

European Research Council



HIV-related travel restrictions: Public health security vs. freedom and rights

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Draft: Not for citation

This research has been made possible through funding from the European Research Council under the European Community's Seventh Framework Programme - Ideas Grant 230489 GHG. All views expressed remain those of the author.

Introduction

The world should make war against AIDS, not against people with AIDS.

UN Secretary-General Javier Perez de Cuellar, 1 December 1998

Through this final rule, the Centers for Disease Control and Prevention (CDC), within the U.S. Department of Health and Human Services (HHS), is amending its regulations to remove “Human Immunodeficiency Virus (HIV) infection” from the definition of communicable disease of public health significance and remove references to “HIV” from the scope of examinations for aliens. ... As a result of this final rule, aliens will no longer be inadmissible into the United States based solely on the ground they are infected with HIV, and they will not be required to undergo HIV testing as part of the required medical examination for U.S. immigration.

This final rule is effective January 4, 2010.

Centers for Disease Control and Prevention, 2 November 2009

For over 20 years United States immigration regulations stated that HIV+ individuals were inadmissible for entry into the country without a waiver. Having formally removed that restriction in 2010 – a year designated by UNAIDS as the ‘year of equal freedom of movement for all’ – the US has finally aligned itself with those countries which no longer (or in some cases never did) impose entry restrictions on people living with HIV (PLWHIV). Other states – including Canada, South Korea and China – have also removed their restrictions in the last few years. It may be too early to declare victory for those who have long opposed the imposition of such restrictions, but there is a real sense that the tide has at last begun to turn.

The debate around such entry restrictions has been ongoing since the 1980s. They have generally been justified on two grounds. The first is public health security/public safety, with the argument being made that allowing PLWHIV to enter the country exposes the domestic population to a public health risk. The second common justification is an economic one: that allowing PLWHIV to enter, particularly on a long-term or permanent basis, imposes significant economic costs on the domestic health system. Whilst these logics provide the rhetorical justification for HIV-related travel restrictions in virtually all cases, there have often been suspicions that other concerns, not least homophobia and other prejudices, have been an important (although unstated) factor motivating proponents of restrictions.

The opposing side in the debate has sought to both counter these arguments directly (through arguing that there is a lack of evidence to support the claims made about public safety and economic costs) and also to link the travel restrictions issue to broader concerns about human rights and stigmatisation. In attempting to ‘re-frame’ the issue of travel restrictions in rights terms, advocates have utilised a wide variety of techniques including the use of individual testimony to dramatise the issue and demonstrate the human costs of travel restrictions; moral shaming, though linking the imposition of restrictions by governments with prejudice and discrimination; and legal argument, through the claim that such restrictions are incompatible with various aspects of international human rights law. A wide range of actors, especially drawn from civil society and the UN system, have consistently sought to forward such arguments over the last 25 years to delegitimize HIV-related travel restrictions. Indeed in many ways the global debate has been a static one, with opponents of restrictions consistently forwarding these same arguments, but to little effect. These advocates have done precisely the things which scholars who have examined the use of framing as

an advocacy tool would suggest: they have convincingly re-framed the issue in terms of human rights – a paradigm which is widely seen as legitimate within international society and which ‘resonates’ with a range of audiences - and have made use of exactly the kinds of advocacy techniques which have proven effective in other cases. Why, then, has the tide seemingly only begun to turn in the last few years?

This paper begins by briefly examining the literature from within and outside global health which has addressed the use of framing as a strategic policy advocacy tool. It then moves on to examine the lengthy campaign against HIV-related travel restrictions, arguing that that campaign has been remarkably consistent in its arguments over time and that re-framing travel restrictions as a violation of human rights has been central to this effort. Finally, the paper puts forward some possible explanations for what seems to have been a recent breakthrough, in the process seeking to shed light on a number of political and contextual factors which, alongside framing, play a crucial role in successful advocacy for policy change.

Framing, advocacy and policy change

Framing has been widely portrayed in the literature as a tool which enables advocates to apply pressure on governments for policy change. Frames are usually described as linguistic, cognitive and symbolic devices used to identify, label, describe and interpret problems and to suggest particular ways of responding to them. In policy debates actors often deliberately (and in many cases strategically) forward particular frames “to help fix meanings, organize experience, alert others that their interests and possibly their identities are at stake, and propose solutions to ongoing problems” (Barnett 1999, 25). In other words, actors engaged in framing are pursuing a strategy of persuasion, aiming to use the strength of a particular frame to call attention to an issue, influence other actors’ perceptions of their own interests, and convince them of the legitimacy/appropriateness of the framer’s preferred policy response. When they are successful in doing so, the chosen frame “resonates with public understandings and are adopted as new ways of talking about and understanding issues” and actors will modify their behaviour accordingly (Finnemore and Sikkink 1998, 897).

The social constructivist literature has examined a number of cases in which framing has been a successful advocacy strategy. Keck and Sikkink (1998), for example, argue that the fact that transnational networks sought to frame violence against women as a human rights issue, rather than as a discrimination issue, was crucial to their success in getting it onto the international agenda. Elsewhere Lawson et al (1998) have argued that there was a conscious decision taken by campaigners against anti-personnel landmines to frame that issue in terms of human rights rather than disarmament and to deliberately downplay the implications for national security, a tactic which helped persuade states (who tend to guard national security issues jealously) to accept a norm against landmines.

In recent years within global health a number of scholars have examined the ways in which different framings of health issues have impacted on policy debates at both the global level (e.g. Shiffman and Smith 2007; Rushton 2010) and the national level (e.g. Labonté and Gagnon 2010). Building on this earlier social constructivist work, what they have found is that the ways in which health issues are framed has a significant impact upon policy outcomes. A wide variety of factors have been identified as determining the success or failure of a particular framing including who is doing the framing, the nature of the audience they are trying to persuade, the extent to which the frame resonates with other deeply-embedded ideas, and the intrinsic credibility of the frame. Furthermore, they have found that global health issues such as HIV and AIDS are susceptible to being

framed in a wide variety of different ways: as public health issues; as security issues; as economic issues; as international development issues; as human rights issues and more.

The global debate on HIV-related travel restrictions

The imposition of restrictions has usually been justified by governments (and, much less frequently, by scholars (e.g. Nelson, 1987)) on two principle grounds. The first is securing public health against the supposed threat posed by HIV positive visitors and/or immigrants. The second is an economic argument: that the long-term costs of providing the necessary treatment and care for PLWHIV is a burden upon the state's resources, and as such grounds on which to deny entry.

The arguments which have been put forward by those opposing travel restrictions have been in two parts. The first has been an attempt to refute these public health and economic arguments on their own terms. Opponents of restrictions have long argued that the scale of the 'threat' posed by HIV+ travellers is very small; that the imposition of various kinds of restrictions are in any case an ineffective method of dealing with that threat; and that, in fact, the imposition of restrictions may actually have adverse public health consequences. In relation to the economic costs argument, the tendency has been to challenge the evidence underpinning the economic case, arguing that there is little economic evidence to justify blanket HIV-specific bans, that PLWHIV are often able to contribute productively to an economy for many years, and that the costs of enforcing restrictions are disproportionate. In both of these sets of arguments, then, we see opponents of restrictions responding to the security and economic frames which have been utilised by their proponents. Advocates do not seek to argue that ensuring public health security or seeking to minimise the costs faced by national health systems are not valid and appropriate policy goals - they do not challenge the legitimacy of those frames in and of themselves. Rather, they challenge the extent to which the types of measures in question can make a meaningful contribution to achieving those ends. The debate, then, is not over whether or not public health security and economics are legitimate ways of understanding and responding to health issues, but rather their applicability to the case in question.

The second part of the argument used against HIV-related travel restrictions, however, has involved a deliberate reframing of the issue in terms of human rights. Here advocates have pointed to a range of rights which are denied by the imposition of HIV-related travel restrictions including freedom of movement, non-discrimination, the right to privacy, and the rights of refugees – often backing-up these arguments with the provisions of international human rights law.

Since the mid-1980s the terrain on which this debate over HIV-related travel restrictions has been played out has been remarkably stable. Indeed in comparing some of the latest interventions in that debate – for example the findings of the International Task Team on HIV-Related Travel Restrictions, discussed in further detail below – with documents and scholarly works from the mid-1980s it is striking how consistent the arguments have been over time. In this section I attempt to show this consistency through a brief examination of some of the key institutions which have engaged in this debate and the most prominent global statements in which the types of argument which have characterised the anti-restrictions campaign have appeared.

Public health security

Although it is true that the majority of HIV-related travel restrictions were introduced in a period in which far less was known about the virus and appropriate prevention strategies, the WHO made a strong case against the imposition of such restrictions from a very early stage in the development of

the epidemic. As early as 1985, the year in which a reliable HIV test first became available, a meeting of Directors of WHO Collaborating Centers met to discuss the issue after member states had sought the WHO's advice. The meeting concluded that testing and certification of international travellers was not warranted. As that meeting was reported in the *Weekly Epidemiological Record*, that advice appeared to be on two primary grounds: that such testing and certification were not warranted on public health grounds; and that they were not required under the International Health Regulations (i.e. there was no certification requirement in international law) (WHO, 1986).

From that point onwards, the fact that there is no evidence to support the claim that travel restrictions serve a useful public health purpose has been one of the main arguments used against them both by international organizations and civil society. A range of shortcomings of using travel restrictions to protect public health have been identified. These include the limitations of testing technology, which mean that recently-infected immigrants may not be identified as HIV+ (e.g. Cimini, 1991-2, 380-5; UNAIDS/IOM, 2004, 8); the fact that HIV is not like other infectious diseases such as yellow fever which can be transmitted through casual contact; that there is little evidence to suggest that visitors or immigrants are any more likely than the general population to engage in risk behaviours (e.g. Public Health Service, 1991); and that those countries which have not imposed entry restrictions have not in practice found themselves subjected to a flood of HIV+ immigrants (e.g. Nieburg et al, 2007)

Indeed the argument has often gone beyond the claim that travel restrictions are ineffective to add that they may actually be counterproductive in public health terms, creating a false sense of security (e.g. Ganczak et al, 2007) and dissuading would-be immigrants from undergoing testing and seeking treatment (e.g. John Bradshaw, cited in Bristol, 2009). Again these arguments have been regularly made since the 1980s. Here a link has often been made between public health and respect for rights. In 1988, for example, the World Health Assembly addressed the issue of travel restrictions from the point of view of human rights, specifically the problems of discrimination and stigmatization of PLWHIV. The WHA identified travellers as one group at risk from discriminatory policies, urging member states

(2) 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 provision of services, employment and travel. (WHA 1988)

Yet the WHA resolution did not present discriminatory measures against travellers solely as a human rights issue but also one of public health efficacy by stressing that discrimination and stigmatization in fact increase the danger to health. From that point onwards the argument that efficacy and discrimination are linked has been reflected in almost all of the UN System's engagements with the travel restrictions issue. Jonathan Mann, who as head of the WHO's Global Programme on AIDS was a prominent and passionate advocate of the human rights dimensions of the pandemic, laid out this case most clearly. In an address in June 1988, for example, he argued that

The public health rationale for preventing discrimination against HIV-infected persons is cogent and practical. If HIV infection, or suspicion of HIV infection, leads to stigmatization and discrimination ... then those already HIV-infected and those who are concerned they might be infected will take steps to avoid detection and will avoid contact with health and social services. ... Stigmatization and discrimination – these are threats to public health.

...

In thinking about AIDS, some seek to oppose the "right of the many" to remain uninfected against the "rights of the few" who are already HIV-infected. This is a false dilemma, for the

protection of the uninfected majority depends precisely upon and is inextricable bound with protection of the rights and dignities of infected persons. (Mann 1988, 9-10)

The evidence-base to support the claims that travel restrictions can have a negative public health impact has gradually increased over time. One of the most commonly-cited examples is a 2006 survey of 1100 people with HIV infection who travelled to the USA (which, at the time, did not allow HIV-infected individuals to enter without applying for a waiver) (Mahto et al, 2006). The study found that a majority of HIV-infected individuals in practice travelled to the USA illegally (i.e. without a visa and without declaring their HIV sero-status) and that, fearing that the discovery of ARV medication in their luggage would lead to them being denied entry, a significant minority of travellers to the USA stopped their treatment for the duration of their visit.

Economic costs and benefits

The expert consensus against the public health efficacy of travel restrictions has been strong, and there has been similarly widespread scepticism about the argument that admitting PLWHIV, particularly on a long-term or permanent basis, puts a significant economic strain upon the national health system. Here, however, the counter-argument has tended to be more nuanced. Rather than arguing that HIV+ immigrants do not impose healthcare costs the argument has tended to be that this is not always the case, and therefore that blanket bans are not appropriate and individual assessments are required (e.g. UNAIDS/IOM, 2004, 9). This has been supplemented by the argument that in this respect HIV is no different to other causes of ill health, and therefore that regulations targeted specifically at HIV are not appropriate (e.g. Academia Mexicana de Derechos Humanos et al, 2008). The *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS 2006) present both of these arguments clearly, stating that

128. Where States prohibit people living with HIV from longer-term residency due to concerns about economic costs, States should not single out HIV/AIDS, as opposed to comparable conditions, for such treatment and should establish that such costs would indeed be incurred in the case of the individual alien seeking residency. In considering entry applications, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic considerations.

The WHO (e.g. WHO, 1988) and others have long argued that in fact the imposition of measures such as widespread HIV testing as part of immigration processes are in fact disproportionately costly, particularly given the fact that PLWHIV are often (especially with the advent of more effective treatment regimens) able to make a significant economic contribution to a society for many years.

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. (UNAIDS/IOM, 2004, 10).

Thus, like the public health efficacy case, the economic arguments in favour of restrictions have been widely and consistently subjected to critique.

Human Rights

As well as addressing the public health and security arguments made by proponents on their own terms, the opponents of travel restrictions have also deliberately sought to re-frame the issue in relation to human rights. Here I briefly focus on four of the most common human rights claims that have been made: i) that restrictions interfere with freedom of movement; ii) that they are discriminatory; iii) that they raise problematic issues of privacy and medical ethics; and iv) that they are particularly problematic in certain cases, for example when applied to refugees and asylum seekers. Often these arguments are supported by reference to international human rights laws and norms. Clearly all of these arguments are linked, and they are frequently deployed together.

The principle of freedom of movement is widely cited, and UNAIDS called for 2010 to be the “year of freedom of movement for people living with HIV” (UNAIDS 2010d). The *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS, 2006) address the ‘right to liberty of movement’, noting that

127. There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status. According to current international health regulations, the only disease which requires a certificate for international travel is yellow fever. Therefore, any restrictions 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.

This striking of a balance between freedom of movement and legitimate restrictions of grounds of public health has been widely addressed, and given the general consensus on the lack of a public health justification for restrictions the case has generally been seen to be clear (e.g. Amon and Todrys, 2008). This balancing is most explicit within the EU where freedom of movement is enshrined within EU law. Whilst EU states *are* entitled to restrict freedom of movement on public health grounds, neither HIV or AIDS are identified as public health threats which would warrant such a response (Hendricks, 1990, 195) (although some EU states – including Belgium, Germany and Greece – have at various times had some form of restrictions in place (Hendricks, 1990, 197)).

Combating discrimination has been central to AIDS activism across all policy areas, not just travel restrictions. Travel restrictions have, however, been seen as a clear case in which the policies of many states have been discriminatory. This argument has been reflected in virtually all of the anti-restrictions rhetoric. Often, significantly, this has been backed-up by reference to international norms and to explicit commitments made by states. Kyung-wha Kang, the UN’s Deputy High Commissioner for Human Rights, for example has argued that

While travel restrictions are a question of State sovereignty, it must be pointed out that States also have obligations under international law within which sovereign rights may be exercised. In particular, under basic norms of non-discrimination, States must provide compelling reasons for any differentiation in treatment, including in restricting travel for people living with HIV. We know that there are no such compelling reasons. (OHCR, 2008).

The 2001 Declaration of Commitment on HIV/AIDS, as part of which all states committed to removing discriminatory legislation, has also been used as a touchstone in the travel restrictions debate (e.g. Academia Mexicana de Derechos Humanos et al, 2008).

The right to privacy has also been a feature of the debate (e.g. UNAIDS/IOM, 2004), particularly in cases where travellers or immigrants are required to declare their sero-status. Even more serious issues are raised by requirements for mandatory testing which, in some cases, has been “conducted without informing people of the test or its results, without providing counselling or confidentiality and without connecting people to HIV prevention and treatment services” (HIVtravel.org, 2008).

Again international law has been used to demonstrate the shortcomings of many states' immigration regulations, for example through the invocation of the International Covenant on Civil and Political Rights which protects the right to privacy (e.g. Ecumenical Advocacy Alliance, 2008, 5).

Finally, particular attention has been paid to the rights of refugees and asylum seekers. These vulnerable groups have been subject to some of the most high-profile instances in which HIV-related travel restrictions have had serious consequences for individuals. The infamous case of the US's quarantining of Haitian refugees at Guantanamo in 1993 (Johnson, 1994) caused a significant international outcry. Yet UNHCR had made it clear in its policy guidelines as early as 1988 that refugees and asylum seekers should not be targeted for special measures regarding HIV infection and that there is no justification for screening being used to exclude HIV-positive individuals from being granted asylum. Neither did the UNHCR find any legitimate justification for states returning refugees to countries where they may face persecution as a result of their HIV status (the principle of non-refoulement). The International Guidelines on HIV/AIDS and Human Rights (UNAIDS, 2006) make the same points.

The persistence of restrictions

As has just been shown, various institutions and organizations have consistently made the case against the imposition of HIV-related travel restrictions over many years. The essential outlines of the arguments used to support that position were in place from an extremely early stage and have changed relatively little despite the massive changes which have taken place in the nature and scale of the pandemic in the intervening period. These statements have been regularly endorsed by member states in bodies such as the WHA and the UN General Assembly. But despite the unambiguous nature of these international statements and guidelines, despite almost universal expert consensus on the ineffectiveness of restrictions (Hendricks, 1990, 196), those restrictions have been remarkably persistent.

In the majority of cases these measures were put in place in the 1980s when far less was known about HIV and the global pandemic was less advanced. Nevertheless, it is striking that the real boom in the imposition of such restrictions came after the WHO's clear advice against such measures. The academic literature of the late 1980s and early 1990s pointed to an increasing prevalence of restrictions (e.g. Closen and Wojcik 1990; Duckett and Orkin, 1989; Hendricks, 1990), with Nelson (1987, 232) arguing that a new international norm concerning the imposition of restrictions on travellers was developing as more and more states imposed restrictions. The form that those restrictions took varied widely. In some cases all visitors were required to declare or prove their HIV status, in other cases regulations only applied to those staying for extended periods or immigrating permanently. In some cases PLWHIV were denied entry automatically, in others they were allowed to enter in certain circumstances, or subject to certain restrictions.

A 1989 global survey found that 50 countries imposed some kind of restrictions and that 32 countries had refused entry and/or deported individuals with AIDS or infected with HIV (Duckett and Orkin, 1989). The survey found that a further 11 countries were at that stage considering introducing restrictions. The authors concluded (Duckett and Orkin, 1989, S251) that "while a significant number of countries have, or claim to have, rejected travel restrictions as a measure to control the spread of HIV, an increasing number of countries are imposing such restrictions." In 2008 UNAIDS, drawing on the Global Database on HIV-Specific Travel & Residence Restrictions (www.hivtravel.org) reported that 59 countries denied the entry, stay or residence of HIV-positive people because of their HIV status (UNAIDS, 2008, 7). UNAIDS's December 2010 figures show a reduction: 49 countries by their count imposed some form of restrictions at that time, 128 did not (UNAIDS, 2010a). The accuracy of

these figures is open to some dispute, with all of the global surveys which have taken place recording that there is a lack of clarity around the policies and regulations of some countries, and that in some cases contradictory information has been provided.

Overall, however, it seems that the figures remained more or less stable between 1989 and 2008, with over one in four imposing some sort of restrictions. Nevertheless, in recent years there have been some high-profile cases of countries removing their restrictions, not least the cases of the US, the People's Republic of China, South Korea and, all of which occurred in 2010 and are discussed in the next section of this paper. This leaves us with a puzzle. Given the consistency of the arguments against travel restrictions over the years, and given that those arguments have been framed in ways which, one would think, ought to be convincing, why is it only in very recent years that the tide has begun to turn? The remainder of the paper addresses that puzzle, putting forward four possible explanations for the timing of recent policy changes, explanations which may help shed some light on the conditions under which framing can be a successful advocacy strategy.

Framing is not enough: explaining a new wave of policy change

Here, I focus on three high-profile recent examples of policy change in this area, all of which took effect in 2010 (although in some cases they were the result of processes which started some years earlier): the United States, China, and the Republic of Korea.

The US case has been by far the most high-profile of these cases, a result of both the US's status as a global leader (including a global leader in terms of responses to AIDS) and also the ferocity of the domestic policy debate. The US restrictions were originally introduced in 1987 when, as the result of an amendment introduced by Republican senator Jesse Helms, HIV was designated a "dangerous contagious disease" under the terms of the Immigration and Nationality Act of 1952. This meant that, with some limited exceptions for which a waiver could be granted, PLWHIV were essentially barred from entering the US. Huge lobbying efforts were made by domestic opponents of the travel restrictions and a series of attempts were made to remove them. In 1990 CDC recommended that HIV should be removed from the "dangerous contagious disease" list and indeed it was due to be removed in 1991 until a last-minute u-turn by the Bush administration. An effort under Clinton to remove the restrictions in 1993 was defeated in Congress.¹ Eventually, in 2008, George W. Bush began the process of removing the ban, a process which was completed by the Obama administration in 2009 and which came into effect in January 2010. South Korea's travel restrictions were eased, specifically for those on short-term visits, at the same time as the US's, in January 2010. Whilst those changes were welcomed by campaigners some, such as Human Rights Watch's Joe Amon (2010), had concerns about continuing discriminatory measures in the Korean case (in particular around foreign workers who are found to be HIV positive). The Chinese government originally announced its intention to remove its ban at the 2008 International AIDS Conference (China Daily, 2008), although the change was not finally confirmed until April 2010, shortly after the US change came into effect and in advance of the 2010 World Expo being held in Shanghai (BBC News, 2010). With the exception of a temporary lifting of the ban for the 2008 Beijing Olympics, China had previously prevented PLHIV from entering the country. Senior UN figures – including UN Secretary-General Ban Ki-moon and UNAIDS Executive Director Michel Sidibé publicly praised China's actions, with Sidibé saying "This is yet another example of China's leadership in the AIDS response." (UNAIDS, 2010b).

¹ Macko (1995, 547-552) and Cimini (1991-2) amongst others provide more detailed histories of the development of the US restrictions.

Here, then, we have three cases of the removal (or at least partial removal) of travel restrictions in a very short period of time and in each case by relatively powerful states, all of which are G20 members. Given the remarkable stability of the arguments being put forward, and the evidence used to support them, over the two decades prior to these changes, how can the timing of these changes be explained? Here I put forward a number of factors which can help to explain some of these changes. Consistently framing travel restrictions as a human rights issue, arguing that such restrictions are contrary to international human rights law, and the efforts which have been made to dismiss the public health and economic arguments, have all played a part but have not in themselves been sufficient to bring about national policy changes. Rather the pressure for change in these cases seems to have come about as a result of a coming together of various factors, including a gradual change in ideas about the severity of the ‘threat’ posed by PLWHIV; the domestic political context within these states; the existence of opportunities to apply pressure on governments, particularly around major events; a sense of international momentum building up behind the issue from 2008 onwards; and the role of the US as a global leader and an example to others in both a positive and a negative sense. It is inherently dangerous to predict the creation of an international norm at such an early stage, but there appears to be a feeling amongst many in the AIDS field that we may be witnessing a gradual emergence of a new international norm proscribing HIV-specific travel restrictions.

Changing knowledge and attitudes

From the very early days of the pandemic, HIV and AIDS have been heavily politicized and responses to them have been in part at least driven by a variety of non-science based considerations including fear and prejudice. These are not, of course, ordinarily put forward as justifications for imposing restrictions even if they are in reality part of the explanation. Opponents of travel restrictions have often argued that prejudice has played an important part in policy development. Senator Jesse Helms, for example, was a key figure in the development of the US’s regulations, with the 1987 ‘Helms Amendment’ being responsible for adding HIV to the list of “dangerous and contagious diseases” which would prevent people from entering the US (Macko 1995, 547-52).² Helms was also at the centre of a successful attempt to prevent President Clinton removing the HIV travel ban in the early 1990s, accusing Clinton of “kowtowing to the arrogant and repugnant AIDS lobby and to the homosexual rights movement which feeds it” (quoted in Macko, 1995, 552). Helms was consistently criticised for his outspoken views on AIDS and homosexuality, and his statements have been widely used by opponents of travel restrictions to support the claim that the origins of US policy lie in prejudice rather than any real concern with public health or the economic costs of providing treatment and care. The International AIDS Society, for example, links the US travel ban with Helms’s own views on homosexuality, repeating his infamous statement that “We’ve got to have some common sense about a disease transmitted by people deliberately engaging in unnatural acts” (Kallings & McClure, 2008, 17). Whilst such attitudes have not entirely disappeared they tend to be far less commonly found in contemporary political discourse. Even Helms eventually reversed his position in 2002 as the religious right in the US took up the cause of AIDS in Africa, a reverse which he attributed to the influence Franklin Graham, Kofi Annan and Bono had on his view of the AIDS crisis (Behrman, 2004, 270). Thus a softening of attitudes amongst political elites, at least in the West, has undoubtedly contributed to the creation of an environment where HIV-related travel restrictions have come to appear even more anachronistic.

² The Helms amendment also included a number of other highly controversial requirements which are beyond the scope of this paper, including banning the use of federal money for the creation of HIV/AIDS education material which would “promote or encourage, directly or indirectly, homosexual activities”

Alongside this there has also been a gradual change in social attitudes in many countries towards PLWHIV, changes which have been a product partly of public health education efforts and a better understanding of the modes and risks of transmission, but which are also in part attributable to the passage of time since the emergence of HIV and AIDS as new health threats. Certainly some saw this as an important factor in the US policy change with Victoria Neilson, legal director of Immigration Equality, being quoted as saying "I think it's a sign of changing attitudes across the board ... It just seemed like more of a non-issue at this point" (Agence France-Presse, 2010). Such attitudinal changes have, however, been gradual, complex and non-linear. Herek et al's study of changing attitudes within the US over the 1990s found that over that decade support for punitive policy measures such as quarantine and public identification of PLWHIV declined (Herek et al, 2002) although in other areas the news with less positive with the research finding, for example, that respondents in 1999 were more prone to overestimating the risk from casual social contact than respondents in 1991. Nevertheless, three decades on from the emergence of HIV/AIDS onto political agendas the climate in the West has changed dramatically amongst both politicians and their electorates. Thus timing – or 'ripeness' – certainly had a part to play in the recent examples of policy change.

Transnational advocacy and the International Task Team

Advocacy groups, in many cases groups with their origins in the gay community, have been vocal opponents of HIV-related travel restrictions from the outset. Whilst many of these groups, particularly those within the US and Canada, originally focussed their efforts on lobbying their own governments, a number of high-profile advocacy organisations have engaged in a broader global campaigning effort in an attempt to delegitimize travel restrictions on PLWHIV. Human Rights Watch has been one such organisation, consistently arguing against such restrictions on human rights grounds whilst at the same time holding governments to account for their policies (e.g. Human Rights Watch, 2007a) and documenting the effects which such restrictions have on individuals in practice (e.g. Human Rights Watch, 2007b). A host of others including the International AIDS Society (discussed below), the Ford Foundation and the Canadian HIV/AIDS Legal Network have also made high-profile interventions on this issue. Beyond this, as discussed above, there was from an early stage clear and explicit policy guidance from major global health institutions, originally the WHO and latterly UNAIDS and the Global Fund.

From around 2007 onwards an even greater sense of international leadership on the issue began to be apparent. Ban Ki-moon, who began his term as UN Secretary-General in January 2007, made it known that he saw combating HIV-related stigma and discrimination as a personal mission (Agence France-Presse, 2009). Ban has frequently been outspoken on the travel restrictions issue, making a number of high-profile speeches criticising countries for their discriminatory legislation. Ban's campaign against travel restrictions included attempts to persuade his home country, South Korea, to remove their travel ban, which they did for the majority of travellers in 2010. It was subsequently reported that Ban had continued to press the South Korean government on the issue:

UN Secretary-General Ban Ki-moon is urging South Korea to scrap a requirement that foreign teachers take an HIV test, an official said Tuesday.

South Korea dropped a travel ban in January for most foreigners with the virus that causes AIDS, drawing praise from the United Nations. But it still requires foreign teachers, most of whom teach English, to take HIV tests. The ban is largely the result of pressure by parents.

In a meeting last week with Prime Minister Kim Hwang-sik in Seoul, Ban urged that the HIV test requirement be abolished, said Yoo Sung-sik, a spokesman for Kim. Ban, a former South Korean foreign minister, was in Seoul to attend a summit of the Group of 20 leading economies. (China Daily, 2010)

Kim told Ban he would carefully review the request, Yoo said.

Michel Sidibé, Executive Director of UNAIDS, has been similarly forthright on the issue and was responsible for the creation of the International Task Team on HIV-related Travel restrictions, which was set up by UNAIDS (with support from the Global Fund and the WHO) in 2008 in order to spearhead a major global effort for the elimination of such restrictions. The Task Team brought together a range of individuals from national governments, the UN System, civil society and the private sector (UNAIDS, 2008, 37-9) in what Michel Sidibé described as an example of “the new multilateralism needed to take on complex and inter-connected problems posed by the AIDS epidemic and generate a movement for practical solutions” (UNAIDS, 2008, 3). Many of the civil society organisations which have played a high-profile role in the global debate were represented on the Task Team, including Human Rights Watch, the Canadian HIV/AIDS Legal Network, the International AIDS Society, the Ford Foundation, the International HIV/AIDS Alliance, the Terrence Higgins Trust, the Ecumenical Advocacy Alliance and others. The Task Team carried out a number of activities including an audit of current restrictions (drawing on the HIV Travel database); a review of the evidence; and the drawing up of recommendations which were then passed on to governments and other bodies including UNAIDS’ PCB and the Global Fund Board. From the outset, however, the Task Team was designed to perform an advocacy role. Although part of its role was to review the existing evidence, its terms of reference did not require it to reach impartial judgements on the efficacy or legitimacy of travel restrictions, but rather “to galvanize attention to HIV-related travel restrictions on national, regional and international agendas, calling for and supporting efforts toward their elimination” (UNAIDS, 2008, 35).

That is not a criticism of the Task Team’s approach (even if it had conducted an impartial review of the evidence it would surely have come to the same conclusions), but it does suggest that what the Task Team actually represented was a relatively institutionalised form of ‘transnational advocacy network’ (Keck and Sikkink, 1998). Bringing together a range of organisations and individuals who had been engaged in largely separate efforts over many years, the Task Team fulfils all of the criteria which Keck and Sikkink (1998, 12) suggest contribute to advocacy network emergence:

Transnational advocacy networks appear most likely to emerge around those issues where (1) channels between domestic groups and their governments are blocked or hampered or where such channels are ineffective for resolving a conflict ... (2) activists or “political entrepreneurs” believe that networking will further their missions and campaigns, and actively promote networks; and (3) conferences and other forms of international contact create arenas for forming and strengthening networks.

The travel restrictions issue also fits with the kinds of issue around which Keck and Sikkink suggest advocacy networks often emerge in debates where rights are at stake, and that they are most likely to have an influence in

(1) issues involving bodily harm to individuals, especially when there is a short and clear causal chain (or story) assigning responsibility; and (2) issues involving legal equality of opportunity. (Keck and Sikkink, 1998, 27).

A key part of the Task Team's approach was what amounted to a 'naming and shaming' exercise, publishing listings of those countries which impose restrictions. China, South Korea and the US all appeared amongst the 59 countries on the Task Team's June 2009 list (UNAIDS, 2009a). As noted above, by the time of the December 2010 list the number of countries had reduced to 49, and China and the US had been removed. Whilst it would clearly be over simplistic to attribute the removal of restrictions in those cases to a single cause, the Task Team's approach represents a clear attempt to use governments' reputational concerns to apply pressure for policy change.

Applying pressure: event hosting as an opportunity for shaming governments

In the cases analysed here, however, it is also notable that as well as such general attempts at shaming, specific events have been strategically used by advocates as opportunities to apply pressure to governments. In at least two cases in recent years the influence of the International AIDS Society (IAS) has been widely credited with having a significant policy impact. The International AIDS Society grew out of a series of International AIDS Conferences which began in 1985 and which eventually grew in scale to an extent demanding a dedicated body to organize and run those conferences (Kallings and McClure, 2008). Founded in 1988, the IAS was from an early stage a vocal critic of HIV-related travel restrictions, and particularly of the US government's stance. Given that such restrictions directly impacted upon the ability of PLWHIV to attend the International AIDS Conferences, the IAS has sought to use the International AIDS Conference

as a vehicle for calling attention to HIV-related travel and residence restrictions. The International AIDS Conference is also a vehicle to change harmful host country HIV-specific policies on travel and residence. (IAS, 2009 , 6)

The Conferences were originally intended to alternate between France and the US, but the refusal of the US government to revoke the ban led to the cancellation of the 1992 conference, scheduled to be held in Boston, and a policy decision by the IAS to hold no further conferences in the US (or, indeed, any other country imposing such restrictions) until the restrictions had been removed. Following President Bush's pledge to rescind the ban, the IAS announced in June 2009 that it would consider Washington, DC as a venue for the 2012 conference if the ban were lifted (Bristol, 2009). The conference venue was confirmed following the 2010 change in US legislation. The introduction to the conference by the co-Chairs demonstrates just how closely linked the conference venue and the policy change are:

The return of the International AIDS Conference to the United States in July 2012 represents a significant victory for public health and human rights. The selection of Washington, DC as the site for the XIX International AIDS Conference (AIDS 2012) is the result of years of dedicated advocacy to end the nation's misguided entry restrictions on people living with HIV – restrictions that were based on fear, rather than science. (Katabira and Havlir, 2011)

Whilst the IAS' lobbying seems to have had an effect in the US case, its impact in the case of Canada was even more direct. The nature of the Canadian restrictions was somewhat more subtle than the US case. Whilst HIV was not officially a bar to entry for short-term visitors, the visa application form then in force required applicants "to disclose highly sensitive personal information such as their HIV status for no legitimate purpose. It presented a de facto barrier to people living with HIV/AIDS entering Canada, including for the 2006 International AIDS Conference." (Canadian HIV/AIDS Legal Network, 2005, 2). After discussions between a number of organizations involved in organizing the conference (including the AIDS2006 Toronto Local Host organization, IAS, the International Council of AIDS Service Organizations (ICASO) and UNAIDS) and the Canadian government agreed to

permanently change the visa form to remove the requirement for a declaration of HIV status (Canadian HIV/AIDS Legal Network, 2005, 2). It has been reported that during these discussions the IAS threatened to move the 2006 conference from Toronto to Geneva if the Canadian government did not change its policy (Mellors, 2008).³

The Global Fund has also sought to use its influence to pressure governments into making policy changes. The Global Fund Board made a statement in 2007 that it would not hold its Board meetings in countries which imposed HIV-restrictions on short term visits and specifically referred to its ongoing dialogue with China (the venue for the 16th Global Fund Board meeting) and the fact that

The Chinese authorities have worked very closely and constructively with the [Global] Fund to find solutions for the existing concerns. In this context these Chinese authorities have confirmed to the Global Fund in their letter of 17 October 2007, that the Chinese Frontier Health and Quarantine Law is currently being amended and is expected to be submitted in the first half of 2008. (Global Fund, 2007, 1).

Although China's change did not in fact come into effect until 2010, it seems clear from these cases that major events such as the International AIDS Conference and Global Fund Board meetings offer such organisations at least the opportunity to engage in a meaningful way with governments, and perhaps to exert leverage over them in pursuit of policy change. Again it would be over simplistic to attribute recent policy changes solely to these events, but it is clear that they offer the possibility for advocates to place national governments in a position in which their reputations are at stake. Coupled with the power of the human rights framing, this puts advocates of policy change in a potentially strong position.

US leadership

Finally, and this should come as no surprise, the travel restrictions case shows what an important role the US can play as a global policy leader. Indeed in this case the US has played both positive and negative roles as its own position has changed over time.

Although public health security and economic rationalizations were by far the most common justifications of travel restrictions, in Quereshi's 1995 study of a number of countries with restrictions a further common argument was detected: that "Many of the countries with restrictive policies barring HIV-positive aliens have rationalized their policies by reference to those of the United States" (Quereshi, 1995, 91). Quereshi (1995, 94-6) details in particular statements from Vietnam, the Philippines and Indonesia, all of whom pointed to the US restrictions then in force as precedent and justification for their own regulations. Here, then, we see evidence that the US's own travel restrictions served as a justification and validation of similar measures in other countries. This only heightened the extent to which achieving US policy change would be likely to ripple-out across the international community. As Craig McClure, Executive Director of the IAS, said on the announcement of the US's intention to remove its restrictions: "The U.S. always sets the tone. This is huge not only for the people who have not been able to enter the U.S., but finally these laws might be overturned throughout the world." (USA Today, 2008).

As the US increasingly came to see itself as a global leader in the fight against AIDS – particularly under the administration of George W. Bush who put in place the President's Emergency Plan for

³ "It is important to note as well that the International AIDS Society was prepared to move the Toronto conference if the law was not changed in time for the International AIDS Conference in 2006, and they had actually gone as far as reserving the conference center in Geneva." (Mellors, 2008)

AIDS Relief – the anachronistic nature of the US's entry restrictions became a source of potential embarrassment which was seized upon by the opponents of restrictions both within and outside the US. Democratic Senator John Kerry, a long-term opponent of the US's policy, argued that their continuation "squanders our moral authority" (Bristol, 2009), and in a similar vein a CSIS report argued that

the current HIV inadmissibility policy is viewed increasingly as antiquated and incompatible with the goals and practices of the President's Emergency Plan for AIDS Relief (PEPFAR) and as a liability in ensuring effective U.S. global leadership on HIV/AIDS. (Nieburg et al, 2007, 2)

Clearly given its commitment to the fight against AIDS the US government would have been uncomfortable finding itself on a number of embarrassingly short lists. The 2009 International Task Team mapping exercise, for example, identified the United States as one of only seven countries requiring "declaration of HIV status for entry or for any length of stay and either bar HIV-positive people from entering or apply discretion concerning their entry" (UNAIDS, 2009a, 6). The other countries on the list were Brunei Darussalam, China, Oman, Sudan, United Arab Emirates and Yemen. Similarly the same report named the US as one of only 26 countries which deport people once their HIV-positive status becomes known (UNAIDS, 2009a, 8). What we see in this case, then, is a clear use of shaming techniques, the success of which was heightened by the US's own developing (and self-proclaimed) 'global leadership' status.

Conclusion

It is too early to know how quickly and how far the US's change of policy will ripple out to other countries. The early signs, however, seem promising given the almost simultaneous changes in China and South Korea. Namibia also removed its restrictions in 2010, whilst India and Ecuador "issued clarifications to underline that they too no longer employ such restrictions" (UNAIDS, 2010c). Advocates, including Ban Ki-moon, have been explicitly using the US's policy change as an example for other states to follow (UNAIDS, 2009b). The emergence of new international norms, however, is often dependent upon a 'tipping point', following which a norm cascade is set in train, diffusing the new standard of appropriate behaviour through international society (Finnemore and Sikkink, 1998). It is possible, although not yet certain, that the recent US change in policy could be just such a tipping point. What the travel restrictions case shows more broadly is that framing can be a valuable tool for advocates, but that framing is not enough, and neither does the existence of an expert consensus mean that that consensus will be followed by all states. In this case a combination of political and contextual factors came together in the latter part of the last decade including changing social attitudes, concerted global leadership and the creation of a coordinated transnational advocacy network, and the strategic use by certain groups of opportunities to individually put pressure upon governments.

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