

At the Nexus: How HIV-Related Immigration Policies Affect Foreign Nationals and Citizens in South Korea

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Abstract

Effective HIV prevention requires the protection and empowerment of marginalized groups at high risk of infection. However, many policies persist that stigmatize these groups and hinder HIV prevention efforts, including HIV-related travel restrictions. In the Republic of Korea, which requires HIV tests for certain visa categories, these restrictions negatively affect the national HIV response and access to accurate information on effective HIV prevention. In addition, they violate migrants' human rights to confidentiality and informed consent to testing and the rights of persons living with HIV (PLHIV) to privacy, work, medical care, bodily integrity, and freedom from discrimination. Furthermore, the discrimination and misconceptions perpetuated by this policy may be driving South Korea's burgeoning infection rates.

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Introduction

The human immunodeficiency virus, or HIV, has been at the nexus of health and human rights since it first emerged as an epidemic in the early 1980s.¹ Because of its connection to male-to-male sexual contact, commercial sex work, and injection drug use—behaviors that are criminalized in many countries—its prevention and control quickly became the focus of significant controversy.² In the years following HIV's emergence, communities affected by the epidemic, human rights activists, and public health experts stressed that, contrary to traditional public health responses, the effective response to HIV required the protection of the human rights of those affected by and at risk of the epidemic. This approach, termed by Michael Kirby as the "HIV paradox," has since been confronted with substantial backlash from politicians and groups who view the criminalization of behaviors that spread the virus, and the further marginalization of those engaged in them, as acceptable means of controlling the epidemic.³

While substantial progress has been made in developing and strengthening the evidence base for effective HIV prevention strategies, these initiatives still face social and political hurdles. Social stigma persists, and laws and public health policy that harm efforts to control the spread of infection are common.⁴ One such measure that is still frequently employed today—despite being consistently demonstrated as ineffective and roundly condemned by human rights and public health bodies around the world—is HIV-related travel and immigration restrictions. Immigration restrictions based on HIV status are enforced by the Republic of Korea (hereafter Korea) for specific visa categories, despite international treaty commitments and public statements to the contrary.⁵ Many countries across the world still apply such restrictions, maintaining laws and policies that deny the entry, stay, and residence to people living with HIV on the basis of their HIV status.⁶ These restrictions have been universally condemned as violating migrants' human rights to confidentiality and informed consent to testing, and the rights of PLHIV to privacy,

dignity, bodily integrity, work, and medical care. In addition, Korea's policies also deprive its own citizens of the right to health and accurate information on effective HIV prevention.

HIV in Korea: Past and present

History of the epidemic and early policy responses

Korea's first case of HIV was identified in 1985.⁷ The appearance of the virus coincided with the country's symbolic opening to the outside world with the hosting of the 1988 Summer Olympics in Seoul, and fears that the influx of tourists would result in the rapid spread of HIV were widespread among government officials and media commentators.⁸

There were strident calls for requiring "AIDS certificates" to certify that all who entered the country were not infected, and Korean government officials proposed the idea at the World Health Assembly in 1987.⁹ The World Health Organization instead reaffirmed that "information and education on the modes of transmission ... are still the only measures available that can limit the further spread of AIDS."¹⁰ Meanwhile, Korea passed the AIDS Prevention Act in November 1987, which in addition to requiring HIV diagnoses to be reported to the Korea National Institute of Health, implemented mass compulsory screenings for groups identified by the government as "high risk," including commercial sex workers, prison inmates, overseas sailors, and food industry sanitation workers.¹¹ This continued until 2000, when mandatory testing was abolished and funding priorities shifted from testing to medical care for PLHIV.¹² Korea's HIV travel ban remained in place until 2010.¹³

Exclusionary epidemiology: "Domestic" versus "foreign" infections

Epidemiological data on HIV in Korea are provided by the Korea National Institute of Health and the Korean Centers for Disease Control and Prevention. Although Korea has a comparatively low prevalence of HIV and is considered a low-burden country, the number of newly acquired HIV infections has increased nearly every year since the

first case was discovered, and new cases have risen substantially since 2000.¹⁴

In 1992, Korea's HIV epidemic shifted from the virus being brought in from overseas to it being transmitted through domestic sexual contacts.¹⁵ However, the perception of HIV as a foreign contagion persists. Annual reports of the Korea National Institute of Health and Korean Centers for Disease Control and Prevention distinguish between "domestic" and "foreign" cases, and while detailed statistics on demographic information, modes of transmission, and CD4 counts at diagnosis are provided for Koreans, little to no data to this effect is given on foreign nationals diagnosed with HIV. The Korean HIV Cohort, which consists of patients aged 18 or older diagnosed with HIV who agreed to be enrolled in the study, is declared in scientific publications to be "representative" of the epidemic in the country. However, it was established in 2006, when the HIV travel ban was still in place and foreign nationals diagnosed with HIV were deported.¹⁶ Peer-reviewed journal articles and publications on the topic of HIV in Korea appear to refer exclusively to HIV infections among native Koreans when describing the country's epidemic, as the figures provided match the number of infections among Korean nationals as reported by the Korean Centers for Disease Control and Prevention.¹⁷ This apparent exclusion of migrants with HIV from Korea's body of HIV-focused epidemiological scholarship even after the removal of the travel ban precludes their consideration in the development of evidence-based prevention strategies. The absence of migrants from the discourse surrounding HIV in the Korean epidemiological research community deepens the public health marginalization they experience, which is, at least in part, driven by HIV-related immigration restrictions to which they are subjected.

Specific travel restrictions

The Department of Immigration continues to require HIV tests for certain visa categories, despite a declaration from a Ministry of Foreign Affairs official that the country had lifted all HIV-related travel restrictions.¹⁸ These mandatory screenings

are required for native English teachers, manual laborers under the Employment Permit System and industrial trainee programs, maritime workers, and entertainment workers. Those who test positive are usually denied work visas and forced to either leave the country or work illegally, in which case they cannot access treatment or medication.

Korea shifted from a labor-exporting country to a labor-importing one during its rapid development in the 1980s and began attracting migrant laborers soon after it hosted the 1988 Olympics.¹⁹ The D3 visa was established in 1993 to process and employ these migrants under the existing Industrial Trainee System, providing a steady stream of cheap labor that had no right to benefits or medical care and no ability to form unions to lobby to improve their working conditions; the following year, compulsory HIV testing began.²⁰ Additionally, there have been reports of health officials visiting factories and asking managers to gather all migrant workers for compulsory HIV tests.²¹ The Industrial Trainee System was replaced by the Employment Permit System (E9 visa) in 2004, which mandates HIV tests for all applicants either before departure or upon entry (or both), and annually thereafter.²² These workers are often forced to pay out of pocket for these tests.²³ Migrants who are HIV positive or who wish to avoid testing are driven to enter the country illegally, cannot access regular medical care, and are forced to forgo treatment. Those who do test positive have their test results reported to their employers and immigration authorities, denying their right to privacy and confidentiality, and their visas are revoked.

Testing for sexually transmitted infections and other infectious diseases has been required of women working in bars and hostess clubs—formally employed as entertainers but who often engage in sex work—nationwide since 1977, and HIV was added to the testing scheme in 1986, shortly after it emerged on the peninsula.²⁴ Following the trend of manual laborers, the population of women working in the "pleasure industry" has shifted from being mostly Korean to consisting largely of migrants from the Philippines, Russia, the former Soviet Republics, Nepal, and Sri Lanka, and the government

has accommodated the influx of these migrant women (despite the fact that prostitution is officially illegal) by allowing them to enter and work under the E6 “entertainment visa.”²⁵ Also similar to manual laborers, the women are deprived of their rights to accurate health information and medical confidentiality: they receive no counseling, their health checks are provided and processed in Korean (rather than their native language), and their test results are reported to their employers.

There are close to 16,000 native-speaking foreign language teachers in Korea, most of them English teachers from the United States, Canada, the United Kingdom, Ireland, South Africa, Australia, and New Zealand.²⁶ The advent of mandatory HIV tests for these native-speaking English teachers, who work in Korea under the E2 visa program, has been extensively documented by Benjamin Wagner and Matthew VanVolkenburg.²⁷ Until recently, the Korean government required E2 visa applicants to undergo annual HIV and drug testing as part of a policy that it had implemented in 2008 in response to a moral panic sparked by the Interpol arrest of Christopher Paul Neil, a Canadian national and child sex predator. Although Neil was arrested for activities that took place in Thailand, and there was no evidence that he had committed sex crimes in Korea nor that he was HIV positive, the revelation that he had been living and teaching English in South Korea generated nationwide outrage and fears of sexual exploitation and corruption of Korean women by “predatory” foreign men.²⁸ Several conservative nativist citizen groups seized on the opportunity to pressure the government to implement annual HIV and drug tests for foreign English teachers.²⁹ Notably, there was no such requirement for Korean citizens, and even noncitizens of Korean ethnicity who hold F4 visas (a multiple-entry visa designated for ethnically Korean foreign nationals) are not subject to the testing requirement.³⁰ Teachers were required to submit to the test when they arrived in country, and teachers who worked for public schools were retested annually when renewing their contracts.³¹ Those who tested positive faced the possibility of being denied a visa and potentially being deported.³² Their results were reported to

immigration authorities and their employers, and no health information or counseling was offered in their native language. Many did not even realize that they were being tested when they went to the hospital for their required health check. Although the HIV testing requirement was lifted in July 2017, Korea’s Ministry of Justice still requires that E2 applicants undergo mandatory testing for drugs and now syphilis, making it possible that they are still being tested for HIV without their knowledge or consent.³³

Although there are no HIV-specific restrictions tied to the D2 visa required for university-level students, several scholarship programs operated by the Korean government list HIV/AIDS as a potentially disqualifying factor. For example, the Teach and Learn in Korea program, which recruits native English speakers with at least two years of undergraduate study to teach English in rural areas for six to twelve months, states in its contract that the participant’s employer may terminate the contract if the participant is found to be HIV positive, and that the employer can request a “physical examination” (which presumably includes an HIV test) at any time.³⁴ Also, the Korean Government Scholarship Program, which provides funding and airfare for non-Koreans interested in pursuing a postgraduate degree at a Korean university, lists a medical examination as a stipulation for receiving the scholarship and specifies HIV as a cause for disqualification.³⁵

HIV infection, medical care, and stigma in Korean society

New cases rising rapidly

While the Korean government assuages the public’s fear of HIV by citing its HIV-related immigration restrictions, it is neglecting the country’s own burgeoning infection rates. The number of new infections has risen steadily since the beginning of the epidemic, increasing by an average of 12% each year since 2000 among Korean nationals, even as the overall global trend declines.³⁶ One 2013 analysis modeling the number of future infections based on previous case counts predicted that new HIV in-

fections would increase rapidly if trends continued unchanged, and the number of new cases has either matched or surpassed the model's prediction in the three years since.³⁷ Multiple Korean public health experts have pointed out the potential for the epidemic to escalate quickly and the inadequacy of the government's current policies in slowing the rate of new infections.³⁸

Homophobia and the gender disparity in infections

The ratio of HIV-positive Korean males to females rose from 6:1 in 2000 to 11:1 by 2011, and it is projected to rise to as high as 19:1 in 2017.³⁹ The growing gender disparity in infections indicates strongly that new infections are driven largely by male-male sexual contact.⁴⁰ However, official surveillance data and most surveys of men diagnosed with HIV have found that less than half (and often as low as a quarter) of respondents report that their infection resulted from sexual contact with other men.⁴¹ This is most likely due to underreporting, as homosexuality is deeply stigmatized in Korean society, and many men who have sex with men may be reticent to disclose their sexual orientation.⁴²

Stigma in society and medical care

Ignorance about HIV, how it is transmitted, and what measures can be taken to protect oneself from infection is widespread among Koreans. Discrimination against PLHIV is deeply entrenched in Korean society. Surveys of attitudes toward PLHIV have found high percentages of respondents who would feel uncomfortable living near someone with HIV, refuse to care for a family member living with HIV, and support the isolation of PLHIV.⁴³ Such attitudes toward PLHIV are common even among medical professionals who are educated about HIV and have a professional obligation to provide appropriate care to PLHIV. It is not uncommon for hospital personnel to refuse to treat or touch patients with HIV, or even to force them to leave the facility when they disclose their status. Tragically, this is found even in long-term care facilities *specifically designated for AIDS patients*, where patients are neglected by staff, not allowed to leave of

their own free will or contact family members, and even charged additional fees not required of other patients.⁴⁴ Finally, it is worth noting that rates of suicide and suicidal thoughts are much higher among PLHIV than the general population.⁴⁵

At the nexus: HIV restrictions against migrants to protect citizens violate the rights of both

Travel restrictions as prevention: A failure for public health and human rights

Governments often couch HIV-related travel restrictions in terms of protecting public health. However, this rationale has been explicitly rejected by international health and human rights organizations, including the World Health Organization, UNAIDS, and multilateral human rights bodies (such as the International Organization for Migration, the International Labour Organization, and the Inter-American Commission on Human Rights).⁴⁶ HIV-related restrictions on travel, immigration, or residence violate the principles of nondiscrimination and equal treatment included in all international human rights laws, treaties, and agreements.⁴⁷ The International Covenant on Civil and Political Rights guarantees the right to equal protection under the law, without discrimination based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status, and the United Nations Commission on Human Rights has determined that this includes discrimination based on health status, including HIV infection.⁴⁸ According to the Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, while international human rights law allows governments to restrict rights in cases of emergency or serious public concern, the restrictions must, among other things, be the minimum necessary to effectively address the concern.⁴⁹

HIV-related travel restrictions have been overwhelmingly deemed overly intrusive and ineffective. Numerous health and human rights organizations have made it clear that screening

travelers and migrants for HIV is ineffective in preventing the spread of HIV, as HIV is not transmitted by casual contact, and countries that do not have HIV-related travel restrictions have not reported any additional negative public health consequences compared to those that do.⁵⁰ Nonetheless, according to UNAIDS, 35 countries still have some form of official HIV-related travel restrictions, while others, including Korea, allow employers and individual government agencies to discriminate against PLHIV with impunity.⁵¹

HIV as “foreign contamination”

Public discussions of HIV in Korea cast the disease as a product of the contamination of Korean society by foreign elements, propagated by social deviancy (such as promiscuity and prostitution). This has been well documented by Sealing Cheng, who demonstrates “how the discourse of AIDS is embedded within larger nationalist fears of foreign contamination in a globalized world” in her coverage of a nationwide “Purity Campaign” led by a Korean nonprofit established for HIV prevention and supported by government funds and endorsed by the Korea National Institute of Health.⁵² She documents how this discourse has been legitimized by opposition politicians and the Korean media (who have historically cited the government’s failure to track and deport HIV-positive migrants in their criticism of the government) and embraced even by Korean public health officials (who attributed the spread of the virus to homosexuality and teenage prostitution at the time of the campaign). As Cheng notes, rather than providing accurate information about modes of transmission and effective prevention strategies, the campaign portrayed HIV infection as a consequence of promiscuous sexuality outside of marriage and sexual contact with foreigners (who represent deviancy and sexual corruption). This view of HIV as foreign contamination continues to be perpetuated by media reports and statements from government officials.⁵³

Felicia Chang et al. point out that an overwhelming proportion (89%) of WHO member states with high percentages of foreign nationals have HIV-related travel restrictions and suggest

that governments may employ them to exclude foreign workers from jobs, address citizens’ concerns on foreign influences and cultural infringement, and appease voters.⁵⁴ Korea’s immigration policies, much like its officially endorsed HIV-prevention messaging, support this view, marginalizing migrants from public life both by restricting their access to employment and health care and by portraying them as carriers of foreign disease and moral decay.

Violating migrants’ rights to privacy, work, and medical care

The compulsory HIV testing of migrants and their exclusion on the basis of HIV infection is a blatant violation of numerous human rights. Forced testing violates the right to bodily integrity and dignity, and the accompanying deportation or loss of employment and residency status on the basis of infection violates the rights of PLHIV to privacy, work, appropriate medical care, and non-discrimination.⁵⁵ The International Labour Organization has stated that neither HIV tests nor private HIV-related personal information should be required of employees or job applicants.⁵⁶

HIV-related restrictions against entry, stay, and residence, in addition to being an ineffective public health measure to protect health and prevent the spread of infection, regularly violate the rights of travelers, migrant workers, and asylum seekers. Furthermore, these policies also violate migrants’ human rights to confidentiality and informed consent to testing and expose them to exploitation by their employers. A 2007 study on immigration policies in Asian countries that require HIV tests found that migrants entering Korea were routinely tested without their informed consent, not provided with test counseling, and deprived of the confidentiality of test results; further, those who tested positive were denied treatment and employment, and in some cases deported.⁵⁷ Subsequent investigations by Amnesty International have confirmed that this testing continues.⁵⁸

Additionally, a 2015 decision by the United Nations Committee on the Elimination of Racial Discrimination established that such policies can

constitute racial discrimination. The decision, issued in response to a complaint filed by a New Zealand national who had lost her job for refusing to submit to Korea's HIV testing policy targeting E2 visa holders, found that the policy constituted racial discrimination and was not "justified on public health grounds or any other ground, and is a breach of the right to work without distinction to race, colour, [or] national or ethnic origin."⁵⁹

Violating citizens' right to health

Rather than accomplishing their supposed goal of protecting a country's citizens from HIV infection, immigration policies banning or restricting entry or employment based on HIV status frequently have the opposite effect. Such policies legitimize and exacerbate the stigma surrounding HIV, further marginalize citizens living with HIV, and deprive citizens of accurate information on how to protect themselves from infection and their right to health. Regulations requiring HIV tests of immigrants can promote the idea that foreigners are dangerous to the national population and a public health risk, as well as create a false sense of security by reinforcing the notion that only migrants are at risk of infection.⁶⁰ Additionally, such attitudes can adversely affect the host country's HIV rates, as HIV-positive citizens who underestimate their own HIV risk and avoid testing due to stigmatization are more likely to transmit the virus to others, driving up infection rates.⁶¹

This chain of events appears to be playing out in Korea, contributing to the country's rapidly growing number of new HIV infections each year. The lack of robust evidence-based HIV-prevention programs marginalizes migrants and Korean PLHIV and perpetuates widespread ignorance and misinformation about how HIV is transmitted and how individuals can protect themselves from infection.⁶² The stigma attached to HIV and the virus's association with foreigners and social deviants actively discourage Koreans from accessing HIV testing and treatment—two of the most effective public health strategies for reducing viral transmission and preventing new infections.⁶³ Bizarrely, the Korean government cites the general public's "terror" toward HIV and PLHIV as justification for

maintaining its current policies—which perpetuate human rights abuses against both migrants and Korean citizens, contribute to diminished social participation and quality of life for PLHIV, and exacerbate the epidemic—rather than pursuing evidence-based HIV prevention strategies or enacting policies that actively protect human rights and empower HIV advocates.⁶⁴ These policies have fallen woefully short on both the health and human rights fronts, and their continuation will inevitably result in more human rights abuses against migrants and more new HIV infections in the country.

Conclusion

HIV-related immigration restrictions are framed as measures to protect public health by governments who employ them, including South Korea. However, this rationale has been explicitly rejected by international health and human rights experts and organizations. These policies have systematically deprived migrants to Korea of their rights to work, health, privacy, freedom from discrimination, and dignity, and they have been exposed as a public health failure and an ineffective means to control the spread of HIV. Furthermore, they are contributing to Korea's domestic HIV epidemic by failing to combat misinformation and ignorance about HIV prevention and transmission and by entrenching stigma and discriminatory attitudes, which leads to Koreans avoiding HIV testing and treatment.

The recent removal of the HIV testing requirement for E2 visas demonstrates the potential of international human rights frameworks to challenge these restrictions. In September 2016, the National Human Rights Commission of Korea issued a decision determining that the testing policy had no public health justification and constituted racial discrimination, and recommended its removal.⁶⁵ Additionally, the decision found that the policy violated Korea's obligations as a signatory to the International Convention on the Elimination of All Forms of Racial Discrimination and was a direct response to the Committee on the Elimination of Racial Discrimination's ruling the previous year.

In July 2017, the Korean Ministry of Justice

removed the HIV testing requirement, citing the recent commission ruling.⁶⁶ These decisions based on Korea's treaty obligations—which have the same weight as domestic law under the Korean Constitution—could, along with consistent pressure from international human rights and public health organizations, provide a mechanism to challenge HIV testing requirements for other visa categories.⁶⁷ However, this is only a partial solution, as local authorities and individual employers can still force workers to undergo testing either through coercion or by testing workers without their knowledge. It is worth noting that drug tests for E2 applicants remain in place, and a syphilis test is now required, leaving the potential for employers to request an HIV test from the health facility without informing their employees.⁶⁸ This surreptitious testing has already been documented for E6 and E9 visa workers, and even among Korean citizens.⁶⁹

Laws forbidding discrimination against residents on the basis of HIV status are the surest way to protect the health and human rights of PLHIV and those at risk of infection. Without these explicit legal protections, HIV-related immigration restrictions have the potential to be revived even after being previously struck down. These types of restrictions are very popular among the Korean public, and similar measures have recently been discussed and even implemented in other nations.⁷⁰ Rather than using widespread horror toward HIV and cultural taboos about sexuality and risk behaviors as a shield for its current ineffective policies, the Korean government should abolish HIV-related travel restrictions for all visa categories, pass laws prohibiting the discrimination of PLHIV, and implement proven HIV prevention and education strategies on a nationwide scale.⁷¹ In this way, Korea can bring its HIV epidemic under control and ensure the protection of human rights for citizens and migrants alike.

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