease's ability to threaten the health security of the United States.

grounds for inadmissibility. Section 34.3 allows CDC to determine which diseases to screen for, which geographic areas are subject to this screening, and whether a disease may "threaten the health security of the United States."[60] As written, the present regulations allow for reactionary measures that may be nearly unreviewable given an impenetrable health security rationale,[61] even if such screening is disproportionately required of certain groups of people. These new categories are particularly conducive to discrimination, like the Trump administration's implementation of Title 42.

The current Class B medical conditions, which may not render an applicant inadmissible, include physical or mental health conditions, diseases, or disability serious in degree or permanent in nature.[62] To determine "serious in degree," U.S. Citizenship and Immigration Services (USCIS) elaborates:

> This may be a medical condition that, although not rendering an applicant inadmissible, represents a departure from normal health or well-being that may be significant enough to: [i]nterfere with the applicant's ability to care for himself or herself, to attend school, or to work; or [r]equire extensive medical treatment or institutionalization in the future.[63]

42 C.F.R. § 34.3. Today, these diseases include pandemic flu, SARS, smallpox, and polio. *Frequently Asked Questions About the Final Rule for the Medical Examination of Aliens*, CDC (Jan. 26, 2016), https://www.cdc.gov/immigrantrefugeehealth/laws-regs/revisions-medical-screening/medical_examination_aliens.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fimmigrantrefugeehealth%2Flaws-regs%2Frevisions-medical-screening%2Ffaq.html [https://perma.cc/2LS9-RLNZ].

60. 42 C.F.R. § 34.3(d)(2).

61. *Id.* According to CDC, the purpose of this change was to provide for greater flexibility and rapid responses. Medical Examination of Aliens—Revisions to Medical Screening Process, 81 Fed. Reg. 4191, 4196 (2016) (amending 42 C.F.R. § 34). Such a shift reflected U.S. anxieties at the time about organic and bioterrorist threats, particularly after the SARS pandemic. The subsequent swine flu, Ebola, Zika, and COVID-19 pandemics have likely only validated the inclusion of these flexible categories. Throughout the twenty-first century, the U.S. government expanded executive power and discretion for security reasons. Here, the need for a "rapid" and "flexible" response for "unanticipated" emergencies has authorized new presidential and executive authority to determine Class A conditions, mirroring other security justifications for drones or wiretaps. In this way, the present Class A conditions reflect a greater priority on border health security than did the earlier lists, which were more focused on excluding undesirable individuals from the population. *See infra* Subpart II (discussing the evolution of Class A conditions alongside racial and other exclusions).

62. 42 C.F.R. § 34.2, 34.4.

63. USCIS POLICY MANUAL, vol. 8, pt. B, ch. 2, available at https://www.uscis.gov/policy-manual/volume-8-part-b-chapter-2 [https://perma.cc/W7LR-T52N].

The goal of the present regulations is, as understood by USCIS, to restrict incoming applicants to individuals those with "normal" functioning, although health conditions like addiction or disability already exist in the United States.

As part of an individual's visa application, they must complete a medical examination to screen for Class A and B conditions.[64] Although PHS has the primary statutory authority to conduct medical examinations, PHS medical officers complete very few examinations.[65] Instead, USCIS and the U.S Department of State (State Department) appoint the majority of examiners and provide some guidance for examinations, supplemented by CDC guidance.[66] The State Department appoints panel physicians to conduct examinations abroad, while USCIS appoints civil surgeons for domestic examinations.[67] The majority of medical examinations are thus conducted by people appointed by entities with no public health purpose but instead manage the exclusion of noncitizens. Evidently, the purpose of these examinations is border control, not public health.

C. Effects of Mandatory Screening of Applicants for Syphilis and Gonorrhea

In this Subpart, I overview the effects of mandatory STI testing. In Subpart C.1, I look specifically at the effects of the policy to require screening of some, not all, noncitizens in the admissions process. In Subpart C.2, I address the effects of mandatory screening on applicants in general, regardless of test results. Finally, in Subpart C.3, I describe the immigration consequences of a positive test result.

1. Effects of Selective Screening of Noncitizen Applicants

Not all individuals crossing the border are screened for Class A and B conditions. Rather, only immigrant visa applicants, refugees, internationally adopted orphans, and some nonimmigrant visa applicants are required to have overseas medical examinations prior to arrival.[68] Additionally, noncitizens present in the United States seeking adjustment of status or derivative asylum

64. *Id.*
65. 42 U.S.C. § 252. *See also* USCIS, Chapter 2, *supra* note 63.
66. *Technical Instructions for Civil Surgeons*, CDC (Aug. 17, 2021), https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons.html [https://perma.cc/B2MD-XYU8].
67. *Designated Civil Surgeons*, USCIS (Dec. 21, 2022), https://www.uscis.gov/tools/designated-civil-surgeons [https://perma.cc/M54B-DL4V].
68. 8 C.F.R. § 245.5.

status are required to complete a domestic medical examination.[69] In 2022, this means that around at least one million people were required to complete a medical examination.[70] However, it also means that millions of other individuals—citizens and noncitizens—are able to enter the United States each year without undergoing mandatory STI screening. There is no logical reason to conclude that temporary visitors are less likely to carry STIs than permanent or longterm entrants from the same country.[71]

The uneven application of the medical examination requirement to different categories of applicants instead seems to rely on stereotypes and suspicions about the individuals who seek these particular visas or statuses. The U.S. government does not screen most tourists or other nonimmigrant visa holders because it predicts people coming to the United States temporarily will not travel if they are unwell, whereas immigrants have more reason to attempt entry regardless of their health.[72] Similarly, requiring examinations for individuals seeking derivative asylum but not asylees again reflects suspicions about people tacking onto a so-called legitimate claim. This type of reasoning reflects anxieties about people who plan to stay, assuming they will commit fraud, misrepresentation, or other manipulative means to gain entry.

69. *Id.*

70. In 2022, the United States received 964,342 new lawful permanent residents (excluding asylees) and 24,819 K visa holders. Because nonimmigrant visa holders are subject to consular discretion for medical examinations, it is difficult to estimate how many were required to complete one. *Legal Immigration and Adjustment of Status Report Fiscal Year 2023, Quarter 2*, OFF. OF HOMELAND SEC. STATS. (Jan. 2, 2024), https://www.dhs.gov/immigration-statistics/special-reports/legal-immigration [https://perma.cc/65L2-4QXJ]. These figures do not include applicants who completed a medical examination but did not ultimately receive admission, meaning the number of individuals undergoing medical examinations for the United States is much greater.

71. In fact, CDC warns that many travelers might be more inclined to engage in risky sexual behaviors, given the temporary nature of their journey. *See Travelers' Health: Sexually Transmitted Infections*, CDC (Sept. 15, 2022), https://wwwnc.cdc.gov/travel/page/std [https://perma.cc/2CVK-9TQW] ("About one in three travelers will have sex with a new partner while on a trip. The excitement of being in another country and meeting new people may lead travelers to engage in risky behaviors that can lead to sexually transmitted infections (STIs), including HIV, gonorrhea chlamydia, and syphilis."). *See also* Krzysztof Korzeniewski & Dariusz Juszczak, *Travel-Related Sexually Transmitted Infections*, 66 INT'L MAR. HEALTH 238 (2015) ("Over the last several decades 5 percent to even 50 percent of short-term travellers engaged in [casual sex encounters] during foreign trips. It is estimated that only 50 percent of travellers use condoms during casual sex abroad.").

72. SUBCOMM. NO. 1 OF H. COMM. ON THE JUDICIARY, 88TH CONG., 1ST SESS., SPECIAL SERIES NO. 12, STUDY OF POPULATION AND IMMIGRATION PROBLEMS, INQUIRY INTO THE ALIEN MEDICAL EXAMINATION PROGRAM OF THE U.S. PUBLIC HEALTH SERVICE 10 (1963) [hereinafter PHS REPORT].

Moreover, the differential visa requirements based on nationality render these divisions even more discriminatory. Individuals not in the Visa Waiver Program[73] may be required to complete a discretionary medical examination. Nonimmigrant visa seekers or Temporary Protected Status applicants may be required by the U.S. consulate to complete an examination if an officer "has concerns as to the applicant's inadmissibility on health-related grounds."[74] It is unclear how officers develop "concerns" about an individual: whether there are any standards beyond assumptions or stereotypes. Because most of the countries in the Visa Waiver Program are European, Oceanic, and East Asian, these nationals do not risk this discretionary application of a medical examination when they enter for less than ninety days. The authorized preference for visitors from the Global North and primarily majority white countries leads to the differential application of the medical examination requirement.

In sum, selective screening does not reflect different health risks, but rather different preferences for noncitizens.

2. Effects of STI Screenings on Applicants

Despite making essentially no impact on public health, the medical examination creates a substantial additional burden to the already arduous process of admission. This next section describes the components, costs, and timeline of mandatory STI screening.

CDC decides which individuals seeking admission must be screened for syphilis[75] and for gonorrhea[76] in its Technical Instructions for all panel physicians and civil surgeons. According to this guidance, both examiners must screen all applicants between eighteen and forty-four years old for syphilis, but examiners

73. A list of countries whose nationals are not required to obtain a nonimmigrant visa for certain short-term entry. *Visa Waiver Program Requirements*, U.S. DEP'T OF HOMELAND SEC. (June 1, 2023), https://www.dhs.gov/visa-waiver-program-requirements [https://perma.cc/H5SP-R34F]. The waiver countries are primarily European, Oceanic, and East Asian countries.

74. USCIS POLICY MANUAL, *supra* note 63, at vol. 8, pt. B, ch. 3. "In general, nonimmigrant visa applicants, nonimmigrants seeking change or extension of status, and Temporary Protected Status (TPS) applicants are only medically examined if the consular officer or immigration officer has concerns as to the applicant's inadmissibility on health-related grounds." *Id.*

75. *Syphilis Technical Instructions for Panel Physicians*, CDC (Jan. 17, 2023), https://www.cdc.gov/immigrantrefugeehealth/panel-physicians/syphilis.html [https://perma.cc/B5CK-ETGB] [hereinafter "*Syphilis Instructions for Panel Physicians*"].

76. *Gonorrhea Technical Instructions for Civil Surgeons*, CDC (Aug. 30, 2021), https://www.cdc.gov/immigrantrefugeehealth/civil-surgeons/gonorrhea.html [https://perma.cc/5X8R-RJEV] [hereinafter *Gonorrhea Instructions for Civil Surgeons*].

may screen younger applicants if there is reason to suspect infection.[77] If the laboratory tests confirm syphilis, then the applicant is subject to an external genital and rectal examination.[78] If an applicant tests positive for syphilis, HIV testing is recommended, but it must be made known that this is not required. For gonorrhea, all applicants between eighteen and twenty-four years old must be tested, and examiners may test other applicants if they suspect infection.[79] CDC also notes that many gonorrhea tests also test for chlamydia, and if no single gonorrhea tests are available, an applicant may be tested for both gonorrhea and chlamydia. If this happens and the applicant tests positive for chlamydia, it will be noted on their medical examination form and becomes part of their medical record.[80] If an applicant tests positive for any STI, CDC also recommends testing for additional STIs. The Technical Instructions do not provide criteria for when an examiner may permissibly suspect an applicant of syphilis or gonorrhea when the applicant is outside of the mandatory testing age range, so it is left to the examiner's discretion. As such, any applicant has the potential to receive an STI test during the examination process, and if they test positive for syphilis or gonorrhea, they may be subjected to additional screening.

Though significantly less invasive than the earlier days of medical examinations,[81] the current medical examination process still inquires into an applicant's sexual history and lets examiners make discretionary judgments about whether a person merits STI testing. The examiner can use as much information as they deem necessary to make a conclusion about the presence of any "physical or mental abnormality, disease, or disability,"[82] which may include additional

77. However, guidance for Form I-163 states that anyone over fifteen years old must be screened for syphilis or gonorrhea. *See Syphilis Technical Instructions for Panel Physicians*, *supra* note 75.
78. A chaperone must also be present. *Id.*
79. Genital exams must not, however, be performed to screen for gonorrhea, though a throat and/or rectum swab may be needed to collect a sample. *Gonorrhea Instructions for Civil Surgeons*, *supra* note 76.
80. *Id.*
81. *See generally* AMY FAIRCHILD, SCIENCE AT THE BORDERS (2003) (detailing the experiences of the medical examinations in the early twentieth century, which occurred in lineups. Examiners would write their medical suspicions about a person with chalk right on the individual, who was then removed for individual examinations. These examinations were initially done with rudimentary invasive procedures such as using a button hook to lift an applicant's eyelids or strip-searches to check for syphilis.).
82. 42 CFR § 34.3(b)(2). The regulation legitimizes the ableist binary of normal-abnormal, granting the physician the power to suspect a noncitizen of abnormality, disease, or disability and then subject to a higher degree of examination.

studies or testing.[83] Additionally, for overseas medical examinations, CDC can require additional medical screening and testing on certain populations in a geographic area, based on the risk of the condition spreading to the United States. As a result, the scope of the examination could be far greater than the minimum announced in the Technical Instructions. Any individual who must complete an examination faces the possibility that any number of health conditions could be discovered, which may be used to deny them entry.

These examinations amount to a substantial, additional burden within the visa application process. An individual must separately find and schedule with an available medical examiner. Further, applicants must pay for the examination themselves.[84] Abroad, the U.S. consulate approves the fees for the panel physicians, but they vary greatly by country and by physician.[85] Domestically, USCIS does not regulate fees charged by civil surgeons,[86] which can range between seventy-five and five-hundred dollars.[87] As these examinations must occur before the application interview, they can substantially delay an application, particularly if treatment is required.

The examination also poses an emotional and privacy burden to applicants who may not want to disclose their sexual history, behavior, partners, or other

83. *Id.* The regulation legitimizes the ableist binary of normal-abnormal, granting the physician the power to suspect a noncitizen of abnormality, disease, or disability, subjecting them to a higher degree of examination. CONSULATE GENERAL OF THE U.S. MUMBAI, INDIA, MEDICAL EXAMINATION AND VACCINATION INSTRUCTIONS: LIST OF APPROVED PANEL PHYSICIAN SITES FOR INDIA (2018) [hereinafter U.S. CONSULATE MUMBAI], https://in.usembassy.gov/wp-content/uploads/sites/71/panel-physician-list-rates-09282018.pdf [https://perma.cc/WEZ4-UBHE]; U.S. CONSULATE GEN.—H.K. & MAC., INFORMATION CONCERNING THE MEDICAL EXAMINATION (2022) [hereinafter U.S. CONSULATE H.K.], https://hk.usconsulate.gov/wp-content/uploads/sites/266/iv-medical-01–2022.pdf (last visited Nov. 30, 2022); *Medical Examination Instructions*, U.S. EMBASSY & CONSULATES IN BRAZ., https://br.usembassy.gov/visas/immigrant-visas/medical-examination-instructions/?_ga=2.20993659.1199891803.1669834296–1477678292.1669834296 [https://perma.cc/NVK7-Z8PA].

84. 42 C.F.R. § 34.3(c); *see* Brown v. Barr, 784 F. App'x 647, 652 (10th Cir. 2019).

85. *See, e.g.*, U.S. CONSULATE MUMBAI, *supra* note 83; U.S. CONSULATE H.K., *supra* note 83; *Medical Examination Instructions*, *supra* note 83.

86. *Finding a Medical Doctor*, USCIS (July 26, 2023), https://www.uscis.gov/green-card/green-card-processes-and-procedures/finding-a-medical-doctor [https://perma.cc/5QX5-4HL2].

87. Based on a Google search conducted November 2022. *See also* Sarah Morando Lakhani & Stefan Timmermans, *Biopolitical Citizenship in the Immigration Adjudication Process*, 61 SOC. PROBS. 360, 366 (2014) ("In an interview, a lawyer described a client on 'the brink of homelessness' who could not spare the $240 it would cost for her and her three children to undergo medical exams in order to apply for permanent residency").

information to an examiner they do not know.[88] An applicant might have experienced sexual trauma, have reasons to distrust medical professionals, or have cultural, social, or religious beliefs that could make this portion of the medical examination difficult. The examiner, of course, does not provide follow-up care for the applicant but is simply screening them for admission, which could further reduce an applicant's trust. Additionally, a finding of an inadmissible STI might create complicated familial or personal situations for an individual who was not expecting to get denied. Thus, even if the examination does not result in exclusion, the barrier of the examination itself and its financial, logistical, or personal difficulties, might discourage immigration, naturalization, or entry for certain migrants. This burden affects millions of potential applicants, but it does not apply to large groups of entrants, such as those entering under the Visa Waiver Program. As such, it functions more like a racial preference than a true public health intervention.

3. Effects of a Finding of Syphilis or Gonorrhea

The most significant result of the screening for syphilis and gonorrhea is that the applicant is deemed inadmissible. However, examiners must report the results from the applicant's STI screening to the DHS officer or to the consular officer,[89] so even if an applicant is not rendered inadmissible, their health information still becomes part of their admissions profile.

An examiner's statement that an applicant has a Class A condition is conclusive evidence that the applicant is inadmissible.[90] An applicant with a Class A condition has three options. One, they can accept that they are inadmissible, refuse treatment, and give up on the process. Two, if they meet certain qualifications, they might be able to obtain a waiver or appeal. However, waivers are generally limited to direct relatives of citizens or lawful permanent residents,[91] and findings of inadmissibility may only be appealed to the board of PHS,[92] whose

88. See Lakhani & Timmermans, *supra* note 87 for a discussion of the impact of medical examinations on applicants in Los Angeles.
89. 42 C.F.R. § 34.4. "The medical notification shall state the nature and extent of the abnormality; the degree to which the alien is incapable of normal physical activity; and the extent to which the condition is remediable. The medical examiner shall indicate the likelihood, that because of the condition, the applicant will require extensive medical care or institutionalization."
90. USCIS POLICY MANUAL, *supra* note 63, at vol. 8, pt. B, ch. 11.
91. These are limited. *See* 9 Foreign Affairs Manual (FAM) § 302.2 for a discussion of the eligibility and requirements.
92. *Id.* An applicant must pay for one expert medical witness to testify on their behalf. *Id.*

decisions cannot be judicially reviewed.[93] Three, they can receive treatment according to CDC guidelines.[94] Thus, applicants are essentially required to receive treatment to be admitted. If an applicant does not want to be treated—whether due to lack of trust with the examiner, desire to be treated by another provider, inability to pay, or any other reason—they risk remaining inadmissible.

If the applicant has a positive syphilis or gonorrhea test result, they are considered Class A and remain Class A until they are treated.[95] For gonorrhea, treatment must be onsite and directly observed, and applicants are subject to a follow-up test performed two weeks after treatment.[96] For syphilis, if the applicant was infected prior to the examination, but is presently uninfected, they must provide the panel physician with proof that they have been treated or a justification to have refused treatment.[97] After successful completion of treatment, the applicant is moved to Class B, which signifies "a physical or mental abnormality, disease, or disability serious in degree or permanent in nature amounting to a substantial departure from normal well-being."[98] The reasoning implicates ableist ways of thinking about "normality," which an individual cannot return to if they have had, but treated, an STI.

An examiner's statement that an individual has a Class B condition does not render them inadmissible, but it may be used as evidence that the applicant is inadmissible as a public charge.[99] Those admitted with Class B conditions are registered in the Electronic Disease Notification (EDN) system, which alerts state and local health departments that a noncitizen has arrived who requires medical

93. *See* Aslam v. DHS, Civil Action No. 19–2132 (ABJ), 2021 U.S. Dist. LEXIS 57804 (D.D.C. Mar. 26, 2021); *cf.* Castro v. Mayorkas, No. 2:21-CV-00315-SAB, 2022 U.S. Dist. LEXIS 66858 (E.D. Wash. Apr. 11, 2022) (holding that because the Advisory Committee for Immunization Practices failed to abide by current policy in deny petitioner's visa application, their decision was judicially reviewable).

94. *Syphilis Instructions for Panel Physicians*, *supra* note 75; *Gonorrhea Instructions for Civil Surgeons*, *supra* note 76.

95. *Syphilis Instructions for Panel Physicians*, *supra* note 75; *Gonorrhea Instructions for Civil Surgeons*, *supra* note 76.

96. *Gonorrhea Instructions for Civil Surgeons*, *supra* note 76. There is no discussion of supervision in the syphilis technical instructions.

97. *Medical Examination FAQs*, U.S DEP'T OF STATE, https://travel.state.gov/content/travel/en/us-visas/immigrate/the-immigrant-visa-process/step-10-prepare-for-the-interview/medical-examination-faqs.html [https://perma.cc/5NZT-DL9X].

98. 42 C.F.R. § 34.4(c); *See* Jeanne Batalova, Adriy Shymonyak & Michele Mittlestadt, *Immigration Data Matters* (Nov. 2020), https://www.migrationpolicy.org/research/immigration-data-matters [https://perma.cc/7FNW-W6E4].

99. *See* Batalova et al., *supra* note 98.

follow up.[100] The results of the examination are sent either directly to the U.S. consulate or embassy, USCIS, or the individual must bring the results in a sealed envelope to their interview.[101] The individual thus has no control over whether they become part of a medical surveillance program once admitted, nor do they have access to the medical records from the examination.[102]

The classification of these STIs as Class A pressures applicants to treat infections immediately and prior to departing for the United States. Moreover, the applicant bears the cost of treatment, as well as the delay for themself and any other companion applicant. Such mandatory, surveilled treatment again shows how the United States does not trust noncitizens with their sexual health decisions and instead imposes sexual health management.

When it comes to actual exclusions, there is little data as to how many applicants are rejected for a Class A STI. The numbers, however, appear to be low. The most recent overview of medical examinations from CDC uses information reported to the EDN system between 2014 and 2019.[103] During this period, 3.5 million people moved to the United States, and within this group, medical examinations only detected fifty-four cases of primary or secondary syphilis, 761 cases of latent syphilis, and 131 cases of gonorrhea. CDC celebrated that "the overseas medical examination system prevented importation of . . . 815 cases of syphilis, and 131 cases of gonorrhea." This appears to mean that these applicants were treated and allowed entry.[104] Of this data, most of the individuals identified

100. *Electronic Disease Notification System*, CDC (Sept. 26, 2019), https://www.cdc.gov/immigrantrefugeehealth/Electronic-Disease-Notification-System.html [https://perma.cc/3X8X-E3BZ].

101. *Medical Examination FAQs*, *supra* note 97.

102. The U.S. government has enacted other forms of registration and surveillance of noncitizens as part of the "security" apparatus, such as efforts to register all Muslims or male visitors from predominantly Muslim or Arab countries. *See, e.g.*, Faiza Patel, *Muslim Registry or NSEERS Reboot Would Be Unconstitutional*, BRENNAN CTR. FOR JUST. (Nov. 22, 2016), *https://www.brennancenter.org/our-work/analysis-opinion/muslim-registry-or-nseers-reboot-would-be-unconstitutional* [https://perma.cc/CVJ4-DNAJ]. Though health-based tracing might appear less discriminatory or politically charged, such a registration and tracking system for noncitizens carries the same dangers of discriminatory surveillance.

103. Christina R. Phares et al., *Disease Surveillance Among U.S.-Bound Immigrants and Refugees—Electronic Disease Notification System, United States, 2014–2019*, CDC (Jan. 21, 2022), https://www.cdc.gov/mmwr/volumes/71/ss/ss7102a1.htm [https://perma.cc/8YAF-8N46].

104. Recall that any individual in the Electronic Disease Notification (EDN) system must have been admitted to the United States with a Class B notification—EDN is not used for Class A denials. This data does not reflect everyone who was denied, but rather those admitted with treated conditions (and presumably, conditions that were discovered and treated through the medical examination process).

as having syphilis or gonorrhea were from the Democratic Republic of Congo, Somalia, Burma, and Iraq. However, the study acknowledges that the EDN system only collects information about applicants who were approved for entry, which is about 10 percent of those who have received an overseas medical classification.[105]

While CDC's information is limited by excluding domestic examinations, it suggests three conclusions. First, the prevalence of syphilis and gonorrhea in incoming applicants is extremely low. This has stayed relatively constant since the introduction of syphilis and gonorrhea as Class A conditions in 1903,[106] indicating that migrants do not pose a substantial risk of transmitting these STIs in general.[107] Second, this data indicates that this screening has disproportionately resulted in refugees from African countries being required to complete treatment. Third, these screenings seem to have no effect on the overall caseload of syphilis and gonorrhea in the United States.

These findings beg the question: if STI screening has little to no impact on public health, then what else might explain this burdensome, intrusive requirement?

II. EVOLUTION OF MANDATORY SCREENING FOR SEXUAL HEALTH CONDITIONS

In Part II, I look to the origins of U.S. border health policy, showing how disease control became conflated with immigration control and how the two work within the broader U.S. project of white supremacy. I highlight how medical examinations and excludable health conditions were introduced alongside racial bans or national origin limits, which worked for and with each other. I trace the development of U.S. immigration policy alongside the eugenics movement and other contemporary forms of domestic sexual management, to reveal how sexual panics shape health and immigration policy.

105. Phares et al., *supra* note 103.

106. PHS REPORT, *supra* note 72, at 34. For example, in 1960, one of every 1000 notifications were for communicable diseases other than tuberculosis, 72 percent of which were for STIs. *Id.*

107. Mi-Kyung Hong, Reshma E. Varghese, Charulata Jindal & Jimmy T. Efird, *Refugee Policy Implications of U.S. Immigration Medical Screenings: A New Era of Inadmissibility on Health-Related Grounds*, 14 INT'L J. ENV'T RSCH. & PUB. HEALTH 10 (2017). "Such policy can promulgate the misperception that disease burden is predominantly of foreign origin and can only be managed through border controls rather than treatment, public health education, and other preventative methods." *Id.*

Racial or national limitations on admissions in the United States date back to the policies of the pre-revolutionary colonies as early as 1700.[108] These exclusions sought to maintain a white settler population while establishing an exploited labor class of enslaved Africans and racially subjugated workers.[109] Yet the definition of whiteness slowly expanded from Protestant Anglo-Saxons to incorporate white Europeans, in part through evolving judicial interpretation of immigration and naturalization laws.[110]

While the United States was developing its race-based immigration regime, it began enacting health-based exclusions. Initially, the first disease to render someone inadmissible was cholera, when in 1892 the president was granted the power to suspend the entry of anyone with cholera or other infectious diseases into the United States.[111] Many states first developed entry bans against people with disabilities or illnesses, or those "likely to become a public charge."[112] Racial requirements and health requirements were complementary projects of population selection, coinciding with the eugenics movement.

From the beginning, exclusions based on race, gender, and sexual behavior supplemented health-based exclusions. The first federal immigration act—the Page Act—barred Chinese, Japanese, or "Oriental" laborers from entry, in response to growing white hostility against Chinese workers on the West Coast.[113] At the same time, the act prohibited women entering for the "purposes of prostitution."[114] This prohibition sought to exclude Chinese women, who were

108. For further history, *see generally* Edith Abbott, *Federal Immigration Policies*, 2 UNIV. J. BUS. 133 (1924); MICHAEL LEMAY & ELLIOT R. BARKAN., U.S. IMMIGRATION AND NATURALIZATION LAWS AND ISSUES: A DOCUMENTARY HIST. (1999).

109. That is, the United States has long encouraged exploitative temporary laborer relationships, beginning with workers from Mexico, China, and Japan. White settlers in the western United States also subjected Indigenous people to coerced labor.

110. The negotiation of whiteness has consumed centuries of legal debate as the United States constructed and remade the artificial boundaries of a "white" race. *See, e.g.*, People v. Hall, 4 Cal. 399 (1854); Ozawa v. United States, 260 U.S. 178 (1922); United States v. Thind, 261 U.S. 204 (1923); Saint Francis Coll. v. Al-Khazraji, 481 U.S. 604 (1986). For a history of these changing legal boundaries, *see generally* IAN HANEY LÓPEZ, WHITE BY LAW (2006), particularly chapter 2.

111. *History of Quarantine*, CDC (July 20, 2020), https://www.cdc.gov/quarantine/historyquarantine.html [https://perma.cc/YP9N-UGNF]. For a more detailed history, see PHS REPORT, *supra* note 72, at 22–23.

112. Jonathan Kuo, *The History of the Public Charge and Public Health*, PUB. HEALTH ADVOC. (Dec. 29, 2020), https://pha.berkeley.edu/2020/12/29/the-history-of-the-public-charge-and-public-health/#:~:text=The%20Immigration%20Act%20of%201882, charge"%20from%20entering%20the%20country [https://perma.cc/586U-FKNV].

113. Act Supplementary to the Acts in Relation to Immigration, ch. 141, 18 Stat. 477 (1875) (repealed 1974) (known as the Page Act).

114. *Id.*

presumptively excluded as sex workers,[115] in order to prevent Chinese workers from settling with families.[116] This exclusion was also based on a myth that Chinese women had STIs that would kill white American men.[117] The first impulses of U.S. immigration regulation rested on racist justifications to define and exclude economic, sexual, and racial threats to the country, which the government wanted to design (counterfactually) as white, Anglo-Saxon, and Protestant.

Following the Page Act, the United States enacted a series of immigration restrictions against Chinese and East Asian laborers, which it joined with the public charge exclusion. In 1882, the explicitly racist Chinese Exclusion Act prohibited the immigration of all Chinese laborers for ten years.[118] After the Chinese Exclusion Act, the United States passed broad federal immigration regulations with the Immigration Act of 1882, which included an entry ban for anyone who might become a "public charge."[119] "Public charge" was not defined, affording broad discretion to immigration officers to prohibit the entry of anyone deemed unproductive, unhealthy, or otherwise undesirable.[120]

Health inspections and health-based exclusions were formally added to immigration law in 1891. In 1891, the United States expanded the health-based exclusions, prohibiting the entry of "idiots, insane persons, paupers or persons likely to become a public charge, persons suffering from a loathsome or a dangerous contagious disease," as well as those convicted of "misdemeanors involving moral turpitude."[121] The 1891 exclusions plainly reflect eugenic thinking, barring "idiots," "imbeciles," and the "feeble-minded," pseudoscientific diagnoses based on racial science.[122]

115. *See* Pooja R. Dadhania, *Deporting Undesirable Women*, 9 U.C. IRVINE L. REV. 53, 57–8 (2018).
116. As Chinese laborers (men) were prohibited from dating or marrying white women through state anti-miscegenation laws, and the Page Act made it nearly impossible to bring their wives from China. Shoba Sivaprasad Wadhia & Margaret Hu, *Decitizenizing Asian Pacific American Women*, 93 UNIV. COLO. L. REV. 325, 343–44 (2022).
117. EITHNE LUIBHÉID, ENTRY DENIED: CONTROLLING SEXUALITY AT THE BORDER (2002).
118. While the Chinese Exclusion Act initially provided for the reentry of individuals already in the United States, the Scott Act of 1888 removed this provision and effectively banned any Chinese person to enter the country, longtime resident or otherwise. This ban on incoming Chinese laborers was extended for another ten years with the Geary Act of 1892.
119. Immigration Act of 1882, Pub. L. 47–376, 22 Stat. 214.
120. *Id.*
121. Immigration Act of 1891 Act, Pub. L. 51–551, 26 Stat. 1084.
122. *See, e.g.*, Andrew Colman, *'Scientific' Racism and the Evidence on Race and Intelligence*, 14 RACE 107 (1972).

PHS began as the Marine Hospital Service in 1870, stationed at port cities to screen ships entering the United States.[123] PHS is a military-adjacent agency operating under HHS, working to "protect, promote, and advance the health and safety of the nation."[124] In 1878, the U.S. Congress enacted the National Quarantine Act in response to smallpox and yellow fever outbreaks across the globe, which began to nationalize border health security and grant quarantine authority to the Marine Hospital Service.[125] In 1891, the Marine Hospital Service began conducting medical screening of immigrants at border sites to "fulfill[] the commitment to prevent disease from entering the country."[126] PHS exemplifies the logic of health security, specifically border health security, because its very existence is an investment into the fiction that disease can be stopped at the border.[127]

The 1903 Immigration Act (the Act) created the medical certification process.[128] To accompany the Act, the Marine Hospital Service[129] enumerated Class A conditions, where Class A referred to "loathsome and dangerous contagious diseases" and Class B referred to conditions that would render a noncitizen "likely to become a public charge."[130] Trachoma,[131] for example, was a dangerous and contagious disease, whereas syphilis, gonorrhea, and "leprosy"

123. *See* David Satcher, *The History of the Public Health Service and the Surgeon General's Priorities*, 54 FOOD & DRUG L.J. 13, 14 (1999).

124. *Who We Are*, COMMISSIONED CORPS OF THE U.S. DEPT OF HEALTH & HUM. SERVS., https://www.usphs.gov/about-us [https://perma.cc/WJN3-YT4R]. Operating under the Department of Health and Human Services, PHS is one of the seven uniformed services.

125. *See* Satcher, *supra* note 123, at 14. The Public Health Act of 1879, however, created the National Board of Health, through which quarantine authority was shared with the U.S. Army and U.S. Navy. This arrangement was not reauthorized by the U.S. Congress in 1883, and its powers reverted solely to the Marine Hospital Service. The Marine Hospital Service adopted some quarantine powers and constructed hospitals at key ports. *Id.*

126. *Who We Are*, *supra* note 124; *see also* KRAUT, *supra* note 44, at 51, 59.

127. On its government website, PHS contends it has protected against the spread of disease and maintained the health of immigrants for over 200 years. *Who We Are*, *supra* note 124. "Maintaining" the health of immigrants is of course misleading, as PHS screens and evaluates immigrants for health benchmarks rather than provides comprehensive health services. *See also*, PHS REPORT, *supra* note 72, at 21 ("Guarding the United States against the introduction of disease from abroad is one of the oldest and most important missions of the Public Health Service.").

128. Pub. L. 57–162, 32 Stat. 1213.

129. The PHS, then the Marine Hospital Service.

130. *See* FAIRCHILD, *supra* note 81, at 34.

131. *Id.* (noting that trachoma was considered rare except within Mediterranean, Polish, Armenian, and Russian Jewish immigrants). For a discussion of how these conditions were racially motivated, *see infra* Parts II and III.

were declared "loathsome."[132] By the first half of the twentieth century, PHS maintained 110 quarantine stations,[133] and it stationed officers abroad to examine prospective immigrants prior to passage.[134]

Health-based exclusions continued to develop alongside racial and national exclusions. For example, in the 1907 Immigration Act to limit the number of Japanese immigrants, Congress expanded upon previous health requirements to exclude:

> [A]ll idiots, imbeciles, feebleminded persons, epileptics, insane persons, and persons who have been insane within five years previous; persons who have had two or more attacks of insanity at any time previously; paupers; persons likely to become a public charge; professional beggars; persons afflicted with tuberculosis or with a loathsome or dangerous contagious disease; persons not comprehended within any of the foregoing excluded classes who are found to be and are certified by the examining surgeon as being mentally or physically defective, such mental or physical defect being of a nature which may affect the ability of such alien to earn a living.[135]

This legislation is a clear example of the complementary efforts to ban undesirable nationalities and undesirable health conditions. The medical examiner is afforded a high degree of discretion to determine "defectiveness," which at the time was considered any deviation from "normalcy" or whiteness.[136] The 1907 Act also introduced loathsome and contagious diseases as inadmissible conditions, suggesting that they too represent another type of mental or physical defect. Evidently, the purpose of the Act was the exclusion of undesirable entrants, whether that be for race, health, or other so-called defects.

Moreover, the U.S. government used medical examinations—particularly STI screening—to achieve race- or nationality-based exclusions.[137] The 1907

132. FAIRCHILD, *supra* note 81, at 34; KRAUT, *supra* note 44, Appendix.
133. *Who We Are*, *supra* note 124.
134. FAIRCHILD, *supra* note 81, at 58, 259–61 (explaining that while at first consular officers lacked capacity to refuse passage to the United States, later consular officers at foreign ports were able to reject travelers).
135. Immigration Act of 1907, Pub. L. 59–96, 34 Stat. 898.
136. *See generally* Anna Stubblefield, '*Beyond the Pale*': *Tainted Whiteness, Cognitive Disability, and Eugenic Sterilization*, 22 HYPATIA 162 (2007); TROY DUSTER, BACKDOOR TO EUGENICS (2004); Steven Selden, *Eugenics and the Social Construction of Merit, Race and Disability*, 32 J. CURRICULUM STUD. 235 (2000). PHS officer Alfred Reed stated that the most important feature of the medical examination was to sift out "physically and mentally defective" applicants. FAIRCHILD, *supra* note 81, at 5.
137. *See* Ian Harper & Pavrathi Raman, *Less Than Human? Diaspora, Disease and the Question of Citizenship*, 46 INT'L MIGRATION 3 (2008); KRAUT, *supra* note 44. "'Loathsome and contagious

Act granted the medical examiner the power and discretion to deny people entry. These health-based grounds initially targeted Eastern Europeans—particularly Jewish people—who were not excluded through explicit prohibitions but disproportionately assigned disqualifying conditions compared to Protestant, Anglo-Saxon Western Europeans at the eastern border.[138] At the southern and western borders, medical examiners disproportionately found Chinese and Mexican immigrants inadmissible, particularly through sexual health exclusions.[139] In this way, the medical examiner became part of border enforcement and population management, in which the boundaries of the United States were maintained through the sorting and exclusion of individuals based on health and race.

Throughout the early twentieth century, PHS steadily added to its classification of "loathsome" or "dangerous" diseases,[140] which often mirrored contemporary anxieties about the population or served other exclusionary projects. For example, in 1910, PHS added "feeble-minded persons" to those excludable under Class A[141] and introduced the short-lived Class C classification, which only included pregnancy.[142] By the 1910s and 1920s, immigration officials were excluding Mexicans at the southern border for STIs and pregnancy at a much higher rate than at any other port of entry.[143] Similarly, the Immigration Act of 1917 created the "Asiatic barred zone."[144] That same year, PHS added "Oriental sores" as a "loathsome" disease, coinciding with this period of extreme anti-Asian racism.[145] Depending on the year, Italian, Chinese, Japanese, Korean, Pacific Islander, African, east Indian, Lithuanian, and Turkish immigrants received

diseases' and 'feeble-mindedness' were increasingly associated with 'other races' attempting to invade the body of the nation." Harper & Raman, *supra*, at 7.

138. *See generally* FAIRCHILD, *supra* note 81.

139. *See generally* KRAUT, *supra* note 44, at 65. From 1907 to 1914, officers used these examinations to exclude Jewish immigrants, and any marginal calls or diagnoses often were against Jewish workers. *Id.* Overall, Chinese, Mexican, and Eastern European immigrants were certified with more Class A conditions than any other nationalities. FAIRCHILD, *supra* note 81, at 211.

140. FAIRCHILD, *supra* note 81, at 34–35.

141. Paralleling the language used in the eugenic laws discussed in Part I.C, *infra*.

142. *Id.*

143. FAIRCHILD, *supra* note 81, at 153, 174.

144. Immigration Act of 1917, Pub. L. 64–301, 39 Stat. 874. The Act also banned alcoholics and "persons with constitutional psychopathic inferiority," again combining race- and health-based exclusions in the same legislation.

145. FAIRCHILD, *supra* note 81, at 34; KRAUT, *supra* note 44, Appendix. Also in 1917, PHS declared alcoholism a Class A condition, coinciding with Prohibition. *Id.* Class A conditions thus served other efforts to manage the U.S. population.

disproportionate findings of inadmissible conditions.[146] Anglo-Saxon Western Europeans, however, were rarely found inadmissible. During this time, the majority of all immigration exclusions were on health grounds.[147] Both PHS's choice of conditions and its selective enforcement reflected the U.S. government's evolving idea of who could become part of the country, as well as certain groups' incorporation into whiteness.

Eugenics was a concerted national effort to determine the bounds of whiteness. Early U.S. efforts to reduce STIs emerged within the eugenics movement,[148] as the federal and state governments tried to conform sexual relationships and behaviors toward creating white, able-bodied nuclear families.[149] Eugenics sought to curb immoral sexuality and prevent "undesirable" procreation,[150] particularly by disabled individuals, to improve the white race.[151] Eugenicists claimed that social issues such as criminality, immorality, degeneracy, or addiction were genetically transmitted through reproduction. Thus, they framed their work as progressive in that the exclusion or sterilization of risky procreators would improve the population, treating such problems as sexually contagious.

Eugenics advocated for the preservation of whiteness through the exclusion of other races to eradicate these social problems, but the refinement of whiteness was a goal in and of itself. Attributing illnesses and social "ills" to certain races, eugenics fueled longstanding white supremacist claims that other races were

146. *Id.* at 221–52. The data does not disaggregate "Africa."

147. *Id.*

148. As early as the eighteenth century, the United States attempted to select for the "quality" of the white population through a series of eugenics projects justified as preventative health measures. *See generally* EDWIN BLACK, WAR AGAINST THE WEAK: EUGENICS AND AMERICA'S CAMPAIGN TO CREATE A MASTER RACE (2003); DUSTER, *supra* note 136; Eugenics mobilized a series of sexual health interventions against people with disabilities, single women, incarcerated people, and people of color to "improve" the future white population.

149. These intentions were explicit, with laws such as the Racial Integrity Act of 1924 in Virginia, which banned intermarriage and required racial classification at birth. *See generally* Jessica Vasquez-Tokos & Priscilla Yamin, *The Racialization of Privacy: Racial Formation as a Family Affair*, 50 THEORY & SOC'Y 717 (2021); Dorothy Roberts, *Who May Give Birth to Citizens?*, 1 RUTGERS RACE & L. REV. 129 (1998).

150. *See generally* GUILLAUME DREYFUS, RACIAL HYGIENE (2013); HARRY BRUINIUS, BETTER FOR ALL THE WORLD (2007); DUSTER, *supra* note 148; Nicole H. Rafter, *Claims-Making and Socio-Cultural Context in the First U.S. Eugenics Campaign*, 39 SOC. PROBS. 17 (1992).

151. Eugenicists portrayed disability as a threat to whiteness, deviating from the ideal white norm. *See generally* ELI CLARE, BRILLIANT IMPERFECTION (2017); Phil Smith, *Whiteness, Normal Theory, and Disability Studies*, 24 DISABILITY STUD. Q. (2004).

inherently inferior.[152] Eugenic projects included sterilization and selective reproduction,[153] but eugenicists also turned to immigration law to exclude people of color from the population, fearing that American whiteness was being diluted by a growing nonwhite population.[154] This fear of racial contamination was also gendered, as eugenicists mobilized fears of sexual violence from immigrant men in their appeals to purify the white race.[155] Despite calling itself progressive science, eugenics was a racist, pseudoscientific project that pathologized every deviation from able-bodied whiteness.

Eugenics also advocated for restrictive immigration policy alongside domestic reproductive restrictions. During the height of the eugenics movement, the Emergency Quota Act of 1921 and the National Origins Act of 1924 enacted provisions to retain the racial makeup of the United States to that of the 1890 census, capping the entry of noncitizens based on nationality. These provisions favored white immigrants from Western Europe and disadvantaged almost everyone else.[156] By the Great Depression, the United States was also mass

152. KRAUT, *supra* note 44, at 256; *see generally* ROBERTS, *supra* note 149 (explaining how not only was eugenics implemented as a so-called remedy social problems, it was also used as a punishment—mostly for Black men—for antisocial behavior, such as rape).

153. *See, e.g.*, Buck v. Bell, 274 U.S. 200 (1927); Madrigal v. Quilligan, 639 F.2d 789 (9th Cir. 1981) (a class action suit filed by Latina women coerced into sterilization); Relf v. Weinberger, 372 F. Supp. 1196 (D.D.C. 1974) (prohibiting the practice of involuntary sterilization or required sterilization for women on public benefits, which primarily targeted Black women); Gregory W. Rutecki, *Forced Sterilization of Native Americans: Later Twentieth Century Physician Cooperation with National Eugenic Policies?*, 27 ETHICS & MED. 33 (2011); IRIS LÓPEZ, MATTERS OF CHOICE (2008) (detailing the forced and coerced sterilization of Puerto Rican women in the twentieth century); Quiara Algría Hudes, *#OurMothersToo: Reckoning With My Abuela's Coerced Sterilization*, THE NATION (June 17, 2021), https://www.thenation.com/article/society/ourmotherstoo-reckoning-with-my-abuelas-coerced-sterilization [https://perma.cc/RB9W-5X4N] (situating Puerto Rico's state-run sterilization program—leading to the highest sterilization rate in the world—within the U.S. eugenics movement); Vasquez-Tokos & Yamin, *supra* note 149.

154. Eugenicists, such as Teddy Roosevelt, cautioned against an American "race suicide" due to the increase of foreign immigrants and interracial marriages. Gray Brechin, *Conserving the Race: Natural Aristocracies, Eugenics, and the U.S. Conservation Movement*, 28 ANTIPODE 229, 233 (1996); *see also* DUSTER, *supra* note 148. At the time, eugenicists were concerned about Southern and Eastern Europeans, and Jewish people, infiltrating the white race. Roberts, *supra* note 149, at 132; *see also* DOROTHY ROBERTS, FATAL INVENTION (2011) (explaining how Charles Davenport promoted the idea that selective immigration policies could prevent the reproduction of "bad stock").

155. *See generally* ASHA NADKARNI, EUGENIC FEMINISM (2014).

156. *See* MATTHEW FRYE JACOBSEN, WHITENESS OF A DIFFERENT COLOR 82–83 (199) (quoting prominent eugenicist Harry Laughlin, "Henceforth, after 1924, the immigrant to the United States was to be looked upon, not as a source of cheap or competitive labor, nor as one seeking asylum from foreign oppression, nor as a migrant hunting a less strenuous life, but as a parent of future-born American citizens. This mean that the hereditary stuff out of which future

deporting individuals with Mexican ancestry, many of whom were citizens.[157] Immigration controls explicitly separated an idealized white America from nonwhite entrants, but they were aided by health exclusions.

As the U.S. government sought to exclude certain groups from the population,[158] it also turned to regulate the sexual behavior and health of incoming immigrants. In the first decades after examinations were introduced, medical examiners were screening applicants for morality and sexual behavior.[159] Screening for STIs was a way to screen for immorality, alongside screening for "homosexuality" and "sexual perversion."[160] Syphilis and gonorrhea remained very rare diagnoses when it came to medical screenings,[161] yet they remained inadmissible conditions because of the domestic push against STIs occurring at the time.[162] Even when a latent case of syphilis or gonorrhea could have been certified as Class B, many examiners treated them as Class A conditions and grounds for inadmissibility, because of the moral implications of the disease.[163]

Sweeping sexual policing conducted by the government and driven by the eugenics movement created conditions for broadscale STI eradication campaigns, intersecting with more general moral panics of the twentieth century. STIs

immigrants were made would have to be compatible racially with American ideals."). The caps were set based on the 1890 census and excluded Black people, "aliens ineligible for citizenship" (Chinese, Japanese, and South Asians), immigrants, and Indigenous people, meaning that 85 percent of the quotas went to immigrants from Northern and Western Europe. DERRICK BELL, CHERYL L. HARRIS, JUSTIN HANSFORD, AMNA A. AKBAR, ATIBA ELLIS & AUDREY G. MCFARLANE, RACE, RACISM, AND AMERICAN LAW: LEADING CASES AND MATERIALS, 2023 (SUPPLEMENTS).

157. LÓPEZ, *supra* note 110, at 27. The United States launched a similar mass deportation in the 1950s, which again deported over a million citizens and noncitizens alike based on Mexican ancestry. *Id.* at 28.

158. During the height of the eugenics movement, states targeted individual women for sterilization while implementing nationwide programs to manage sexual behavior because they believed promiscuous women were unsafe to their community by perpetuating disease and degeneracy. *See generally* Stubblefield, *supra* note 136. In the twentieth century, generally, federal and state governments severely restricted martial and sexual relationships, including the prohibition of queer sex, adultery, birth control, and no-fault divorces.

159. KRAUT, *supra* note 44, at 62.

160. PHS REPORT, *supra* note 72, at 15.

161. At the time, both Congress and the public believed that immigrants simply had a higher rate of STIs, even though syphilis was still difficult to correctly diagnose. FAIRCHILD, *supra* note 81, at 172–74.

162. The outbreak of WWI and the need for labor also encouraged retention of syphilis and gonorrhea as Class A conditions. *Id.* at 173. Because STIs represented a sort of social disorder and deviance, and because the United States wanted immigrants to serve as obedient labor, a function of STI screening was to identify good prospective workers. *Id.*

163. *Id.* at 176.

represented loose sexuality and the potential for infertility and birth defects. Because so much of eugenics was about protecting white wives and their future children, public health initiatives targeted STIs largely because they were a threat to that imagined family, thought to be caused by cheating husbands, sex workers, or unattached and immoral individuals.[164] The 1930s in particular saw a widespread movement to eradicate STIs, across federal and state branches of government.[165] Dr. Thomas Parran was instrumental in this campaign, in his roles as health commissioner of New York and then surgeon general of PHS.[166] Beginning in 1935, many states passed mandatory premarital blood tests for syphilis and other STIs.[167] Eugenicists and women's organizations supported this practice, viewing premarital testing as a way to protect future wives and children from unfaithful men and the "tragic consequences" of syphilis.[168] Premarital testing was one element of broader public health efforts for routine STI testing. Around the same time, Congress passed the 1938 National Venereal Diseases Act, which provided federal assistance to state projects against STIs.[169] Public health departments issued posters throughout WWII in a media campaign that mobilized security rhetoric, casting syphilis and gonorrhea as an "enemy," a "menace," and a "hidden foe."[170] A coordinated government effort portrayed

164. WALD, *supra* note 44, at 87 (describing how Prince Morrow, who campaigned against syphilis in the late nineteenth century, christened venereal disease as the "social disease," and posited prostitutes and husbands as the perpetrators and "the idolized daughters, the very flower of womanhood," as the victims. The binding chain of marriage makes the daughter-turned-wife "the passive recipient of the germs of any sexual disease her husband may harbor.').

165. Erin Wuebker, *Taking the Venereal Out of Venereal Disease* , NOTCHES (May 31, 2016), https://notchesblog.com/2016/05/31/taking-the-venereal-out-of-venereal-disease-the-1930s-public-health-campaign-against-syphilis-and-gonorrhea [https://perma.cc/75CP-4WEB].

166. *Id.*

167. *Id.* Montana's law was in effect until 2019. *See* Phil Drake, *Premarital Blood Test Moves Closer to Extinction*, GREAT FALLS TRIBUNE (Feb. 16, 2019), https://www.greatfallstribune.com/story/news/2019/02/16/montana-end-premarital-blood-tests/2891538002 [https://perma.cc/9KGS-87M9].

168. Wuebker, *supra* note 165. According to the Mises Institute, the United States spent around $80 million on premarital syphilis tests and found only 456 positive cases. Ryan McMaken, *Why States Don't Require Blood Tests for Marriage Anymore*, MISES INST. (Jan. 30, 2018), https://mises.org/wire/why-states-dont-require-blood-tests-marriages-anymore [https://perma.cc/79Z7-QBWG].

169. *Id.* This campaign lasted through WWII, and it shifted the portrayal of syphilis from a moral failing to a "menace" to worker productivity.

170. *See* Nate Anderson, *The Sheer Terror of Syphilis (As Seen in 1930s Posters)*, ARS TECHNICA (Feb. 8, 2013), https://arstechnica.com/science/2013/02/menace-to-industry-the-sheer-terror-of-syphilis-as-seen-in-1930s-posters [https://perma.cc/2S2V-W73U] ("Syphilis the great crippler," "stamp out syphilis and gonorrhea," "the enemy is syphilis," "syphilis strikes out one of ten adults," "syphilis menace to industry," "syphilis and gonorrhea the hidden foe").

these STIs as threats to national goals of defense and procreation. This domestic push against syphilis and gonorrhea was one of the first widespread U.S. public health campaigns, yet the government's fixation on these two STIs was less about wellness and more about social goals of eugenics, morality, and national security.

As part of this effort to eliminate STIs, PHS enacted a series of racially violent experiments studying syphilis and gonorrhea, most notoriously the Tuskegee Study.[171] PHS conducted the first of these STI interventions abroad, using noncitizens as test subjects for STI studies and targets for forced treatment.[172] PHS directed STI campaigns in the Caribbean, Panama, and Guatemala in which it infected, detained, and treated people living there. In some cases, PHS claimed that the forced treatment of locals would protect American soldiers stationed in these countries. PHS considered race to be a risk factor in STI transmission, which it used to justify white racial superiority.[173] PHS exploited nonwhite, noncitizen, and incarcerated people as test subjects for STIs, treating these individuals as expendable to protect white American families. This imagined family was to be protected from not only STIs but from the Black and Latine people PHS treated as STI carriers.

During WWII, the U.S. government clarified and expanded the role of PHS in the Public Health Service Act of 1944 (PHSA). The PHSA formalized

171. Led by Dr. Thomas Parran, PHS's 1932 "Tuskegee Study of Untreated Syphilis in the Negro Male" denied almost 400 Black men with syphilis medical information and effective treatments (once developed in 1943), after lying about the purpose of the study and not obtaining consent from the 600 participants. The Tuskegee Study was transferred to CDC in 1957 and lasted until 1972. As a result, 128 men died, and many of their wives and children also contracted syphilis and were denied care. *See Historical Perspectives History of CDC*, CDC (Sept. 19, 1998), https://www.cdc.gov/mmwr/preview/mmwrhtml/00042732.htm [https://perma.cc/Q4FA-9QY3]. In 1943 and 1944, PHS also operated two experiments where individuals who were incarcerated at Terre Haute prison were deliberately exposed to and infected with gonorrhea. PRESIDENTIAL COMMISSION FOR THE STUDY OF BIOETHICAL ISSUES, "ETHICALLY IMPOSSIBLE": STD RESEARCH IN GUATEMALA FROM 1946 TO 1948 13 (2015) [hereinafter "ETHICALLY IMPOSSIBLE"].

172. In 1946 in Guatemala, PHS deliberately infected 1308 healthy people with syphilis, gonorrhea, and chancroid to assess the efficacy of penicillin. These individuals were largely psychiatric patients and sex workers. *See* ETHICALLY IMPOSSIBLE, *supra* note 171. Around the same time, the United States gained control of the Panama Canal Zone, and in its construction project, conscripted PHS to detain and treat Panamanian women for syphilis and gonorrhea, who they presumed to be sex workers or otherwise posing sexual risks to the U.S. men stationed there. *See generally* AHUJA, *supra* note 22, at 71–101; Alexandra M. Stern, *The Public Health Service in the Panama Canal: A Forgotten Chapter of U.S. Public Health*, 120 PUB. HEALTH REPS. 675 (2005).

173. Dr. Oliver Wegner, one of the main health officials in the study, believed race was a risk factor in sexually transmitting diseases, and he frequently degraded participants with racial slurs. AHUJA, *supra* note 22, at 72.

longstanding but disjointed federal involvement in both border control and sexual health, and it remains one of the most enduring pieces of U.S. health policy.[174] The PHSA built off earlier legislation passed in 1943 granting PHS more quarantine and military authority, and the PHSA was an effort to clarify and organize this law. The primary purpose of the PHSA was to grant federal quarantine authority to PHS to prevent the transmission of communicable diseases from foreign countries at the border and ports of entry.[175] The PHSA also granted PHS the ability to conduct physical and mental examination of noncitizens,[176] as well as the authority to detain and examine individuals within the United States "reasonably believed to be infected with a communicable disease."[177] In its conception, PHSA joined border health security and medical screening with STI control, with the goal of preserving the U.S. military at a time of geopolitical crisis looming heavy in Congress.[178]

174. Pub. Health Serv. Act, Pub. L. 371-373, 58 Stat. 682, Chapter 373, 42 U.S.C. ch. 6A § 201 et seq (1944). Around the same time that Congress disavowed health as a national right by rejecting the Second Bill of Rights, it passed the PHSA to establish quarantine power during WWII. This effort to federalize health initiatives came long after most late-liberal states had codified national public health infrastructure. PHSA did not create any national health program beyond a health security apparatus to respond to a global crisis. *See generally* DOROTHY PORTER, HEALTH, CIVILIZATION AND THE STATE (1999). The PHSA instead authorized PHS to implement quarantine and immigration screening. Subsequent efforts to graft reproductive management, newborn screening, or affordable health care onto the PHSA seem to reinterpret it as a public health project, departing from its origins as a health security response to external threats. *See* Fam. Planning Serv. and Population Rsch. Act of 1970, Pub. L. 91–572, 84 Stat. 1504; 42 U.S.C. § 300–300a; Improved Newborn and Child Screening for Heritable Disorders, Pub. L. 106–310, 114 Stat. 1164, 42 U.S.C. § 300b–8 (2000); Patient Prot. and Affordable Care Act of 2010, Pub. L. 111–48, 124 Stat. 119; 42 U.S.C. § 18001.

175. By 1921 quarantine was fully nationalized, but it was not formally legalized until the PHSA in 1944. *See* Jared P. Cole, *Federal and State Quarantine and Isolation Authority*, 17 CURRENT POL. & ECON. U.S., CANADA & MEXICO 273 (2015).

176. 42 U.S.C. § 252.

177. 42 U.S.C. § 264.

178. During a congressional hearing on the PHSA, then-surgeon general of PHS, Dr. Parran, described the functions of PHS as, in part, to "aid the States through the control of disease" and "*to prevent the introduction of certain dangerous contagious diseases into the United States* and its territories and their spread in interstate commerce." SEN. COMM. ON EDUC. & LAB., LAWS RELATING TO THE PUB. HEALTH SERV. 6 (1944) (emphasis added). "That authority may be very important because of the possibility that strange diseases may be introduced in the country and become a threat." *Id.* Justifying PHS as a defense against "dangerous contagious disease" to protect "our people," Dr. Parran asserted the border health security role of PHS, defending the border against an imagined outside world of health threats. Dr. Parran also recommended incorporating the simultaneously proposed tuberculosis management bill into PHSA, because it would "fit into the general mechanism of giving grants to the States for venereal-disease control and other activities." *Id.* at 15.

Much like PHS, the development of CDC was buttressed by wartime responses. In 1946, PHS physician and officer Dr. Joseph Mountin established the Communicable Disease Center, which became CDC.[179] During the Korean War in 1950, CDC expanded to epidemiology to defend against bioterrorist threats.[180] CDC assumed PHS's venereal disease program in 1957.[181] Quarantine authority was transferred to CDC in 1967. Currently, CDC operates eighteen quarantine stations through the Division of Global Migration and Quarantine (plainly linking the movement of bodies with the spread of disease).[182]

In the later twentieth century, immigration restrictions remained a racist and eugenic sorting project, as the United States attempted to limit its population to white nuclear families. The 1952 Immigration and Nationality Act upheld the national origins quota system and introduced new preferences based on employment and family reunification.[183] The set of employment preferences similarly disqualified anyone with an illness or disability that prevented them from working, leaving open few other avenues for entry. At this time, queerness was considered a mental defect, so mental or psychiatric exclusions were used to exclude people on the basis of sexuality as well as disability. In 1952, the United States codified "sexual deviation" as an inadmissible condition,[184] using health exclusions to bar individuals outside heterosexual family norms.

179. Tanja Popovic & Dixie E. Snider, Jr., *60 Years of Progress—CDC and Infectious Diseases*, 12 EMERGENCY INFECTIOUS DISEASES 1160 (2006).

180. *See Historical Perspectives History of CDC*, *supra* note 171 ("The threat of biological warfare loomed, and Dr. Langmuir, the most knowledgeable person in PHS about this arcane subject, saw an opportunity to train [CDC] epidemiologists who would guard against ordinary threats to public health while watching out for alien germs").

181. *Id.*

182. *Division of Global Migration Health*, CDC (May 6, 2022), https://www.cdc.gov/ncezid/dgmq/index.html [https://perma.cc/CX4W-2372].

183. Pub. L. 82–414; 66 Stat. 163. This Act officially removed the ban on Asian immigrants, but Asian immigration was still blocked in practice. *The Immigration and Nationality Act of 1952*, U.S. DEP'T OF STATE, OFF. OF THE HISTORIAN, https://history.state.gov/milestones/1945–1952/immigration-act [https://perma.cc/963E-7JXK] ("At the same time, however, the new law only allotted new Asian quotas based on race, instead of nationality. An individual with one or more Asian parent, born anywhere in the world and possessing the citizenship of any nation, would be counted under the national quota of the Asian nation of his or her ethnicity or against a generic quota for the 'Asian Pacific Triangle.' Low quota numbers and a uniquely racial construction for how to apply them ensured that total Asian immigration after 1952 would remain very limited."). *See also* LÓPEZ, *supra* note 110, at 33.

184. *See* INS, IMMIGRATION AND NATIONALITY ACT (8 U.S.C. § 1182)—IMMIGRATION AND NATURALIZATION SERVICE—PUBLIC HEALTH SERVICE—HOMOSEXUALITY AS GROUNDS FOR EXCLUSION 457 (Dec. 10, 1979) (stating that, despite the surgeon general's effort to stop

While the 1965 Immigration and Nationality Act abolished the quota system, it maintained this system of family-based and employment preferences. As immigration restrictions moved from race-based to employment and family requirements, the United States retained health-based requirements to ensure that incoming noncitizens would contribute to the U.S. economy, would not require certain social services, and would not deviate from desired social norms.[185] Today, immigration law is largely based on family or employment preferences.[186] In this way, the U.S. government still tries to regulate the sexual and familial relationships of noncitizens, favoring those who conform to the nuclear family structure encouraged in the United States.

Another war—the Vietnam War—increased CDC's role in border health security. In the 1960s, PHS was conducting around 60 percent of all medical examinations.[187] However in 1975, CDC began to assist in the screening, immunization, and follow up health of Vietnamese refugees, and its recommendations had considerable influence in visas and admissions.[188] This began CDC's direct involvement with admissions, and CDC now works jointly with USCIS to help regulate the border.

With the classification of HIV infection as a "dangerous contagious disease" in 1986,[189] PHS and CDC's motivations behind these exclusions came under public pressure. Prior to the HIV epidemic, medical examiners excluded applicants on the basis of sexuality through mental health requirements.[190] After sexuality could no longer be used as grounds for inadmissibility, the U.S. government used HIV/Acquired Immunodeficiency Syndrome (AIDS) to

classifying homosexuality as "mental defect or disease," INS must still enforce exclusions against applicants considered homosexuals).

185. Requirements relating to immigrant self-sufficiency were expanded upon in the Illegal Immigration Reform and Immigrant Responsibility Act.

186. Which are still subject to nationality-based caps.

187. *See* PHS REPORT, *supra* note 72, at 27.

188. *Id.* Such a project reveals a fundamental hypocrisy of border health security: the United States can intervene in and destabilize Vietnam but then select against Vietnamese refugees at the U.S. border on the basis of health.

189. Medical Examination of Aliens (AIDS), 52 Fed. Reg. 21532 (June 8, 1987) (amending 42 C.F.R. § 34).

190. *See, e.g.*, Hill v. INS, 714 F.2d 1470, 1479 (9th Cir. 1983) (concluding Congress intended to require Immigration and Naturalization Services to obtain a PHS medical certificate before excluding "homosexuals" from the United States on the ground of affliction with a psychopathic personality, sexual deviation, or mental defect, and requiring that the determination must be made by medical offers trained to determine "psychopathic personality, sexual deviation, or mental defect"); *In re Longstaff*, 716 F.2d 1439 (5th Cir. 1983).

achieve similar exclusions.[191] The rampant racism and homophobia in the U.S. government response to HIV epidemic undermined the "public health" claims in favor of making it a Class A condition.[192] Activists and academics called out the exclusion for what it was—a way to exclude queer and Black, especially Haitian, people. Activist efforts succeeded: HIV/AIDS was removed in 2009.[193] Syphilis infections surged during the HIV pandemic, and though syphilis cases have hit a historic low in the United States, syphilis still remains a Class A condition, unlike HIV.[194] It appears the U.S. government does not want to cede its ability to surveil the sexual health of noncitizens, even though like HIV, syphilis and gonorrhea are both treatable.

Presently, the Immigration and Naturalization Act (INA) governs the health requirements and examinations for incoming noncitizens, and the language remains largely the same as the 1891 Immigration Act.[195] While explicit race-,

191. *See* Lyn G. Shoop, *Health Based Exclusion Grounds in United States Immigration Policy: Homosexuals, HIV Infection and the Medical Examination of Aliens*, 9 J. CONTEMP. HEALTH L. & POL'Y 521 (1993).

192. For a discussion of this history, see, *e.g.*, *id.*, Mark Barnes, *AIDS and Mr. Korematsu: Minorities at Times of Crisis*, 7 ST. LOUIS U. PUB. L. REV. 35 (1988); Asmat A. Khan, *United States Immigration Policy and HIV: Projecting Blame*, 15 HAMLINE J. PUB. L. & POL'Y 123 (1994); Donna E. Manfredi & Judith M. Riccardi, *AIDS and United States Immigration Policy: Historical Stigmatization Continues With the Latest Loathsome Disease*, 7 ST. JOHN'S J.L COMMENT 707 (1992). The UN also tried to coordinate international advocacy to remove HIV-related entry bans. UNAIDS, DENYING ENTRY, STAY, AND RESIDENCE DUE TO HIV STATUS (2009).

193. *See* Tom Lantos and Henry Hyde, United States Global Leadership Against mv/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008, Pub. L.11 0–293 § 305, 122 Stat. 2918, to be codified at 8 U.S.C. 1182 (2008); Medical Examination of Aliens—Removal of Human Immunodeficiency Virus (HIV) Infection from Definition of Communicable Disease of Public Health Significance, 74 Fed. Reg. 56547–62 (2009) (amending 42 C.F.R. § 34). However, HIV may still be classified as a Class B notification. *Guidance for HIV for Panel Physicians and Civil Surgeons*, CDC (Jan. 4, 2010), https://www.cdc.gov/immigrantrefugeehealth/panel-physicians/hiv-guidance.html [https://perma.cc/U2KD-QS6S]. I cannot give adequate treatment to the campaign for its removal, as part of a broader campaign against HIV/AIDS-discrimination. But the effort to remove the HIV/AIDs exclusion is singular: no other condition has received such attention.

194. *Detailed STD Facts – Syphilis*, *supra* note 31.

195. The Immigration & Naturalization Act § 212 (A)(1)(a) lists the grounds for inadmissibility and visa ineligibility, and the first of these grounds is health-related grounds. The first health-related ground, under INA § 212(a)(1)(A), is someone with a "communicable disease of public health significance." Though no longer described as "loathsome or dangerous" or "loathsome and contagious," the inadmissibility of communicable diseases remains. INA § 221(d) requires the medical examination process for the issuance of immigrant visas and allows the consular officer to use their discretion to require medical examinations for the issuance of nonimmigrant visas. Lastly, INA § 232(b) allows the attorney general to detain arriving noncitizens for observation and examination by immigration and medical officers. It authorizes the Public Health Service officers and civil surgeons—particularly those specially

nationality-, and sexuality-based exclusions have been removed, the health-based and economic-based exclusions that were introduced simultaneously remain in their original form. However, PHS has altered the language for excludable conditions. Class A conditions became "dangerous" or "contagious" diseases.[196] Class C conditions became "variances from the normal," then were later removed.[197] Despite shifts in language, the laws governing health-based inadmissibility are nearly identical as to their introduction in the late nineteenth century. The continued use of these health grounds for inadmissibility retains the spirit of the explicitly racist measures they were implemented alongside, and the purpose of the categories has remained: to exclude undesirable individuals.

PHS and CDC have used interventions against STIs to screen, detain, treat, and exclude noncitizens—predominantly people of color—a logic that underlies present STI screening of noncitizens during the visa application process. Evidently, health exclusions are not necessarily euphemistic for racial exclusions—which the United States freely and frequently enacted—but serve as another arm of the project of white nation building.

III. DECOUPLING SEXUAL HEALTH FROM IMMIGRATION

In Parts I and II, I have shown that the present STI screening requirements stemmed from a history of racial and national exclusion. In Part III, I recommend removing sexual health from the admissions requirements and provide some concluding theoretical remarks to ultimately support an argument for the end of medical examinations.

A. Recommendations[198]

As demonstrated, there is no scientific or medical reason for syphilis and gonorrhea to render someone inadmissible—though perhaps a historic,

trained "in the diagnosis of insanity and mental defects"—to examine arriving noncitizens. Carried over from the 1903 Act, these examining officers are also granted the discretion to certify individuals who are, though inadmissible for health reasons, are "helpless" and accompanied by another noncitizen who provides necessary protection.

196. By 1970, Class A conditions included tuberculosis, leprosy, and five STIs. *See* Willis R. Forrester, *Medical Examination of Aliens*, 10 IN DEF. OF THE ALIEN 258, 259 (1987).

197. PHS REPORT, *supra* note 72, at 4.

198. Because of plenary power and state sovereignty, there has been little legal pushback to the idea that the United States can create almost any sorting procedure or criteria to determine who or what can enter the country. Presently, international and U.S. law offer almost no opportunity to challenge such exclusions because of the extreme deference given to governments to manage their borders, which is why I focus on a broader interrogation of STI screening, rather than legal analysis, to support alternative forms of advocacy.

xenophobic one. Screening for STIs during medical examinations emerged during the construction of racially exclusive border polices and eugenic projects. This is not to say that CDC deliberately keeps these diseases as Class A conditions to achieve a racist exclusion. However, STI screening was added during a time where nearly every element of immigration law served exclusionary purposes, so retaining this requirement is a choice to uphold parts of that discriminatory system. Because the present implementation of STI screening is inextricable from this history, and because of the ongoing dignitary harms, I recommend removing screening for STIs from the admissions process.

CDC offers several reasons why STI screening remains an important component of the medical examination. In CDC's Technical Instructions, they explain that diagnosing syphilis and gonorrhea is important to "ensure that affected applicants receive appropriate treatment," which might limit their longterm effects and reduce the spread of the disease.[199] In the 2016 Notice of Proposed Rulemaking, CDC justified retaining syphilis and gonorrhea because "continuing to screen for and treat these diseases, when identified in aliens, provides a public health benefit to the United States as well as a personal health benefit to the individual."[200] CDC claims that the medical examinations are win-win: applicants are informed of a treatable disease and the United States avoids an additional case. CDC portrays medical examinations as a low-effort preventative care intervention that protects both parties and stops the spread of STIs.

The State Department, however, informs applicants abroad that the medical examination is not a complete examination and that the panel physician will not assist with any other discovered conditions not relevant to immigrant admissions.[201] The examination cannot be recast as a way to offer preventative care to new arrivals, even if there may be an incidental benefit to some applicants. Moreover, requiring applicants to accept treatment or risk inadmissibility is not altruism, particularly when applicants must pay for the treatment. After receiving

199. *Syphilis Instructions for Panel Physicians*, *supra* note 75.

200. Medical Examination of Aliens-Revisions to Medical Screening Process, 80 Fed. Reg. 35899 (June 23, 2015) (amending 42 C.F.R. 34).

201. *Medical Examination FAQs, supra* note 97 ("The medical examination is not a complete physical examination. Its purpose is to screen for certain medical conditions relevant to U.S. immigration law. The panel physician is not required to examine you for any conditions except those the U.S. Public Health Service specifies for U.S. immigration purposes, nor is the physician required to provide you with diagnosis or treatment even though other matters related to your health might be discovered. This examination is not a substitute for a full physical examination, consultation, diagnosis, or treatment by your primary health care provider.").

treatment, noncitizens remain surveilled and monitored through the EDN system. CDC have engaged in STI campaigns within the United States,[202] but citizens receive no such enforcement: it is voluntary for any citizen to test for or treat an STI. Noncitizens deserve such choice and autonomy.

Another purpose of the screening, according to CDC, is so "noncitizens entering the United States do not pose a threat to the public health of this country."[203] Similarly, PHS explained that they examine noncitizens, rather than review their reported health history, because they presume noncitizens would lie or withhold information about their health to gain admission.[204] Justifications for mandatory testing presume that that noncitizens will not seek out care or choose to engage in less risky sexual behavior. Because STI screening rests on such a xenophobic assumption, it has no place in the application process.

The U.S. government has always held that entry into the country is a revokable privilege,[205] and for this reason, it can be selective about who it wants within its borders. The United States has higher standards for noncitizens in many categories, not just health.[206] The fact that there is a waiver available at all for Class A conditions is a generous concession to an applicant's interest in entering. But the existence of a waiver for communicable diseases further undermines any claim that such conditions need to be excluded.

Mandatory STI screening upholds a dangerous distinction between citizens and noncitizens that can be used to justify more exclusions. The presence of these

202. *See, e.g.*, *About STI Awareness Week*, CDC, https://www.cdc.gov/std/saw/about.htm [https://perma.cc/9RRJ-TE7C]. The U.S. government does not provide full national health care coverage, and it does not maintain a right to health. *See, e.g.*, THE HISTORY OF PUBLIC HEALTH AND THE MODERN STATE (Dorothy Porter ed., 1994). Unlike states that guarantee affirmative rights to health, the U.S. government maintains no obligation to provide, promote, or facilitate health. *See, e.g.*, PORTER, *supra* note 174; CASS SUNSTEIN, THE SECOND BILL OF RIGHTS: FDR'S UNFINISHED REVOLUTION AND WHY WE NEED IT MORE THAN EVER (2004) (explaining how President Franklin D. Roosevelt tried and failed to introduce a right to health in the Second Bill of Rights). The U.S. government does not require STI screening and treatment of citizens, nor does it embrace any obligation to provide such care either.

203. Medical Examination of Aliens-Revisions to Medical Screening Process, 80 Fed. Reg. at 35899.

204. PHS REPORT, *supra* note 72, at 10 ("It, is not like the immigrant who is making the big change of his life from one country to another, who has to go under his own personal circumstances, regardless of whether he is sick or well. The ordinary tourist, for instance, would not be inclined to travel if lie were sick.") (Statement by Dr. James Telfer, then Chief Division of Foreign Quarantine).

205. *See* Harisiades v. Shaugnessy, 342 U.S. 580 (1952) (holding that noncitizens are subject to deportability and that the accrual of time in the United States does not afford a right to remain like citizenship).

206. Certain visas require a job, higher education, or even a world-renowned skill.

infections as inadmissibility grounds could be cited to validate a more reactive or pretextual addition of other sexual health conditions. In fact, the classification of syphilis and gonorrhea as Class A conditions has been used to justify expansions of sexual health screening.[207] Now, as the United States is engaging in reactionary health-based exclusions while experiencing a domestic conservative movement to regulate sexual behavior, concerns about what the U.S. government can do in the name of "public health" only becomes all the more important.[208] Removing syphilis and gonorrhea as inadmissible conditions would remove sexual health from inadmissibility grounds.[209] Retaining STIs as Class A and B conditions allows the U.S. government to exert border control through sexual health management, when the two should not have anything to do with each other.

Therefore, syphilis and gonorrhea must be removed from Class A and B conditions, and no sexual health conditions should be grounds for inadmissibility.

207. For example, CDC explained the inclusion of AIDS as a Class A condition, when it is not in fact "contagious" as popularly understood, was because: "the spread of AIDS by certain high risk sexual practices is not unlike several other diseases currently on the List of 'dangerous contagious diseases' in the regulations implementing our responsibilities under the Immigration and Nationality Act." Medical Examination of Aliens (AIDS), 52 Fed. Reg. 21532 (June 8, 1987) (amending 42 C.F.R. § 34).

208. As seen with the mpox outbreak, fears about infectious diseases and risky sexual behavior are once again converging into media messaging that blames the choices of queer men and attaches racist, anti-African stigma to a global outbreak. *See, e.g.*, Bill Chappell, *WHO Renames Monkeypox as Mpox, Citing Racist Stigma*, NPR (Nov. 28, 2022, 11:41 AM), https://www.npr.org/sections/goatsandsoda/2022/11/28/1139403803/who-renames-monkeypox-as-mpox-citing-racist-stigma [https://perma.cc/6V4F-4AL4]; Spencer Kimball, *WHO Recommends Gay and Bisexual Men Limit Sexual Partners to Reduce the Spread of Monkeypox*, CNBC (July 27, 2022, 8:17 PM), https://www.cnbc.com/2022/07/27/monkeypox-who-recommends-gay-bisexual-men-limit-sexual-partners-to-reduce-spread.html [https://perma.cc/8CQV-EZPW]; Liam Stack, *'It's Scary': Gay Men Confront a Health Crisis With Echoes of the Past*, N.Y. TIMES (July 28, 2022), https://www.nytimes.com/2022/07/28/nyregion/gay-men-monkeypox-health-crisis.html [https://perma.cc/B7FK-SDMC]. While the U.S. government did not make mpox an inadmissible communicable disease, the precedent for such a discriminatory potential exclusion is still embedded in immigration law and regulations.

209. Pregnancy may still be considered a Class B condition. While not on the current Form DS-2054 for panel physicians, pregnancy used to be a listed Class B condition on the version of the form expiring in 2013. *See Form DS-2054 Report of Medical Examination by Panel Physician*, U.S. DEP'T OF STATE, https://omb.report/icr/202207-1405-004/doc/123423800 (last visited Mar. 19, 2024) (access the form by scrolling down and using the PDF viewer feature). Because Class B conditions include a section for "other," many physicians may still screen for and report pregnancy.

B. Interrogating Border Health Security Through Mandatory STI Screening

Mandatory STI screening represents the intersection of two U.S. projects: border control based on xenophobia and sexual control based on similar skepticism of undesirable outsiders. As shown, both projects are rooted in white supremacy, and the STI screening requirements are inextricable from these origins. In this section, I conclude by examining the exclusionary logic that underpins mandatory STI screening and signal to how, beyond removing sexual health from immigration decisions, these problems require a total upheaval of border health security.

1. Attributing Health Threats to Migration

In this Subpart, I show how mandatory STI screening is part of a broader narrative of xenophobia and blame that underpins the U.S. border health security apparatus.

Screening for syphilis and gonorrhea in select noncitizens is more of a discriminatory barrier than a meaningful public health intervention. Moreover, syphilis, gonorrhea, tuberculosis, and leprosy seem to be peculiar choices as the only enumerated excludable conditions. In looking to the history of these four infections, it becomes even clearer that the unifying feature of all four is their longstanding stigmatization and association with outsiders, not any epidemiological rationale.

Since their discovery hundreds or even thousands of years ago, syphilis and gonorrhea have been cast as a signifier of unclean or immoral sexual practices, and the infections have been blamed on already marginalized groups.[210]

210. Gonorrhea has been observed since as early as 2600BC. *See* Predesh P. Jose, Vatsan Vivekanandan & Kunjumani Sobhanakumari, *Gonorrhea: A Historical Outlook*, 2 HIST. 110, 110 (2020). In Europe, syphilis and gonorrhea were once considered a "curse" for immoral sex or for participating in sex work. In 1530, Girolamo Fracastoro wrote an origin myth for syphilis, naming the disease for the first time, and explaining it as a curse that Apollo put on a shepherd in Hispaniola. Eamon, *supra* note 27, at 5. Because of these origin myths and the very nature of the infection as sexually transmitted, syphilis was historically stigmatized and shameful, seen as a punishment for depravity. *See generally* Shayna Cunningham, Deanna L. Kerrigan, Jacky M. Jennings & Jonathan M. Ellen, *Relationships Between Perceived STD-Related Stigma, STD-Related Shame and STD Screening Among a Household Sample of Adolescents*, 41 PERSP. ON SEXUAL & REPROD. HEALTH 225 (2009); Natalie Lambert, J. Imrie, C.H. Mercer, A.J. Copas, A. Philips, G. Dean, R. Watson & M. Fisher *'Dirty Sex and Dirty Diseases': Stigma, Disclosure and Prevention of Syphilis Among Men Who Have Sex With Men on England's South Coast*, 15 INT'L J. STD & AIDS 33 (2004); Bronwen Litchenstein, *Stigma as*

Syphilis was originally thought to be a form of gonorrhea.[211] For example, one origin myth of syphilis believed it was created by sex between a "leper" and a sex worker with gonorrhea.[212] Syphilis, leprosy, and gonorrhea were historically linked and together, blamed on marginalized social groups or undesirable practices. Today, the three remain Class A medical conditions for the United States—they have not been uncoupled from each other or from the stigmas associated with them.

Syphilis especially has been historically associated with outsiders. Throughout the sixteenth to eighteenth centuries, countries with syphilis cases blamed the infection on groups just beyond their borders. According to Mircea Tampa:

> [E]ach country whose population was affected by the infection blamed the neighboring (and sometimes enemy) countries for the outbreak. So, the inhabitants of today's Italy, Germany and United Kingdom named syphilis 'the French disease', the French named it 'the Neapolitan disease', the Russians assigned the name of 'Polish disease', the Polish called it 'the German disease', The Danish, the Portuguese and the inhabitants of Northern Africa named it 'the Spanish/Castilian disease' and the Turks coined the term 'Christian disease'. Moreover, in Northern India, the Muslims blamed the Hindu for the outbreak of the affliction. However, the Hindu blamed the Muslims and in the end everyone blamed the Europeans.[213]

As this chain of finger-pointing shows, syphilis was originally blamed on a nearby "other," whether a neighbor or a minority group.

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a Barrier to Treatment of Sexually Transmitted Infection in the American Deep South: Issues of Race, Gender and Poverty, 57 SOC. SCI. & MED. 2435 (2003); Huw Houssemayne du Boulay, *'The Bad Disorder': Syphilis Before 1944*, 87 SEXUALLY TRANSMITTED INFECTIONS 570 (2011); CLAUDE QUETAL, THE HISTORY OF SYPHILIS (1992).

211. *See* QUETAL, *supra* note 210; Jose, *supra* note 210; Bruce Rothschild, *History of Syphilis*, 40 CLINICAL INFECTIOUS DISEASES 1454 (2005); Marie E. McAllister, *Stories of the Origin of Syphilis in Eighteenth-Century England: Science, Myth, and Prejudice*, 24 EIGHTEENTH-CENTURY LIFE 22 (2000).

212. *See* QUETAL, *supra* note 210; Rothschild, *supra* note 211; McAllister, *supra* note 211. Several origin stories blamed syphilis on "lepers," cannibals, or people having sex with monkeys. Eamon, *supra* note 27, at 3–5. Leonardo Fioravanti also promoted a theory that syphilis was caused by cannibalism. A staunch Catholic, Fioravanti cast syphilis as a manifestation of evil and corruption. *Id.* at 3. Other rumors claimed that "vengeful Spaniards" mixed leper's blood with wine to form syphilis, or that sex between a leprous knight and a courtesan produced the infection. *Id.* at 5.

213. Mireca Tampa, *Brief History of Syphilis*, 10 J. MED. LIFE 4 (2014); *see also* Eamon, *supra* note 27, at 5; *and Tuberculosis*, *supra* note 24, at 41.

Not only did governments use syphilis to delineate boundaries, but European governments particularly used syphilis as evidence that those outside its boundaries were morally or hygienically inferior. When an outbreak of syphilis in Europe coincided with the arrival of Europeans to the Western Hemisphere, Europeans suggested that the Columbus expedition brought syphilis from the Americas to Spain.[214] Locating syphilis in the Americas shifted the blame from European doctors (who could not treat the rapidly spreading disease) to Indigenous Americans. As syphilis was already a marker of immorality and uncleanliness, this shift was used to bolster justifications for colonization that defined Indigenous people as inferior.[215] Medical advances have dispelled many of these myths and stigmas. But when the United States mandates STI screening of noncitizens, it enacts the same type of othering project as these historic narratives by blaming outsiders (and their health practices, hygiene, and sexual behaviors) for infections common in the country.

Paul Farmer's concept of geography of blame help under the spatialization of fear and blame at work in this and other border health security policies.[216] Farmer observed that certain groups are assigned—by science or popular narrative—responsibility for diseases due to their supposed proximity to the disease.[217] When diseases become tracked to certain spatial origins, people from these places become treated as the disease itself, because if a disease becomes thought of as inherent to a certain place, anyone from that place becomes a disease risk. The U.S. government identifies disease risk by mapping it onto identity categories (such as national origin), onto which it bases its exclusions. This risk-mapping

214. Eamon, *supra* note 27, at 6. The role of Columbus's arrival in the Americas is the main point of contention between the three dominant theories for syphilis's origin: the Columbian Hypothesis, pre-Columbian Hypothesis, and the Unitarian Hypothesis. The Columbian Hypothesis, as described above, is still considered a valid theory. *Id.* The pre-Columbian theory contends that the STI developed from endemic syphilis in Southwestern Asia, mutating and spreading to Europe from there. Tampa, *supra* note 213. *See generally* M. POWELL & D. COOK, THE MYTH OF SYPHILIS (2005). The Unitarian Hypothesis posits syphilis and non-venereal treponemal diseases are different variations of the same infections and the differences occur only because of "geographic and climate variations and to the degree of cultural development of populations within disparate areas." Tampa, *supra* note 213. Following this hypothesis, how "civilized" a society is can change how a biological disease presents itself. *Id.* This theory blames lack of "cultural development" or personal behaviors with this infection, much like the earlier origin myths. Regardless of their differences, all three theories still attribute the disease to individuals who are non-European, whether due to geography or cultural differences. *See* Rothschild, *supra* note 211; Eamon, *supra* note 27.

215. Eamon, *supra* note 27, at 6, 19.

216. S*ee generally* FARMER, *supra* note 24.

217. *Id.*

project quickly resembles other efforts to exclude individuals from the United States for racist, eugenic, or xenophobic reasons, like people considered public charges or terrorists, under the guise of being "too risky" and therefore undesirable for entry.[218] Justifications for the inclusion of syphilis and gonorrhea as Class A and B medical conditions rely on geographies of blame, suggesting that these diseases come from outside the United States and do not belong within the border or the population, even though these infections are common domestically.

As recent pandemics have made clear, disease "knows no borders."[219] Preventing the entry of certain individuals at the border is not effective public health policy. Still, the U.S. government has long treated migration—and certain migrants—as a site of health intervention.[220] Throughout the immigration of the twentieth century, incoming foreigners were blamed for all sorts of disease outbreaks, from the Italians for polio to the Chinese for the bubonic plague to the Irish for cholera.[221] Health-based exclusions often served as "'a medical rationale to isolate and stigmatize social groups reviled for other reasons,' particularly immigrants and racial and ethnic minorities that personified frightening social change."[222] By associating migration with disease threats, the U.S. government converted "paranoia about 'racial others'" into allegedly neutral public health policy.[223]

218. *See, e.g.*, Lei Zhang, Erika Lee & Eunice Kim, *Xenophobia & Racism*, IMMIGRANTS IN COVID AMERICA, https://immigrantcovid.umn.edu/xenophobia-racism [https://perma.cc/LH83-L979] (describing how the "false linkage between COVID-19 and the 'uncivilized' Chinese habit of consuming wildlife animals . . . revitalized historically-entrenched narratives connecting Chinese people, communities, and spaces to disease"); Andrew Jacobs, *Monkeypox Has a New Name: Mpox*, N.Y. TIMES (Nov. 28, 2022), https://www.nytimes.com/2022/11/28/health/monkeypox-mpox-who.html [https://perma.cc/K4TU-P6KB]; FARMER, *supra* note 24.

219. *See, e.g.*, Antoine de Bengy Puyvallée & Sonja Kittelsen, *"Disease Knows No Borders": Pandemics and the Politics of Global Health Security*, *in* PANDEMICS, PUBLICS, & POLITICS 59–73 (2018).

220. *See supra* Part II (describing the evolution of health-based exclusions for migrants). "The modern conflation of public health vigilance with immigration control is exemplified in the United States by the name of the federal agency whose primary responsibility it is: the federal Centers for Disease Control and Prevention's (CDC) Division of Global Migration and Quarantine." Price, *supra* note 19, at 921.

221. KRAUT, *supra* note 44, at 4. For a broader history on the ways the U.S. media and public blamed noncitizens for disease outbreaks, *see id.*

222. King, *supra* note 14, at 765.

223. Harper & Raman, *supra* note 137, at 8. As Alan Kraut aptly put it, "[T]he double helix of health and fear that accompanies immigration continues to mutate." KRAUT, *supra* note 44, at 272.

Present border health security measures like mandatory STI screening reflect this entrenched blame on noncitizens. Unlike some border security measures such as airport body scans or luggage screening that all travelers must undergo, many U.S. border health security policies focus solely on *noncitizen* movement. Immigrants and other noncitizens face a stricter pre-entry health screening than temporary and citizen travelers, despite U.S. citizens returning from travel with higher rates of infectious diseases.[224] Border health security varies the permeability of the U.S. border based on identity categories.

The current health scrutiny that noncitizens receive is still premised on little more than the assumption, rooted in racism, that the Global North is healthier than the Global South. "Border health security relies on binaries: between safe versus unsafe spaces, ill versus healthy bodies, and us versus them.[225] By treating others as unsafe and unhealthy,[226] the United States defines its own population as safe and healthy, even when that's not true.[227] Following this logic, anyone perceived as outside the United States must be safe and healthy to enter the border. Thus, border health security makes the U.S. border more of a barrier for noncitizens by creating arbitrary health requirements.

Equating migration with infection or contagion[228] is not limited to literal disease; the U.S. government has used metaphors of migrants *as* disease to justify

224. *See, e.g.*, Price, *supra* note 19, at 921; Maggie Fox, *Migrants Don't Bring Disease. In Fact, They Help Fight It, Report Says*, NBC (Dec. 5, 2018), https://www.nbcnews.com/storyline/immigration-border-crisis/migrants-don-t-bring-disease-fact-they-help-fight-it-n944146 [https://perma.cc/F5SD-TC7X].

225. *See* Harper & Raman, *supra* note 137; Brown et al., *supra* note 24; Peggy Teo, Brenda S.A. Yeoh, & Shir Nee Ong, *Surveillance in a Globalizing City: Singapore's Battle Against SARS*, *in* NETWORKED DISEASE: EMERGING INFECTIONS IN THE GLOBAL CITY (2011).

226. "Migration health screening is often used to provide the mechanism for a health-based exclusion process because of a real or perceived threat of importation of disease into a healthier or cleaner population." V.P. Keane & B.D. Gushulak, *The Medical Assessment of Migrants: Current Limitations and Future Potential*, 39 INT'L MIGRATION 29, 30 (2001). The U.S. has also created internal borders around perceived foreigners. *See, e.g.*, KRAUT, *supra* note 44, at 89–92 (explaining that San Francisco, perceiving the plague as a Chinese problem, repeatedly quarantined Chinatown, and describing how state governments on the West Coast forced inoculation for cholera for Chinese and Japanese immigrants). Border-drawing serves not only as an exclusionary tactic but also to identify certain groups with reduced rights, such as the right to refuse medical treatment.

227. For example, the United States has the highest total cases of COVID-19. *See WHO Coronavirus (COVID) Dashboard*, WORLD HEALTH ORG., https://covid19.who.int/ [https://perma.cc/RD74-ER4Y].

228. *See* Harper & Raman, *supra* note 137; WALD, *supra* note 44; FAIRCHILD, *supra* note 134, at 47; KRAUT, *supra* note 44, at 2. Immigrants have been blamed with infecting the "aesthetic order, the political order, the social order, and especially the sanitary moral order . . . also the cultural and moral order" of states. Harper & Raman, *supra* note 137, at 4. Migrants, because

xenophobic and exclusionary border policies.[229] As Ian Harper and Parvathi Raman explain, "regardless of the evidence, metaphors of plague, and infection have circulated and been used to marginalize and keep out diaspora communities in host countries in an effort to 'exclude filth.'"[230] Attributing health problems to noncitizens perpetuates U.S. efforts to blame other social problems to noncitizens, such as crime or job insecurity.[231]

Medical examinations in general perpetuate the idea that noncitizens are inherently less healthy than U.S. citizens, which is inaccurate and dangerous. These examinations serve as a border-drawing project to delineate certain people as "outsiders," regardless of their location in relation to the physical border. Certain people (like visa waiver travelers) can enter the border without medical scrutiny, while others (like refugees or individuals adjusting status within the United States) are treated with medical skepticism. The unevenness of the examination's application reveals that it is not a public health intervention but a means of regulating noncitizens the U.S. government has identified as threatening. The medical examination as a whole is an unjustifiable burden to noncitizens.

2. Excluding Undesirability From the United States

Mandatory STI screening also exemplifies how the U.S. government treats particular groups as undesirable and as sexually threatening. In this Subpart, I

of their mobility, have often been scripted by governments as risky bodies, representing the potential to bring sickness, disease, or other health threats into the otherwise "safe" country. *See id.*

229. *See* Harper & Raman, *supra* note 137; Alison Mountz, Kate Coddington, R. Tina Catania & Jenna M. Loyd, *Conceptualizing Detention: Mobility, Containment, Bordering, and Exclusion*, 37 PROGRESS IN HUM. GEOGRAPHY 522 (2013). BROWN, *supra* note 23, at 82 "The extent to which inside/outside distinctions comport ever less with the boundaries of nations and the activities of states is evident in the widespread association of new immigrants with danger to the nation."

230. Harper & Raman, *supra* note 137, at 3. As governments seek state hegemony, an outsider becomes a "harbinger" of disruption and risk, where "the 'foreign body' has been pathologised as a disease-carrying threat to the nation state." *Id.* at 5.

231. *See, e.g.*, Rupert Neate & Jo Tuckman, *Donald Trump: Mexican Migrants Bring 'Tremendous Infectious Disease' to US*, THE GUARDIAN (July 6, 2015), https://www.theguardian.com/us-news/2015/jul/06/donald-trump-mexican-immigrants-tremendous-infectious-disease [https://perma.cc/3T8Q-8T5Y] (saying, as part of a campaign speech, "The largest suppliers of heroin, cocaine and other illicit drugs are Mexican cartels that arrange to have Mexican immigrants trying to cross the borders and smuggle in the drugs . . . . Likewise, tremendous infectious disease is pouring across the border. The United States has become a dumping ground for Mexico.").

offer frameworks to understand the connection between border health security and sexual management.

Sexual management has long been a part of state security for liberal governments. Governments are particularly interested in managing sexual behaviors for their capacity to reproduce the population.[232] Michel Foucault's theories of biopolitics and anatomopolitics, and Achille Mbembe's supplementary theory of necropolitics, help articulate these government interventions into sexual health. Foucault described a government's management of reproduction and population health as an exercise of *biopower*. To cultivate this ideal population, a government disallows lives that it does not want to be part of the future population.[233] Mbembe's theory of necropolitics further explains that states create certain social groups, boundaries, and hierarchies to determine who must die.[234] This hierarchical valuation of life functions as racism.[235] For

232. *See* Nikolas Rose, *The Politics of Life Itself*, 18 THEORY, CULTURE & SOC'Y 1 (2001); Kristin Sziarto, *Whose Reproductive Futures? Race-Biopolitics and Resistance in the Black Infant Mortality Reduction Campaigns in Milwaukee*, 35 SOC'Y & SPACE 299, 302 (2017) (naming the practice of looking to birth as a means to reproduce the state "reproductive futurism" as, "the logic by which the social good appears coterminous with human futurity, a futurity emblematized by the figure of the child and vouchsafed through reproduction") (citing Rebekah Sheldon, *Somatic Capitalism: Reproduction, Futurity, and Feminist Science Fiction*, 3 ADA, Nov. 2013.).

233. MICHEL FOUCAULT, THE BIRTH OF THE CLINIC: AN ARCHAEOLOGY OF MEDICAL PERCEPTION (1994). Michel Foucault understood the liberal government's interest in reproduction and population management as biopolitics, which describes the modality of state power in which a government exerts control over its population. Whereas sovereignty refers ultimately to a power to take life, biopolitics concerns the management of a population. Alexander Means, *Foucault, Biopolitics, and the Critique of State Reason*, 54 EDUC. PHIL. & THEORY 1968 (2022); *see also* Louisiana Lightsey, *Biopolitics and Globalization*, UNIV. OF VA.: GLOBAL S. STUD. (Nov. 30, 2022), https://globalsouthstudies.as.virginia.edu/key-concepts/biopolitics-and-globalization [https://perma.cc/UQ3S-RJCL]. Giorgio Agamben expanded on Foucault's work with, among other contributions, the idea that the right to "make death" operates as counter to biopower. *See generally* GIORGIO AGAMBEN, THE OMNIBUS HOMO SACER (2017).

234. Achille Mbembe, *Necropolitics*, 15 PUB. CULTURE 11, 26 (2003). Though I use "state" here, this type of cultural-political incorporation work refers to the creation of the nation-state. For a deeper interrogation of the nation, the state, and the nation-state, *see* HOMI BHABHA, NATION AND NARRATION (1990); HOMI BHABHA, THE LOCATION OF CULTURE (2d ed. 1994). According to Bhabha, the nation-state imagines merging the political apparatus of the state with the cultural identity of the nation. For there to be a distinct nation, there must be borders between cultures, which require defined differences between the nation and the other. Michael Shapiro builds upon this concept, explaining that states seek to curate a specific type of ideal nationality, making nationhood a state-building project that becomes deeply entangled with biopolitics. *See generally* Michael J. Shapiro, *Nation-States*, *in* A COMPANION TO POLITICAL GEOGRAPHY 271 (2008).

235. Mbembe, *supra* note 234, at 17.

example, a government might portray the existence of an "other" group as a threat to the life of the state.[236] While biopolitics and necropolitics describe a government's effort to conform the population to an ideal, Foucault's theory of anatomopolitics concerns government efforts to conform individual behavior to ideal standards.[237] When the U.S. government exerts individual-level sexual health interventions on noncitizens, it engages in each of these forms of power to exclude anyone it deems undesirable from admission to its population.

The continued exclusion of syphilis and gonorrhea reflects longstanding U.S. government efforts to exert control over sexual behavior the government deems risky. Through immigration and citizenship legislation, the U.S. government determined that Anglo-Saxon Protestants, later expanded to white Christians, are intrinsically within the ideal political boundary of the United States.[238] For anyone outside that boundary to be allowed in, they could not pose a threat to the ideal U.S. population. The eugenics movement especially was a project to exclude undesirable procreators from the United States, where government and nongovernment actors exerted individual and population level control over reproduction. Eugenicists identified "risky" procreators—based on race, income, disability, or sexual behaviors—to ensure that they did not reproduce or disrupt American families, which they idealized as the heterosexual, nuclear family of affluent white citizens.[239] In particular, eugenicists considered relationships

236. Through the construction of states of exception. Mbembe, *supra* note 234, at 16. "[P]ower (which is not necessarily state power) continuously refers and appeals to the exception, emergency, and a fictionalized notion of the enemy." *Id.*

237. *See generally* FOUCAULT, *supra* note 233; Margo Huxley, *Governmentality, Gender, Planning*, *in* PLANNING FUTURES: NEW DIRECTIONS FOR PLANNING THEORY 136 (Philip Allmendinger & Mark Tewdwer-Jones eds., 2002); Margo Huxley, *Geographies of Governmentality*, *in* SPACE, KNOWLEDGE AND POWER: FOUCAULT AND GEOGRAPHY 185 (Jeremy W. Crampton and Stuart Elden eds., 2007).

238. The United States initially enacted racially restrictive citizenship laws to prevent enslaved Africans and temporary workers from becoming citizens. *See* Nationality Act of 1790, Pub. L. 1–3, 1 Stat. 103. While the passage of the 14th Amendment did expand citizenship to anyone born in the United States, primarily the descendants of formerly enslaved Africans, racial restrictions for people of Asian descent continued, and Elk v. Wilkins, 112 U.S. 94 (1884) held that Indigenous people who were tribally recognized were not citizens of the United States (although this move protected tribal sovereignty). Other expansions of citizenship worked to achieve settler goals. For example, the Dawes Act of 1887 awarded citizenship to Indigenous people who ceded tribal lands, in exchange received individual allotments, if the undivided surplus went to white people, and if the Treaty of Guadeloupe Hidalgo of 1848 offered citizenship to Mexicans on newly acquired U.S. land. It was not until 1952 that all national- and race-based restrictions were removed from naturalization. For a discussion of immigration legislation, *see supra* Part III.A.

239. *See generally* STEPHANIE COONTZ, THE WAY WE REALLY ARE: COMING TO TERMS WITH AMERICA'S CHANGING FAMILIES (BASICBOOKS 1997); Mona Domosh, *Gender, Race, and*

between white people and foreign immigrants or people of color risky to the white race. For example, Henry Laughlin, superintendent of the Eugenics Record Office, alleged that immigrants made up a disproportionate share of the nation's "socially degenerate" members.[240] Accordingly, eugenicists sought to limit nonwhite immigration alongside domestic legislation to criminalize interracial relationships.[241] Having STIs as an inadmissible condition seems to follow this history of deeming noncitizens sexually risky. Required STI screening of noncitizens already within the United States underscores how these examinations continue to cast noncitizens as threatening outsiders, even when they are within the country.[242]

By requiring certain applicants to be screened and treated for STIs prior to admission, the U.S. government embraces the eugenic idea that some people are too risky to make decisions about their sexual health. For example, CDC claimed it added AIDS as a Class A condition because it was spread by "high risk sexual practices,"[243] but given how AIDS overwhelmingly affected the queer community, "high risk" was clearly euphemistic. Today, syphilis and gonorrhea are overwhelmingly blamed on the sexual behaviors of queer men,[244] who receive

Nationalism: American Identity and Economic Imperialism at the Turn of the Twentieth Century, in A COMPANION TO FEMINIST GEOGRAPHY (2005); Vasquez-Tokos & Yamin, *supra* note 149.

240. DOROTHY ROBERTS, KILLING THE BLACK BODY 68 (2014).

241. *See generally* PEGGY PASCOE, WHAT COMES NATURALLY: MISCEGENATION LAW AND THE MAKING OF RACE IN AMERICA (2009). U.S. stereotypes about the sexual behaviors of other cultures is a part of a much larger social phenomenon of how whiteness and white Christian women became cast as sexually pure compared to other cultures. There are numerous examples of how white Americans treat certain places as sexually immoral or hypersexual, though this sexualizing of certain places is a relational project that affects all cultures as they orient themselves against or within certain sexual politics. *See, e.g.*, Jason C. Garvey, Jenna L. Matsumura, J. A. Silvis, Rachel Kiemele, Heather Eagan & Prithak Chowdhury, *Sexual Borderlands: Exploring Outness Among Bisexual, Pansexual, and Sexually Fluid Undergraduate Students*, 59 J. COLL. STUDENT DEV. 666 (2003).

242. Given the high prevalence of syphilis and gonorrhea within the United States, it is very plausible that someone who is adjusting their status and has a positive STI screening could have contracted it from a U.S. citizen. Yet anti-migrant and nativist rhetoric still leans on casting noncitizens as sexually dangerous, as seen with Donald Trump's campaign speech calling Mexican immigrants "rapists." *See 'They're Rapists.' President Trump's Campaign Launch Speech Two Years Later, Annotated*, WASH. POST: THE FIX (June 16, 2017, 1:43 PM), https://www.washingtonpost.com/news/the-fix/wp/2017/06/16/theyre-rapists-presidents-trump-campaign-launch-speech-two-years-later-annotated [https://perma.cc/X8UF-BSV9].

243. Medical Examination of Aliens (AIDS), 52 Fed. Reg. 21532 (June 8, 1987) (amending 42 C.F.R. § 34).

244. *See, e.g.*, Press Release, WHO, New Study Highlights Unacceptably High Global Prevalence of Syphilis Among Men Who Have Sex With Men (July 9, 2021),

heightened attention in CDC outreach. Longstanding stigmas still attribute syphilis and gonorrhea to unclean or promiscuous sexual behavior.[245] Syphilis and gonorrhea are thought to be caused by many of the behaviors eugenicists were worried about—sex work, multiple partners, and queer sex. Given these embedded assumptions about syphilis and gonorrhea, requiring screening only for these STIs suggests that the U.S. government considers certain sexual behaviors or identities less desirable.

Mandatory STI screening also seems to fit within U.S. efforts to exclude disabilities from its population. Medical examinations prevented individuals with "defects" from entering the United States, just as eugenics sought to remove disability from the U.S. population and the white race by preventing disabled people from reproducing. Syphilis and gonorrhea, as explained in Part I.B, can cause physical and mental disabilities within the infected person and any children they have while infected.[246] Recent coverage of syphilis and gonorrhea describes the two as "caus[ing] birth defects and kill[ing] infants."[247] With mandatory

https://www.who.int/news/item/09-07-2021-new-study-highlights-unacceptably-high-global-prevalence-of-syphilis-among-men-who-have-sex-with-men#:~:text=The%20global%20pooled%20prevalence%20of,UI%3A%200.4%2D0.6). [https://perma.cc/UKF3-LYE8]; *Nearly 8% of Men Who Have Sex With Men Estimated to Have Syphilis Globally*, LONDON SCH. OF HYGIENE AND TROPICAL MED. (July 9, 2021), https://www.lshtm.ac.uk/newsevents/news/2021/nearly-8-men-who-have-sex-men-estimated-have-syphilis-globally [https://perma.cc/UZ23-BRDT]. The World Health Organization (WHO) identifies men who have sex with men, sex workers, and pregnant people as those most at risk for syphilis, which hardly varies from the original groups scrutinized for the disease. *Data on Syphilis*, WHO, https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/data-on-syphilis [https://perma.cc/35X6-6TE6]. In recent studies, the prevalence of syphilis in queer men has been framed as a risk to straight people. *See, e.g.*, Noah Kojima & Jeffery Klausner, *An Update on the Global Epidemiology of Syphilis*, 5 CURRENT EPIDEMIOLOGY REP. 24 (2018) ("Syphilis continues to persist among MSM [men who have sex with men] and other groups who tend to have multiple sex partners, and could likely return in heterosexual populations without public health vigilance."). CDC also identifies queer men, Black people, and sex workers as at the highest risk for gonorrhea. *See supra* Part I.A (discussing the current CDC guidance on gonorrhea). While the structural divestment from these groups might create the conditions for untreated STIs, labeling these identities as inherently "risky" is dangerous.

245. *See* SANDER L. GILMAN, *What Is the Color of the Gonorrhea Ribbon? Stigma, Sexual Diseases, and Popular Culture in George Bush's World*, 3 CULTURAL POL. 175 (2007); J. Dennis Fortenberry et al., *Relationships of Stigma and Shame to Gonorrhea and HIV Screening*, 92 AM. J. PUB. HEALTH 378 (2002). Until the mid-twentieth century, syphilis was too taboo to even name, discussed as the "social disease" or "moral hygiene." *See* Wuebker, *supra* note 165.

246. A Class B condition specifically allows examiners discretion to identify departures from "normal," an ableist and white supremacist method of devaluing any deviation from the imagined white, able-bodied norm. Syphilis and gonorrhea, if treated, can be a Class B condition.

247. Law, *supra* note 30.

STI screening, the government tries to exclude certain types of people from the U.S. population: individuals or potential children with "defects." The screenings become a biopolitical project to ensure a higher standard of health for people who become part of the future U.S. population than for those just passing through, even though both groups may spread communicable diseases. More broadly, medical examinations work to exclude individuals with disabilities as "inadmissible,"[248] implying the U.S. government considers them undesirable additions to the population.

Mandatory STI screening is a remnant of a broader government sexual management project, one that was more about excluding undesirable outsiders at the border than it ever was about health. By interrogating some of the implications of mandatory STI screening, I have also signaled how medical examinations as a whole function as a tool of population management at the border, where health-related inadmissibility grounds target and exclude groups the U.S. government considers undesirable. Medical examinations and health-related inadmissibility are not legitimate public health measures, and they should be removed from immigration law.

Conclusion

In this Comment, I have shown that the requirement of STI screenings at the border is unjustifiable and impossible to disentangle from its origins in eugenic governance and xenophobia.

As health emergencies become more common, it is important to examine the assumptions underlying invocations of public health within U.S. border policy. While some border health security projects have become hotly contested and politically salient, the examinations and exclusions for syphilis and gonorrhea have received little public attention. They remain a longstanding element of U.S. border legislation. Categorizing STIs as disqualifying medical conditions represents racist anxieties about the perceived (hyper)sexuality of migrants. Moreover, the retention of some STIs as Class A conditions authorizes the U.S. government to use sexual health as a form of exclusion, and STI screening in the examination authorizes the U.S. government to legally interrogate the sexual health of noncitizens. Given the ways the United States has engaged in violent sexual health management at and across the border in the past, it is concerning that the U.S. government holds authority over the sexual health of noncitizens—

248. Immigration & Naturalization Act § 212 (A)(1)(a) (classifying certain physical and mental disorders and drug addiction as inadmissible conditions).

authority that it may adapt or expand in the future. This troubling history, as well as present dignitary harms, indicates that sexual health should have no place in U.S. border policy.

In general, medical examinations on the border do not keep the country healthier or safer from disease. Instead, CDC and DHS disproportionately condemn noncitizens for conditions often already prevalent in the United States, using Class A and B diagnoses as grounds for surveillance and exclusion. This study of syphilis and gonorrhea demands that the medical examination process, as a whole, should be removed from admissions.

Border health security projects, like medical examinations, target outsider groups for increased scrutiny and higher standards of health. Yet there are many other ways the U.S. government could improve national health. This includes offering voluntary, comprehensive, and free medical examinations upon admission to the United States, or providing funded quarantine options to any traveler to the United States—citizens included—who self-report a communicable disease before entry. Instead, the current method of framing the exclusion or forced management of noncitizens as public health measures does little to meaningfully improve health for anyone within the United States, while inflicting grave systemic harm on noncitizens.