

UNAIDS/IOM STATEMENT ON HIV/AIDS-RELATED TRAVEL RESTRICTIONS

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Executive Summary

Since the very beginning of the AIDS epidemic, countries have established travel restrictions in an effort to prevent the human immunodeficiency virus (HIV) from crossing their borders. Such measures include mandatory HIV testing for persons seeking entry to the country and the requirement that would-be entrants declare themselves to be uninfected. Based on these mandatory tests and declarations, a number of countries have excluded from entry people living with HIV or people suspected of being infected. Restrictions have been imposed upon people wishing to enter the country for short-term stays such as for business or personal visits or tourism, or for longer periods such as for study, employment, refugee resettlement or for immigration.

Two main rationales are put forward by governments that impose HIV-related travel restrictions. One reason given is to protect the public health. A second reason advanced is to avoid an excessive demand on health care and on social services, as well as other economic costs perceived to be generated by HIV-infected non-nationals. The latter rationale has gained greater prominence since the middle of the 1990s, when effective HIV treatment began to become more widely available in high-income countries. Such therapy is still largely unavailable in low- and middle-income countries, where the vast majority – some 95% – of people living with HIV and AIDS live.

Governments which have not enacted HIV-related travel restrictions sometimes find themselves under pressure to do so in order to be perceived by the public as ‘doing something’ to combat the epidemic. In recent years the media in several countries which do not have HIV-related travel restrictions has reported calls for mandatory HIV testing of people wishing to cross their borders.

In the age of globalisation, mobility and migration are an increasingly necessary and natural part of the lives of millions of people. This document, produced jointly by the Joint United Nations Programme on AIDS and the International Organization for Migration, describes HIV/AIDS-related travel restrictions and their impact. It reviews relevant international law and human rights principles, and discusses humanitarian and ethical concerns. The document reinforces previous conclusions that HIV/AIDS-related travel restrictions have no public health justification. It reviews the economic rationale underlying some HIV-related travel restrictions and concludes that a blanket exclusion of people living with HIV on economic grounds is an overly broad mechanism that results in the exclusion of people living with HIV.

This paper distinguishes between short-term and long-term travel, and restrictions thereto. For purposes of definition, the term “short-term travel” refers herein to travel across an international border for a period of one month or less. The term “long term travel” refers herein to travel across an international border for a period of longer than one month. Although neither short-term nor long-term travelers should be subjected to unlawful distinction vis-à-vis nationals of the host country, this paper distinguishes between short and long term travel because each has distinct implications and features in terms of restrictions. The regulation of immigration matters and both short and long-term entry into a country is widely recognized as falling within the sovereign power of the individual State concerned.

The review leads to the following recommendations:

UNAIDS/IOM recommendations regarding HIV/AIDS-related travel restrictions

1. HIV/AIDS should not be considered to be a condition that poses a threat to public health in relation to travel because, although it is infectious, the human immunodeficiency virus cannot be transmitted by the mere presence of a person with HIV in a country or by casual contact (through the air, or from common vehicles such as food or water). HIV is transmitted through specific behaviours which are almost always private. Prevention thus requires voluntary acts and cannot be imposed. Restrictive measures can in fact run counter to public health interests, since exclusion of HIV-infected non-nationals adds to the climate of stigma and discrimination against people living with HIV and AIDS, and may thus deter nationals and non-nationals alike from coming forward to utilize HIV prevention and care services. Moreover, restrictions against non-nationals living with HIV may create the misleading public impression that HIV/AIDS is a “foreign” problem that can be controlled through measures such as border controls, rather than through sound public health education and other prevention methods.
2. Any HIV testing related to entry and stay should be done voluntarily, on the basis of informed consent. Adequate pre-and post-test counselling should be carried out, and confidentiality strictly protected.
3. Restrictions against entry or stay that are based on health conditions, including HIV/AIDS, should be implemented in such a way that human rights obligations are met, including the principle of non-discrimination, *non-refoulement* of refugees, the right to privacy, protection of the family, protection of the rights of migrants, and protection of the best interests of the child. Compelling humanitarian needs should also be given due weight.
4. Any health-related travel restriction should only be imposed on the basis of an individual interview/examination. In case of exclusion, persons should be informed orally and in writing of the reasons for the exclusion.
5. Comparable health conditions should be treated alike in terms of concerns about potential economic costs relating to the person with the condition. Those living with HIV/AIDS who seek entry for short-term or long-term stays should not be singled out for exclusion on this financial basis.
6. Exclusion on the basis of possible costs to health care and social assistance related to a health condition should only be considered where it is shown, through individual assessment, that the person requires such health and social assistance; is likely in fact to use it in the relatively near future; and has no other means of meeting such costs (e.g. through private or employment-based insurance, private resources, support from community groups); and that these costs will not be offset through benefits that exceed them, such as specific skills, talents, contribution to the labour force, payment of taxes, contribution to cultural diversity, and the capacity for revenue or job creation.
7. If a person living with HIV/AIDS is subject to expulsion (deportation), such expulsion (deportation) should be consistent with international legal obligations including entitlement to due process of law and access to the appropriate means to challenge the expulsion. Consideration should be given to compelling reasons of a humanitarian nature justifying authorisation for the person to remain. It is important that in making necessary arrangements for the person’s identification and documentation that s/he be entitled to protection of confidentiality with regard to health, and more specifically to HIV status.
8. Any policy regarding HIV/AIDS-related travel restrictions should be clear, explicit, and publicly available. Implementation of the policy should be consistent and fair, with discretion guided by clear, written instructions.

HIV/AIDS-RELATED TRAVEL RESTRICTIONS

Introduction

Travel restrictions have been imposed on people living with HIV/AIDS since the beginning of the HIV/AIDS epidemic. This practice increased after a reliable HIV test became available in 1985. Today, States that impose travel restrictions on people living with HIV/AIDS cite two main reasons – to protect the national public health, and to avoid the economic costs of providing health care and social assistance to those affected by HIV/AIDS. Over the years, many United Nations agencies and programmes, including the World Health Organization (WHO)¹, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the UN Office of the High Commissioner for Human Rights (UNHCHR), have strongly opposed the use of HIV/AIDS-related travel restrictions. They have recognized them as being ineffective, costly, and discriminatory.² For example, the *International Guidelines on HIV/AIDS and Human Rights* (para 105) note that “there is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. (...) Therefore, any restriction on these rights based on suspected or real HIV status alone, including HIV screening of international travellers, are discriminatory and cannot be justified by public health concerns.”³

This document briefly describes HIV/AIDS-related travel restrictions, their impact and the arguments for and against their use, and makes recommendations concerning their implementation. It is hoped that these recommendations will provide guidance to governments regarding how to address effectively the public health, economic, and human rights concerns involved in HIV/AIDS-related travel restrictions.

The Nature and Scope of HIV/AIDS-Related Travel Restrictions

HIV/AIDS-related travel restrictions usually take the form of a law or administrative instruction that requires people to indicate their HIV-free status before entering or remaining in a country. Some countries require people to undergo an HIV test whereas others require an HIV-free certificate or simply that people declare their HIV status. Restrictions may single out HIV/AIDS; may include HIV/AIDS among excludable communicable or contagious conditions; or may leave discretion to immigration officials to exclude a person living with HIV/AIDS. Many receiving countries require that the testing be done, at the expense of the traveller, in the country of origin.

Given the diversity of HIV/AIDS-related travel restrictions, and the obstacles in gaining access to national laws and practice, it is difficult to establish how many States actually employ such restrictions. A number of government and non-governmental entities have tried to maintain lists for the purposes of informing

¹ A resolution adopted by the World Health Assembly in 1988 URGES Member States, particularly in devising and carrying out national programmes for the prevention and control of HIV infection and AIDS (...) to protect the human rights and dignity of HIV-infected people and people with AIDS, and of members of population groups, and to avoid discriminatory action against and stigmatization of them in the provision of services, employment **and travel**. *WHA41.24 Avoidance of discrimination in relation to HIV-infected people and people with AIDS*.

² See *HIV/AIDS and Human Rights, International Guidelines*, United Nations, Geneva, 1998, HR/PUB/98/1, p.50; *Report of the Consultation on International Travel and HIV Infection*, Geneva, WHO, April, 1987; WHO/SPA/GLO/787.1; *Statement on screening of international travellers for infection with HIV*, WHO, WHO/GPA/INF/88.3; *Report of the Preparatory Meeting for a Consultation on Long-Term Travel Restrictions and HIV/AIDS*, WHO/GPA, Geneva, 1994.

³ *HIV/AIDS and Human Rights, International Guidelines*, United Nations, Geneva, 1998, HR/PUB/98/1, p.50.

citizens and other travellers of the existence of such restrictions, to monitor their development, and in some cases, to advocate against them.⁴ The most recent survey to examine such restrictions, carried out by the Deutsche AIDS Hilfe (DAH) in 1999, reported that one source listed 61 States that impose HIV-related travel restrictions, whereas another source listed 54 States. The 1999 DAH survey found that 101 States (from 164 countries surveyed) impose some form of HIV/AIDS-related travel restrictions.⁵

The scope of the restrictions varies. A minority of States appear to impose a blanket proscription against people with HIV entering their countries.⁶ These countries may require a test or indication of HIV-free status, or may prohibit people living with HIV from entry and subject them to expulsion if discovered. These blanket restrictions apply to all those seeking to enter, including those seeking to enter for short periods, such as tourists, business-people, meeting participants and conference attendees. The majority of restrictions imposed by States, however, are aimed at denying to those living with HIV the opportunity to gain entry and stay for longer periods of time, usually for more than a month, e.g. for work, immigration, asylum, residence, or study.⁷

Many States distinguish between people entering for short periods and those entering for longer periods. As will be considered in detail below, this is because many States fear that if people living with HIV/AIDS are allowed to remain for a significant amount of time the State will bear the costs of eventual health care and social assistance related to their condition. By denying people living with HIV/AIDS the right to remain for long periods, States seek to avoid these potential costs. For this reason and for ease of discussion, travel restrictions are often referred to as either “**short-term travel restrictions**” (barring entry and/or stay for periods of 30 days or less) or “**long-term travel restrictions**” (barring entry and/or stay for more than 30 days)⁸.

The Impact Of HIV/AIDS-related Travel Restrictions

There has been no compilation of data regarding the number of people affected by HIV/AIDS-related travel restrictions, or the manner in which they are affected. However, from the large numbers of mobile people and the large numbers of those living with HIV/AIDS, as well as from anecdotal accounts from those who have been affected, it would appear that the impact is high.

In the age of globalization, mobility and migration are an increasingly necessary and natural part of the lives of millions of people. Mobility and migration are also vital components of the economies of many countries that receive and send large numbers of travellers and migrants. In the year 2000, the World

⁴ See following sources: US State Department (<http://travel.state.gov/HIVtestingreqs.html>); Carlier, J-Y, *The free movement of persons living with HIV/AIDS*, EU HIV/AIDS Programme in Developing Countries, European Commission, Luxembourg, 1999; Deutsche AIDS Hilfe, *Quick Reference, Travel and residence regulations for people with HIV and AIDS*, Berlin, 2000 (<http://www.aidshilfe.de>).

⁵ Deutsche AIDS Hilfe, *Quick Reference, Travel and residence regulations for people with HIV and AIDS*, Berlin, 2000 (<http://www.aidshilfe.de>). See also Lemmen, Karl and Wiessner, Peter, “One World - No Hope? Discrimination against People with HIV/AIDS in the Age of Globalization”, Break-the-silence posting, Thu 5/10/01 10:00 AM.

⁶ The DAH survey lists some thirteen countries imposing a blanket proscription barring entry to people living with HIV.

⁷ Ibid.

⁸ See also, definitions of short and long term travel provided in footnote 1, *supra*.

Tourist Organization estimated that there were 698 million international arrivals world-wide.⁹ The majority of these people are travelling for short periods of time, e.g. for tourism, business, conferences, family visits. In some tourist destination countries, the annual number of short-term visitors exceeds the resident population. With regard to longer-term mobility, the International Organization for Migration (IOM) estimates that some 175 million migrants currently live and work outside their country of citizenship, i.e., 2.9 per cent of the world's population. While this percentage has increased only slightly over the last decades, the absolute figure is larger today than ever before – and it is expected to increase over the next years.¹⁰ A significant percentage of people who move across borders have been forced to seek refuge outside their countries of origin: at the beginning of 2003, according to the United Nations High Commissioner for Refugees (UNHCR), almost 20 million people were refugees and asylum-seekers.¹¹ With regard to those living with HIV/AIDS, UNAIDS/WHO estimate that some 40 million people globally are living with HIV/AIDS.¹² The majority of these people come from the developing world, and large numbers of them may not have access to international travel. However, a significant number may seek to travel for immigration, work, asylum, study, medical assistance, and attendance at conferences. These people are denied, in whole or in part, equal participation in cross-border mobility and migration.

The personal impact of HIV/AIDS-related travel restrictions can be devastating for the individual seeking to immigrate, to gain asylum, to visit family, to attend meetings, to study, or to do business. Testing under such circumstances is akin to mandatory testing¹³, and in many instances is done without appropriate pre- and post-test counselling or safeguards of confidentiality. The candidate immigrant, refugee, student or other traveller may simultaneously learn that s/he is infected with HIV, that s/he may not be allowed to travel, and possibly that his/her status has become known to government officials, or to family, community, and employer, exposing the individual to possibly serious discrimination and stigma¹⁴. Often an entire family seeks to relocate, leaving the family with the painful dilemma of whether to go on and leave the infected member behind or to stay together and renounce immigration plans. For those already in a receiving country, they may face summary deportation without due process of law and protection of confidentiality.¹⁵ Under such circumstances, there is every incentive to hide or deny one's HIV status and to avoid contact with immigration authorities and health care workers. Both immigration controls and public health efforts are thereby undermined, while individuals are cut off from prevention, assistance and, perhaps, needed health services.

⁹ See article "Millennium Tourism Boom in 2000", January, 2, at World Tourism Organization website <http://www.world-tourism.org>

¹⁰ See:, IOM News December 2002

¹¹ For statistics on refugees, see <http://www.unhcr.ch> (United Nations High Commissioner for Refugees)

¹² See *AIDS Epidemic Update*, December, 2003, available from UNAIDS, Geneva; <http://www.unaids.org>

¹³ In 1990 the United Nations High Commissioner for Refugees and the International Organization for Migration expressed serious concern about policies of mandatory HIV testing of refugees, stating, in jointly issued 'Guidelines on the Management of HIV/AIDS Among Refugees in Thailand', that: 'Both UNHCR and IOM are opposed to the principle of such screening' but that, until such time as the policies might be changed, partners implementing such HIV testing would maintain confidentiality, and assure pre- and post-test HIV counselling. IOM/UNHCR, June 1990.

¹⁴ See editorial "Health and Human Rights", *Migration and Health Quarterly Newsletter*, 3/3, Geneva: International Organization for Migration, 1993.

¹⁵ See Verghis, Sharuna, "Promoting and Protecting Human Rights to Reduce the HIV Vulnerability of Migrant Workers", in *South East Asia HIV Development Project, Population Mobility in Asia: Implications for HIV/AIDS Action Programmes*, UNDP Bangkok, April, 2000.

International Law, Human Rights, and Humanitarian and Ethical Concerns

Under international law, States have broad discretion to exclude, admit, expel and place conditions on the entry and stay of non-nationals. Furthermore, the International Covenant on Civil and Political Rights, for example, does not accord non-nationals a right to entry or residence in the territory of a State party. In this legal sense, States are exercising their sovereignty by implementing HIV-related travel restrictions. However, international human rights law does place constraints on States' actions with regard to their own nationals and others coming under the jurisdiction of the State.^{16 17} It does this primarily in two ways.

First, international human rights law prohibits States from discriminating against a person in the enjoyment and exercise of his/her human rights on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.¹⁸ The Commission on Human Rights has confirmed that "other status" includes health status, including HIV/AIDS.¹⁹ Thus, States carry the legal obligation to treat individuals on an equal basis regardless of status and must refrain from denying equal access to entry and stay based on HIV/AIDS health status.

Though there is no express right to enter a state, there are other rights that may not be denied through the application of HIV-related travel restrictions. These include: (i) **the principle of *non refoulement*, that no refugee should be *refouled* to a country where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion or that no individuals be returned to a country in which they may be subjected to torture,**²⁰ (ii) **protection of the family and family unity,** (iii) **protection of the best interests of the child,** (iv) **the right to privacy** (which should not be violated through mandatory testing and non-confidentiality of status), (v) **the right to freedom of association,** (vi) **right to information** and (vii) **protection of the rights of**

¹⁶ See Article 12 of the International Covenant on Civil and Political Rights which states that "Everyone lawfully in a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence. Everyone shall be free to leave any country, including his own...No one shall be arbitrarily deprived of the right to enter his own country." See also General Comments 15 on the position of aliens under the Covenant, in which the Human Rights Committee stated that "The Covenant does not recognize the right of aliens to enter or reside in the territory of a State party. It is in principle a matter for the State to decide who it will admit to its territory. However, in certain circumstances an alien may enjoy the protection of the Covenant even in relation to entry or residence, for example, when considerations of non-discrimination, prohibition of inhuman treatment and respect for family life arise." (General Comments 15: The position of aliens under the Covenant, 11 April 1986, paragraph 5.) (N.B. Authorities cited in this UNAIDS/IOM Statement include treaties that are binding on State Parties and, if customary law, on other States as well. Reference to regional human rights bodies and documents is generally beyond the scope of this Statement. Other texts cited are not necessarily binding on States.)

¹⁷ See Article 2 of the International Covenant on Civil and Political Rights. See also the Declaration of the Human Rights of Individuals Who are not Nationals of the Country in which They Live.

¹⁸ See Article 2 of the International Covenant on Civil and Political Rights. See also Article 26 of the International Covenant on Civil and Political Rights, which enshrines customary principle of non-discrimination without limiting to the rights set forth in the Covenant.

¹⁹ See *inter alia*, Commission on Human Rights resolutions 1995/44 of 3 March 1995 and 1996/43 of 19 April 1996.

²⁰ See, Article 33 of the 1951 Convention relating to the Status of Refugees. The non-refoulement obligation of states is also present under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment - Article 3 forbids expulsion, return or extradition "where there are substantial grounds for believing that [the person] would be in danger of being subjected to torture."

Though there is no right to asylum, there is the right to seek and enjoy asylum (Article 14 of the Universal Declaration of Human Rights). These two human rights place an obligation on States to grant the status of refugee to a person living with HIV/AIDS once the person fulfills the relevant prescribed requirements.

migrant workers.²¹ Where HIV-related travel restrictions result in the denial of these rights, such restrictions could result in States' violations of their obligations under international human rights law unless national exigencies require derogations and that such measures are consistent with other obligations under international law.

Secondly, even where there is no specific recognized right being violated, the customary natures of the principles of non-discrimination and of equality before the law prohibit States from implementing measures that are in effect discriminatory. International human rights law places on States and other actors the burden of establishing that the compelling reasons supporting any such distinctions as prescribed by law, are necessary, demonstrably contribute to a legitimate aim, are proportional (the least restrictive means possible) and are strictly construed.²²

States cite protecting the public health and protecting the public purse as the primary rationales for imposing HIV-related travel restrictions. These are traditional bases for immigration controls, and protecting public health is a legitimate basis on which to limit certain human rights. However, as is argued below, HIV-related travel restrictions do not serve to protect the public health.

Furthermore, because the restrictions are applied to **all** non-nationals living with HIV/AIDS who seek to enter or stay, they are not the least restrictive means possible nor are they strictly construed. An individual assessment resulting in the identification of **actual** threats to public health or burden on the public purse in a particular case would be a less restrictive method of achieving the stated objectives. Finally, travel restrictions divert funds and political attention away from the more proven means of protecting the public health - HIV prevention education and services.

In addition to obligations under international law, States should also give consideration to broader humanitarian, moral and ethical claims that may be undermined by the implementation of HIV-related travel restrictions. These include: preserving individual dignity and privacy; supporting solidarity; burden-sharing; facilitating access to and transfer of health technology; considering development concerns and acknowledging the privilege of full and equal participation in international travel for persons living with HIV/AIDS.

Finally, using an HIV test to exclude people from travel, work, immigration and study raises serious ethical questions. These are raised here in the context of HIV, but they are becoming of increasing concern in other contexts. The ability to exclude HIV positive people from these benefits is largely based on the availability of an inexpensive and reliable test for the virus. New health technologies, including genetic mapping and testing, will soon make it possible to predict potential disease conditions and disabilities with regard to a myriad of other health conditions. People should not be excluded from fundamental life activities due to the information provided by these tests. Rather, such testing should only be done in order to prevent or treat disease or disability. The information such tests provide should only be used to increase the ability to enhance health.

²¹ See, e.g., International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights, www.unhchr.ch

²² Goodwin-Gill, Guy, "AIDS and HIV, Migrants and Refugees: International Legal and Human Rights Dimensions", in Haour-Knipe M and Rector R (eds). *Crossing Borders: Migration, Ethnicity and AIDS*. London: Taylor and Francis, 1996, p.50-69. See also General Comment No. 18, November 1989, of the Human Rights Committee.

Protecting the Public Health

The greatly increased mobility of people during the second half of the 20th century undoubtedly contributed to the world-wide spread of HIV infection, quite logically, since it is in the bodies of people that the virus is transported from place to place.²³ It has thus been argued that denying the entry of HIV-positive non-nationals could prevent or retard the spread of HIV within a country. However, given the nature of HIV infection and its now significant presence in virtually every country in the world, this claim cannot be supported. WHO and UNAIDS advise that HIV/AIDS-related travel restrictions have no public health justification and are costly and ineffective. This advice has been strongly reiterated and confirmed in various UN-system fora and documents.²⁴

Travel restrictions to protect the public health are relevant only in the instance of an outbreak of a highly contagious disease, such as cholera, plague, or yellow fever, with a short incubation period and clinical course²⁵, a recent example being severe acute respiratory syndrome or SARS. Entry restrictions relating to such conditions can help to prevent their spread by excluding travellers that may transmit these diseases by their mere presence in a country through casual contact. However, HIV is not transmitted casually but rather through specific behaviours. Sexual intercourse and use of contaminated injection equipment to inject drugs are the main routes of transmission. Furthermore, the means of protection against transmission (safer sex and safer injecting behaviour) are not only in the hands of the infected, but also in those of the non-infected. Thus, travel and migration of infected people do not **in themselves** entail a risk to public health. Excluding non-national travellers with HIV in order to prevent HIV transmission is based on the assumption that the infected will engage in unsafe sex or injecting behaviour, **and** that the national will also fail to protect him or herself. Such assumptions are not founded in fact.

Furthermore, it would be extremely difficult, if not impossible, to seal borders effectively against people living with HIV. Most countries do not apply HIV travel restrictions against tourists and short-term visitors. Nor do most countries impose HIV tests on leaving and returning nationals. These people represent by far the great majority of travellers.²⁶ Tests that **are** applied will not always identify all the people living with HIV as some newly infected persons will be in the “window” period during which time the test does not detect the virus. Under these conditions, it is highly unlikely that all HIV-positive travellers would be excluded through this approach.

Moreover, travel restrictions can undermine public health efforts at HIV prevention and care. Travellers and migrants may enter countries and remain there illegally so as to avoid the application of travel restrictions, in which case their clandestine status is likely to prevent them from receiving HIV prevention and care services. On the other hand, travel restrictions may encourage nationals to consider HIV/AIDS a

²³ For more on this, see Decosas J, Adrien A., “Migration and HIV”. *AIDS* 1997; 11 (suppl A): S77-S84

²⁴ *HIV/AIDS and Human Rights, International Guidelines*, United Nations, Geneva, 1998, HR/PUB/98/1; *Report of the Consultation on International Travel and HIV Infection*, Geneva, WHO, April, 1987; WHO/SPA/GLO/787.1; *Statement on screening of international travellers for infection with HIV*, WHO, WHO/GPA/INF/88.3; *WHO Policy of Non-sponsorship of International Conferences on AIDS in Countries with HIV/AIDS-Specific Short-term Travel Restrictions (ACC/1993/2/Add.3)*; *Report of the Preparatory Meeting for a Consultation on Long-Term Travel Restrictions and HIV/AIDS*, WHO/GPA, Geneva, 1994.

²⁵ *HIV/AIDS and Human Rights, International Guidelines*, United Nations, Geneva, 1998, HR/PUB/98/1; *Report of the Consultation on International Travel and HIV Infection*, Geneva, WHO, April, 1987; *Report of the Preparatory Meeting for a Consultation on Long-Term Travel Restrictions and HIV/AIDS*, WHO/GPA, Geneva, 1994, pp. 6-7.

²⁶ Tourists on holiday and nationals returning to partners and friends are arguably more likely to engage in unsafe sex than migrants and immigrants who may come with families and may be rooted in communities whose mores counsel against risky behaviour. Again, however, it is not fair to *assume* such behaviour, particularly if the tourist has had exposure to HIV prevention information and services.

“foreign problem” that has been dealt with by keeping foreigners outside their borders, so that they feel no need to engage in safe behaviour themselves.

Finally, travel restrictions divert funds that could be allocated more efficiently to prevention and care programmes, including **voluntary** testing and counselling, for people entering the country. Such programmes would serve to protect the public health more effectively than travel restrictions.²⁷

Avoiding Economic Costs

States have traditionally excluded non-nationals with specific health conditions on the grounds that, because of their disease, they could potentially become public charges or place an excessive demand on national schemes for social and health care assistance. The majority of States use this argument only to impose long-term travel restrictions, since economic costs are not usually an issue for short-term travellers who will return home within one month of arrival.

Given the economic benefits of the international movement of people (contributing to national revenue, taxes and productivity; contributing to the labour supply and helping to correct a specific shortage of skills; contributing to cultural diversity), as well as the extended productivity and longevity of people living with HIV/AIDS in light of improved HIV therapies, it is increasingly difficult to be certain that people living with HIV/AIDS will incur more costs than produce benefits over a long-term stay or residency. More importantly, blanket exclusions do not identify effectively those who will *in fact* cause costs to be born by the receiving country. To make this identification, an individual assessment must be made. Such an assessment, based on the facts of the individual case, should establish that the cost of care of the person living with HIV/AIDS - as well as, if relevant, any costs of support of dependants - would:

- entail a real and substantial demand on public resources,
- not be offset by contributions made to the society and economy, and
- not be outweighed by human rights obligations or humanitarian concerns.

Factors to be considered include whether:

- the person living with HIV and his/her family are entitled to public aid;
- a real need for health and social services is established at entry or can be anticipated in the relatively near future;
- the person living with HIV/AIDS has an alternative means of financing health care and social support in the receiving country, such as private insurance, employer’s health care fund, private funding, and/or support from community organizations; and whether
- the person, or his or her dependants or those accompanying him/her, will contribute to the economy and society through particular skills, talents, investments, taxes, resources and cultural diversity.

If there is no expected demand on public resources or no entitlement to them, or if the individual or accompanying family members offset this demand through positive contributions, economic considerations for exclusion should not apply.²⁸

²⁷ For a description of effective HIV prevention programmes for migrants and mobile people, see *Population Mobility and AIDS*, UNAIDS Technical Update.

²⁸ On this point see especially Canadian HIV/AIDS Legal Network, *HIV/AIDS and Immigration, A Draft Discussion Paper*, available at www.aidslaw.ca.

Furthermore, immigration policy that seeks to exclude, in a non-discriminatory manner, individuals to avoid possible costs of health care and social assistance brought on by a health condition must treat similar conditions alike rather than singling out HIV/AIDS for special treatment.²⁹ If such considerations are to be non-discriminatory, the potential economic burden of HIV infection and of other chronic conditions for which immigrants or long-term migrants may be screened should be compared. All health conditions that may cause comparable health care costs should raise the same concerns, and should all be the subject of just, humane and non-discriminatory immigration policy. Costs of health care for HIV, as well as for other chronic conditions, will obviously change as new therapies become available.

A different economic argument is sometimes used to exclude people living with HIV/AIDS from entering a country, namely excluding those who would enter for the purpose of education or training. In this instance, even when sufficient funds for health care are available (for example guaranteed by a sponsor, an educational agency or the government of a sending country) a person living with HIV may be excluded and refused the opportunity to study due to the perception that investment in those with a potentially shorter productive and professional life span is a misuse of resources. This argument is becoming increasingly questionable as new HIV-therapies are greatly extending the lives of people living with HIV, allowing them to continue to contribute to the social and economic lives of their families and communities for many years.

Furthermore, exclusion by the receiving country on these grounds is not warranted unless the receiving country is the one making substantial investments in support of the education. An individual assessment to determine the facts of the case should be undertaken, with due consideration being given to the specific educational needs of the individual or the sending country. Again, if such a policy is followed, comparable conditions should be treated similarly without HIV/AIDS being singled out.

In sum:

While recognizing that control of a country's borders and matters of immigration fall under the sovereign power of individual States, national laws and regulations should ensure that people living with HIV/AIDS are not discriminated against in their ability to participate equally to those without HIV in international travel, in seeking entry into a country not their own, and in seeking to remain in a country not their own. Not only is this justified from the point of view of the principle of non-discrimination, it is also justified from the point of view of sound HIV prevention and care strategies, as the greater involvement of people living with HIV/AIDS can increase the effectiveness of these strategies.³⁰ People living with HIV can now lead long and productive working lives, a fact that modifies the economic argument underlying blanket restrictions: concern about migrants' drain on health resources must be weighed with their potential contribution.

²⁹ It has been shown in Canada that the economic impact over the next ten years of admitting immigrants with asymptomatic HIV infection would be similar to that of asymptomatic coronary heart disease. Unfortunately, few other studies compare costs, and none have been done since the availability of new therapies which may significantly change the equation. See Zowall H, Coupal L, Fraser RD, Gilmore N, Deutsch A, Grover, SA. "Modeling health care costs attributable to HIV infection and coronary heart disease in immigrants to Canada" in *Modeling the AIDS Epidemic – Planning, Policy and Predictions*, ED. Edward H. Kaplan, Margaret L. Brandeau. Raven Press, New York 1994; 73-89

³⁰ See *From Principle to Practice, Greater Involvement of People with HIV/AIDS (GIPA)*, UNAIDS/99.43E, September, 1999, Geneva

Conclusion

Today's world is a much different world than when traditional public health measures - which form the basis for HIV-related travel restrictions - were first put into use over a hundred years ago.³¹ It is even a different world than that at the beginning of the HIV epidemic over twenty years ago. Restrictive measures to achieve public health goals have largely been replaced by an emphasis on health education and support, and voluntary compliance, to achieve the same goals. Education and support that promote and reinforce voluntary participation and compliance with health promoting and producing behaviours have proved more effective and lasting than restrictive measures which often drive people away from health interventions and have short-term, if any, effects on changing behaviour and preventing the spread of the virus. On the other hand, travel, mobility and migration have exploded and have become an ordinary and essential part of the lives of millions, as well as a vital aspect in the viability of many economies. Developments in health technology (including new tests such as genetic tests) and in the transfer of health technology, are requiring a re-examination of ethical issues regarding the use of test results, access to benefits based on health status, and inequities in health care and treatment.

In this rapidly evolving scenario, governments must employ the most rational and ethical means possible to protect their citizens and their national interests, while at the same time opening themselves and others up to the benefits of ever-increasing travel and trade. HIV-related travel restrictions are an ineffective and discriminatory anachronism of a by-gone era. As HIV/AIDS becomes, with new therapies, a life-threatening but chronic and treatable condition, it should be destigmatized and demystified, and treated like other serious, chronic health conditions. People living with such conditions, including HIV/AIDS, should have an equal opportunity to participate in our global village and to make economic and social contributions at home and abroad. We are all, at some point in our lives, affected by health conditions. The nature and severity of these conditions should not be allowed to "stop a life". Rather all people should be supported to contribute what they can, for as long as they can, throughout their lives.

³¹ See Gushulak, Brian D. and MacPherson, Douglas W., "Population Mobility and Infectious Diseases: The Diminishing Impact of Classical Infectious Diseases and New Approaches for the 21st Century", *Clinical Infectious Diseases*: 2000; 31:776-80

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