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## Report of the International Task Team on HIV-related Travel Restrictions

## The impact of HIV-related restrictions on entry, stay and residence: an annotated bibliography

# The impact of HIV-related restrictions on entry, stay and residence: an annotated bibliography

This document was commissioned by the
International Task Team on HIV-related Travel Restrictions.
For information about the Task Team and to access its report,
see www.unaids.org.

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This annotated bibliography was commissioned by the International Task Team on HIV-related Travel Restrictions. It was prepared by Mary Haour-Knipe (independent consultant) and is based on her desk review of available research and other materials concerning the impact of HIV-related restrictions on entry, stay and residence. An earlier version was presented to the Task Team at its Third Meeting (Madrid, 24-26 June 2008) at which time the Task Team provided comments and input. This paper does not necessarily represent the views of all members of the Task Team nor the stated positions, decisions or policies of the UNAIDS Secretariat or any of the UNAIDS Cosponsors.

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## Introduction

This bibliography was commissioned by the *International Task Team on HIV-related Travel Restrictions*.[1] It is a based on a desk review of research, reports and other available materials concerning the impact of HIV-related restrictions. The first section presents studies that focus specifically on the impacts of HIV-related restrictions on entry, stay and residence. The second section of the bibliography presents a number of reviews and reports that focus less directly on the subject. The third section presents research that is relevant but more indirectly related assessing impacts. The final section of the bibliography presents some examples of possible approaches to monitoring restrictions on entry, stay and residence, with a view to mitigating their impacts.

Each section begins with a brief introductory discussion; then, for each reference, lists the subjects covered, the location, the methodology used, and selected key findings. Except in the first section presenting studies that directly address the impacts of HIV-related restrictions, the listings are not meant to be exhaustive, but simply to be examples, and points of departure for possible future work in the directions indicated.

## Methodology

- At the outset of the desk review, a call for information was sent to Task Team members and other relevant experts and organizations. This call produced over 50 documents, including reports, letters, brochures and other relevant "grey literature" that is not always widely available. These materials were reviewed, and references to other key sources were identified and followed up.
- A PubMed search[2] was conducted using the key words 'HIV' and 'travel', producing 800 results of which some 200 were screened in on the basis of the relevance of their abstracts to the issues of restrictions on entry, stay and residence and their impacts. [3] The complete text of approximately 100 of these, including their bibliographies, was reviewed.[4]
- Existing files maintained by the consultant on migration and HIV/AIDS, and on HIV-related travel restrictions, were consulted.[5] Sources that directly or indirectly relate to the impact of restrictions were re-examined.
- An additional PubMed search using the key words 'HIV' and 'migr*'[6] was carried out. This

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[1] See *Report of the International Task Team on HIV-related Travel Restrictions: Findings and Recommendations*, available at www.unaids.org. This bibliography was prepared by Mary Haour-Knipe, independent consultant.

[2] The time available for this desk review did not permit searches of other potentially relevant databases, such as Psych Abstracts, Soc Abstracts, Web of Science, and the abstracts of International AIDS Conferences. However, the fact that various key source materials identified via Task Team members and other experts also appeared in the PubMed search results increases confidence that the search has identified much of what can be considered the core literature, even if not fully exhaustive.

[3] Articles were screened in if they made any mention of entry or residence visas, or related legislation; HIV testing or screening of migrants; HIV infection during travel abroad; access to care for non-nationals; health-seeking behaviour of migrants; perceptions of healthcare in destination countries; migrant trust in healthcare providers; HIV- or migration-related stigma; and perceptions of foreigners in relation to HIV or AIDS. Articles were also examined concerning HIV risk and vulnerability among separated couples; and studies addressing migration in relation to human rights and public health. Articles dealing with travel medicine or sexual health for people with HIV were screened out unless the abstract specifically mentioned testing and/or counseling in relation to visa or similar requirements.

[4] The review of the full-text of articles was limited to those available through the libraries of the World Health Organization and the University of Geneva, or published "open-access" via the internet.

[5] This includes postings about the subject on list serves, including NAM Aidsmap, Af-AIDS, Sea-AIDS, ProCAARE.

[6] Using the term 'migr*' will generate results including 'migrants' and 'migration', however results may not always relate to 'migration' in the sense of the movement of people (e.g. 'T cell migration', migration of malignant tumours), and will pick up variations unrelated to the subject at hand (e.g. 'migraine'). Articles addressing internal migration (e.g. movement

wide search led to 1,786 abstracts, including most of the references previously identified. However, two new articles of relevance were screened in through this search.

- References in the most relevant documents were traced using the 'related articles' option in PubMed and the 'cited by' option in Google Scholar.
- A draft of the bibliography was distributed and discussed at the Third Meeting of the Task Team in June 2008, and participants were requested to contribute any additional relevant material of which they were aware.

## A. Studies that focus on the impact of HIV-related restrictions on entry, stay and residence

Very few studies were found to specifically examine the impact of HIV-related restrictions on entry, stay and residence. The most extensive studies available are those carried out by the *Coordination of Action Research on AIDS and Mobility* (CARAM) concerning migrant workers in Asia, a region with several countries that either send or receive significant numbers of migrant workers (or in some instances both) and where some also require that potential migrant workers undergo HIV tests, and deport those found to be infected. Two CARAM reports detailing the impact of HIV-related restrictions on migrant workers are presented in some detail here. One is a 2007 report specifically focusing on mandatory HIV testing as part of the implementation of HIV-related restrictions on entry, stay and residence throughout 16 Asian countries of origin and destination. The other is a 2005 CARAM report from the Philippines, which goes into more detail about the impact of such policies. A report from North America is also described, in which Morin *et al* note that the United States ban on immigration by HIV-positive people has hindered primary HIV prevention and care among Mexican nationals living with HIV in California.

Two studies addressing HIV-related restrictions in relation to travellers are then presented. These concern people who seek to cross international borders for stays shorter than those of migrants; Mahto *et al* examine the behaviour of HIV-positive people in the United Kingdom intending to travel to the United States, and Salit *et al* do the same for Canadians with HIV travelling internationally.

### *Migrants and their families*

**CARAM Asia (2007), *State of Health of Migrants 2007: Mandatory testing*. Kuala Lumpur: CARAM Asia.**
http://www.caramasia.org/reports/SoH2007/SoH_Report_2007-online_version.pdf

Regional analysis of policies and practices; CARAM proposes that, if such testing is to be done, it should be "migrant friendly".

between urban and rural settings) were screened out. Additional searches were run using the key words 'HIV' and 'visa', producing 21 results, all of which were included in the other searches; 'HIV' and 'entry' produced over 4,000 results, however many on 'virus entry'. Adding the key word 'visa' generated two results that had already been identified using the other search terms. A search using the key word 'refugee' led to abstracts that had already been identified in the search using 'migr*'.

***Subjects covered****: Public health; economic, ethical and human rights arguments against mandatory HIV testing of migrants; how HIV testing is carried out and its consequences.*

***Location:*** *Asia (Countries, territories or areas of origin: Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, Philippines, Sri Lanka, Vietnam; Countries, territories or areas of destination: Bahrain, Hong Kong Special Administrative Region of the People's Republic of China, Japan, Malaysia, Republic of Korea, Thailand, United Arab Emirates).*

***Methodology:*** *Participatory research; development of a common framework for each country studied; in-depth interviews with migrants and other stakeholders; focus group discussions; participatory learning and action methods (e.g. mapping, priority ranking).*

**Key findings:** Extremely wide variations in practices: abuses documented, as well as a few examples of good practice.

Problems for migrant workers include:

- **Pre-departure**: costs (including cost of travel to medical exam sites), poor quality exams, lack of counselling or poorly adapted counselling (e.g. not in migrant's language), exams carried out in ways that compromise dignity, lack of information about results. As the official exam will leave a permanent record on the worker's passport, the report documents a practice of 'pre-medicals' carried out before an official exam, so that potential migrants can make sure they will pass the latter. In at least one country, a CARAM researcher posing as a migrant with a problem documented that it can be possible to bribe an official to 'fix' a negative test result.
- **At destination**: necessity to repeat medical exams (thus additional cost), fear of results, lack of explanation, long waits between various elements of the check-up. Generally better exam conditions than in some countries pre-departure, although with language problems (including need to sign consent forms in a language the migrant does not understand).

Those found 'unfit' are simply asked to leave. They may receive no information about test results, no counselling, and no referral. Deportation is often immediate, or the migrant is placed in detention until deported. Some workers who are ill return home for treatment to avoid having 'deported' stamped on their passports.

Undocumented workers have no health checks, and little or no access to care and support. In some instances, countries do not require HIV testing, but employers or recruitment agencies do. Many migrants had misconceptions about who was requiring tests.

Tests may create a false sense of security for the migrant: some interpreted passing the medical exam as a sign that they are healthy, and thus can engage in risk behaviours. On the other hand, well done health checks can be reassuring.
On return, migrants deported for health reasons face severe economic consequences: families had often gone heavily into debt to send a worker abroad, and premature return means loss of that investment, as well as loss of the remittances the worker would have sent home. Returnees also experience stigma, discrimination, lack of referral and of support, inadequate links with national or local treatment and support facilities, exploitation by "quacks" offering false cures for AIDS.

The report ends with a regional analysis of testing policies in places of origin and destination; testing practices (pointing out that health examinations and HIV testing can be an extremely lucrative business, in which it is in the interest of the testing centre to carry out exams as fast as possible, skip time-consuming counselling, and repeat tests whenever possible) and the necessary monitoring mechanisms. The CARAM regional report also discusses informed consent; pre-test and post-test counselling; confidentiality of health testing and test results; the need for sensitivity to gender, dignity and cultural factors; referral; strategies for coping with mandatory health tests; access to treatment and support; deportation; and the impact of results.

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**ACHIEVE and CARAM (2005), *Health at stake: Report on access to health for Philippines overseas workers.* Quezon City, Philippines: Action for Health Initiatives Inc.**
http://www.achieve.org.ph/Philippine%20SoH%20Report.pdf

"[B]ehind good policies and intentions the realities may be different" (Wolffers, p.ix). Point of view of a sending country in which national epidemiological reports indicate that 34% of reported HIV infections are among people who have been working overseas.

***Subjects covered:*** *Health; labour migration from the Philippines, pre-departure, while abroad, on reintegration.*

***Location:*** *Philippines*

***Methodology:*** *Literature review; focus group discussions; interviews with migrant workers and other relevant stakeholders*

**Key findings:** Although the Philippines AIDS law prohibits HIV testing as a requirement for employment, migrant workers may be required to undergo such testing by the governments of the countries of destination. Departing workers may not be aware they have been tested, and it may not occur to them that they may be vulnerable to HIV or other STIs. Many see testing simply as a routine requirement, without which they cannot work abroad: they generally do not mind having to undergo tests as long as they keep getting "clear" results. Anonymity and confidentiality is breached because diagnostic clinics are required by their clients (recruitment agencies) to forward all medical test results to the agency rather than to the worker. Pre- and post-test counselling are not always carried out, and are not sufficiently monitored.

At destination, health is not usually a priority for migrant workers; symptoms are ignored until it is not possible to do so any more. Migrant workers may not know where to go for care. They may not have health insurance, or may be insured but not know that they are, or what is covered by their insurance. Workers in difficulty abroad may be afraid to contact the Philippines Embassy for assistance because of fear that they will be sent back home.
Migrant workers diagnosed HIV-positive abroad will most likely be deported immediately, without counselling and with no chance to organize their possessions or claim their salaries and other benefits. Those who cannot be deported immediately may be detained. Impacts are psychological (discovering HIV status, fear, frustration), loss of income, and possibly exposure to other infections while in detention.

Migrant workers who return home ill are not provided with follow up care and support in any way, and no data is available concerning what happens to them. Embassies are not informed

and thus cannot assist, and workers are unaware of the services the embassies might have been able to provide. The heaviest impact of HIV infection among migrant workers is usually economic: an HIV positive result in the medical examination automatically disqualifies a person from further overseas employment, and unemployment is high in the Philippines.

A migrant worker's HIV infection also affects their family, and the broader community. Where there is insufficient access to HIV prevention, an HIV-positive worker may expose a spouse or other partner to the virus. In the event of HIV-related illnesses, the family's income is further compromised when medical expenses rise. Children's education may be sacrificed to meet medical expenses.

Stigma and discrimination against people living with HIV are still high among the general public in the Philippines, and stigma is spilling over to the migrant worker community: advocacy to create awareness on HIV and AIDS vulnerability of migrant workers may have inadvertently caused labelling. In addition to HIV stigma, migrant workers who return home because of HIV also face diminished status in the family and community, as those who are working abroad (especially those who are successful) are looked up to, even envied. It becomes very difficult to avoid questions from friends and relatives as to why a former overseas worker has not embarked on another contract abroad. It is reportedly common among migrant workers who were diagnosed with HIV to say that they have cancer or leukaemia.

The report concludes that, while laws and policies are important to guarantee the protection and promotion of workers' rights, the mere existence of laws and policies does not necessarily guarantee that health care and services are accessible. Existing laws and policies may not be sufficiently strong, they may not be adequately implemented, or they may be too easy to circumvent.

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**See also:**

- CARAM (2002), *Forgotten spaces.*
- CARAM (2005), Country reports for the 'State of Migrants Health' 2005 report. The Nepal report, especially, discusses the importance of the reason for health checks from the migrant's point of view: being allowed to migrate is the priority, not health.
- CARAM (2002), Report of the consultation with the UN Special Rapporteur on the human rights of migrants (succinct listing of impacts of a positive HIV test for overseas workers and their families)

All available from:
http://www.caramasia.org/index.php?option=com_content&task=section&id=29&Itemid=347

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**S F Morin, H Carrillo, W T Steward, A Maiorana, M Trautwein, and CA Gomez (2004), "Policy perspectives on public health for Mexican migrants in California", *Journal of Acquired Immune Deficiency Syndromes* 37 Suppl 4:S252-S259.**

Addresses public policies that affect primary HIV prevention and access to HIV care for Mexican migrants residing in California; one of five reviews concerning HIV, AIDS and migration among Mexican migrants, published as a special issue of JAIDS.

*Subjects covered:* *public policy; HIV prevention and access to HIV care for migrants.*

***Location:*** *United States of America*

***Methodology:*** *Review*

**Key findings:** California accounts for 15% of the cumulative AIDS cases reported in the United States, with Latinos comprising 20% of these cases. Although Mexico's population is three times larger than California's population, it has only one third as many reported AIDS cases. The higher prevalence of HIV in California is taken to mean that Mexican migrants, on average, are more likely to be exposed to HIV in California than in Mexico.

Laws limiting the entry and stay of people living with HIV may serve as a barrier for primary HIV prevention and care for Mexican migrants. Mexican nationals living in the United States are required to undergo HIV testing when they apply for legalization. If they test positive, they are permanently excluded from entry into the United States, are ineligible for services, and are subject to deportation. For those who have reason to believe they could be infected, the immigration policy can thus be a major deterrent to HIV testing, and a barrier to prevention and early intervention.

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**M Zencovich, K Kennedy, DW MacPherson and BD Gushulak (2006), "Immigration medical screening and HIV infection in Canada", *International Journal of STD & AIDS* 17(12): 813-816.**

This article notes that in 2002 and 2003, 635,000 HIV tests were carried out for immigration health assessments in Canada. Of these, 932 came back HIV-positive. The highest rates of HIV infection were found in migrant applicants from high prevalence areas, and reflected the demographic profile of the source region (predominately women). Of those found HIV-positive, 80% were either already in Canada or nevertheless legally admissible to the country (for example because they were refugees or already had family in Canada). The authors underline the need to adjust services and case management to the linguistic and cultural profile of affected patients.

*Travellers*

**M Mahto, K Ponnusamy, M Schuhwerk, J Richens, N Lambert, E Wilkins, DR Churchill, RF Miller and RH Behrens (2006), "Knowledge, attitudes and health outcomes in HIV-infected travellers to the USA", *HIV Medicine* 7: 201–204.**

***Subjects covered:*** *Travel to the United States by HIV-positive individuals; whether or not United States visa and waiver regulations were respected; effect of travel restrictions on adherence to antiretroviral treatment.*

***Location:*** *United Kingdom (urban centres)*

***Methodology:*** *Questionnaires filled out by patients attending HIV clinics in 2004: Manchester (n=408), Brighton (n=346), London (n=359); overall response rate 67%.*

**Key findings:** Three hundred and forty nine people (31%) had travelled to the United States since testing HIV-positive, usually as tourists. About 60% were aware of the need for a visa waiver, but only 14% actually travelled with one.

Thirty-nine people from Manchester and London had their hand baggage searched on arrival in the United States. None were refused entry. About half of those who could add comments about their travelling experience to the United States did so, reporting worry and stress, feeling discriminated against, and concerns about being discovered.

69% (n=212) of respondents were on antiretroviral treatment, of whom 27 (11%) stopped their medication. Twenty-eight mailed their medication in advance, of whom 25 received it on time. Of those who discontinued treatment, 44% did so without seeking medical advice. Several reported that they did so because they were 'entering a country with an official travel ban for HIV positive subjects', were afraid of being searched by immigration authorities or had a 'fear of being found out'.

Of those discontinuing HAART, 11 were on an NNRTI-based regimen which needs to be stopped sequentially in order to avoid developing NNRTI-resistant virus. Of those who consented to a case-notes review (9/10 in Brighton, 4/7 Manchester), one developed NNRTI-based mutation.

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**E Salit, M Sano, AK Boggild and KC Kain (2005), "Travel patterns and risk behaviour of HIV-positive people travelling internationally",** ***Canadian Medical Association Journal*** **172(7): 884-888.**

***Subjects covered:*** *International travel activities and pre-travel precautions by HIV-positive people; burden of illness and risk exposure during travel.*

***Location:*** *Toronto, Canada*

***Methodology:*** *Anonymous survey among 290 HIV-positive people attending a tertiary care hospital HIV clinic.*

**Key findings:** Only one-fifth of the HIV-positive people surveyed who travelled internationally sought advice from a health professional before their trip. A quarter of those seeking advice enquired about border and visa requirements, 40% about travel-related diseases.

Of the 133 international travellers, 119 (89.5%) were taking antiretroviral therapy. Overall, 53 of the 119 adhered to the therapy while travelling, while 35 either stopped taking the medications or adhered poorly. Fourteen of the 35 reported having stopped antiretroviral therapy just before their trip, only half of whom had discussed the discontinuation with their physician. Ten reported that they stopped their medications because they were afraid to cross borders with antiretroviral medications.

Five of the 119 respondents taking antiretroviral therapy reported that they had been harassed crossing borders; four attributed this to their antiretroviral medication or their HIV status.

## B. Other reviews relevant to assessing the impacts of restrictions

A number of reports, studies and other documents over the years have discussed the public health, cost, and ethical and human rights issues concerning HIV-related restrictions on entry, stay and residence.[7] This section of the bibliography focusing on impact presents more recent reports and analysis that, although they do not attempt to directly assess the impact of travel restrictions, do evoke the subject. The first is an extensive review of population mobility and HIV in Asia, in which a 10 page section discusses the premature return of people who had gone abroad to work.

Three secondary sources are also presented. These are the results of expert reviews in countries considering changes to regulations concerning the entry, stay and residence of people living with HIV (Canada, the United Kingdom and the United States). Although quite different from each other, the three reviews give a comprehensive picture of the issues, including of the problems associated with restrictions.

In some countries, immigrants and travellers who are discovered to have HIV may be placed in detention while awaiting deportation. A final sub-section lists two recent publications about immigrant detention centres.

*Literature reviews and expert findings*

**G Hugo (2001), *Population, Mobility, and HIV/AIDS in Indonesia*. UNDP-SEAHIV, ILO, UNAIDS, and AusAID.**
http://www.hivdevelopment.org/Publications_english/Population%20Mobility.htm

Focuses on a significant country of origin of migrants. Report contains ten pages on migrants returning before the end of their contracts, possibly for health reasons. This is one of the rare studies to explicitly address issues of return migration.

***Subjects covered:*** *population mobility and HIV*

***Location:*** *Indonesia*

***Methodology:*** *Review of the literature*

[7] See in particular:

AJ Zuckerman (1986), "Would screening prevent the international spread of AIDS?" *Lancet* 2(8517): 1208-1209.

M Duckett and AJ Orkin (1989), "AIDS-related migration and travel policies and restrictions: *a global survey", AIDS* 3(Suppl 1): S231-S252.

N Gilmore, AJ Orkin, M Duckett, and SA Grover (1989), "International travel and AIDS", *AIDS* 3(Suppl 1): S225-S230.

LO Gostin, PD Cleary, KH Mayer, AM Brandt and EH Chittenden (1990), "Screening immigrants and international travelers for the human immunodeficiency virus", *New England Journal of Medicine* 322(24): 1743-1746.

G Goodwin-Gill (1996), "AIDS and HIV, Migrants and Refugees: International Legal and Human Rights Dimensions", in M Haour-Knipe and R Rector (eds), *Crossing Borders: Migration, Ethnicity and AIDS*. London: Taylor and Francis, at p.50-69.

J-Y Carlier (1999), *The free movement of persons living with HIV/AIDS*. Luxembourg: European Union HIV/AIDS Programme in Developing Countries, European Commission.

B Hoffmaster and T Schrecker (2000), "An ethical analysis of the mandatory exclusion of immigrants who test HIV-positive". Montreal: Canadian HIV/AIDS Legal Network.

R Coker (2003), *Migration, public health and compulsory screening for TB and HIV*, Asylum and Migration Working Paper 1. London: Institute for Public Policy Research.

**Key findings** (related to return with HIV): Regular workers going overseas are given health checks, but this does not include HIV testing. Some are tested for HIV at destination, as required by country of destination, or by the employer. Testing may be repeated after 6 months, then on renewal of contract. Workers may be sent home if found HIV-positive. They are usually not told that they have HIV, just that they have failed the medical. Irregular workers do not have health checks.

Contracts are usually for three years, but substantial numbers of workers return early, usually for health reasons (from 12 to 60% of all workers, depending on the study). A study from West Java showed that only half returned because they had completed their contract, 9% because they were sick. Negative effects of premature return include the experience itself for the worker; financial losses, especially when the worker had gone into debt to be able to travel; and creating a poor image for Indonesian workers.

Data collected in 1998-99 at the Jakarta airport among returning workers, mostly from the Middle East, found that one-third were returning prematurely: one-quarter after less than a year, one-tenth after less than three months. About 5% returned for health reasons, although some returnees giving other reasons may in fact have failed medical exams at destination. (Information concerning HIV status was not requested.)

The review includes examples of stigmatizing press in destination countries (e.g. Malaysia, Singapore) in which foreign workers are accused of bringing HIV into the country.

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**Alana Klein (2001), *HIV/AIDS and immigration: final report*. Montreal: Canadian HIV/AIDS Legal Network.**
http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=853

> ***Subjects covered:*** *History of restrictions meant to protect the public health and the public purse, internationally and in Canada; Canadian laws and policies; recommended changes.*
>
> ***Location:*** *Canada*
>
> ***Methodology:*** *Research regarding legal issues; key informant interviews; workshop for discussion; extensive consultation on first draft of report.*

**Key findings:**

- The possible benefits of mandatory testing of immigrants are outweighed by its potential for harm.
- Any exclusion of a prospective immigrant with HIV on public health grounds is discriminatory and inconsistent with current, commonly accepted public health practice.
- When assessing whether a prospective immigrant with HIV would create “excessive demands” on health and social services, each person’s individual circumstances must be taken into account, and demands should be considered “excessive” only when the expected cost of government services estimated over a short period (of a few years at most) exceeds the estimated financial contribution that the applicant will make over the same period, and also outweighs the potential social contributions that the individual is expected to make.

- Prospective immigrants with HIV who have compelling compassionate and humanitarian reasons for being in Canada should be granted permanent resident status, rather than being issued more precarious permits.
- All medical barriers to admission of refugees should be removed.

Concerning the potential impact, the report proposed that:
- Attempts to exclude HIV-positive travellers would be ineffective, create a false sense of security, and divert resources from national prevention efforts.
- Claiming that immigrants with HIV are a threat to public health by virtue only of their HIV status and regardless of their behaviour would stigmatize not only immigrants with HIV, but also all Canadians living with HIV, and all immigrants, regardless of their HIV status.

It also proposed that excluding immigrants with HIV could:
- Cause personal hardship, including possibly encouraging families to leave HIV-positive family members behind, where they may suffer without care, treatment, and family support
- Constitute unlawful discrimination since many would be excluded even though they would not engage in exposure-producing activities with the nationals of the excluding country
- Be grossly disproportionate to any benefit, marginal if any, to be gained in protecting the public health
- Constitute an unjustified generalization, and discriminate against those who would not place excessive demands on health or social services by assuming that persons with HIV would all place excessive demands on health or social services
- Constitute a slippery slope to further exclusion of persons more likely to need health or social services, for example of people over 50 years of age, or of people who have been shown by genetic screening to be at risk of developing genetic conditions that are expensive to treat.

**See also the companion document to the above for analysis:** B Hoffmaster and T Schrecker (2000), *An ethical analysis of the mandatory exclusion of immigrants who test HIV-positive*. Montreal: Canadian HIV/AIDS Legal Network.

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**All-Parliamentary Group on AIDS (2003), *Migration and HIV: Improving Lives in Britain: An enquiry into the impact of the UK nationality and immigration system on people living with HIV*. London: All-Parliamentary Group on AIDS.**

***Subjects covered*** *(inter alia): difficulties of migrants living with HIV in the United Kingdom; potential impact of mandatory HIV testing.*

***Location:*** *United Kingdom*

***Methodology:*** *Series of hearings, expert testimony*

**Key findings:** Regarding potential cost, the report observes that the National Health Service in the United Kingdom is under strain, but for reasons unrelated to migration. Clinicians are frequently faced with an ethical dilemma in their work: whether to treat an individual with HIV in need, or to deny treatment if that person's immigration status does not entitle him or her to care.

As HIV prevalence increases globally, it is logical that the number of individuals coming to the United Kingdom with HIV will also rise; there is a recognized "intrinsic link" between what is happening at the national level and what is happening at the global level. "We will be dealing with this challenge in the most effective way when we can ensure that those who do come to the UK with HIV are treated in a timely and effective manner while at the same time working in international partnerships to develop sustainable health systems and access to treatment at the global level" (p.6).

Some elements of asylum and immigration policies – in particular issues related to non-citizens' access to health care (so-called 'treatment tourism') – have been developed in response to media agendas, led more by prejudice and fear than by factual assessment. A culture of blame surrounding HIV, in particular when it is linked to groups viewed as "potential carriers", discourages people from being tested or revealing their status, with serious implications for prevention and care.

The report notes that "Calls for mandatory testing compound the fear and stigma associated with migrants and HIV by giving credence to the idea that these groups are a danger which society must be protected from and further perpetuates the discrimination against them" (para.30). Such a climate of hostility contributes to driving people with HIV underground, where they become increasingly vulnerable. Testing migrants for HIV upon entry risks creating a false sense of security among the general public. They may conclude that they are not at risk of acquiring HIV, and that only immigrants and asylum seekers carry this risk. By actively singling out HIV as an illness which they would like to keep out of the United Kingdom, officials risk discouraging people already in the country to test. This undermines a very significant component of HIV prevention, which rests on individuals feeling comfortable enough to seek out testing.

"The alternatives to exclusionary policies which seek to keep vulnerable and marginalised people out of the country are to examine policies based on inclusion. This would involve harm reduction, persuasion in modifying lifestyles linked to disease, education, voluntary testing and counselling and protecting privacy and social interests. Inclusive border controls can be helpful for improving diagnosis, links with healthcare services and immigration services, facilitating access and reinforcing partnerships between sending and receiving countries" (para.61).

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**P Nieburg, JS Morrison, K Hofler and H Gayle (2007), *Moving beyond US government* policy *of inadmissability of HIV-infected non-citizens*. Washington, DC: Center for Strategic and International Studies.**

***Subjects covered:*** *United States ban on entry of people living with HIV; issues and rationale at the time the policy was established in 1987; subsequent efforts to change the policy; current procedures regarding visa application and HIV waiver process for various categories of entrants; policy options. Includes extensive footnotes and basic reading list for US issues.*

***Location:*** *United States of America*

***Methodology:*** *Expert panel review*

**Key findings:** Exact data on numbers of HIV-infected persons admitted — or denied admission — through the current waiver system are not publicly available, but based on annual US Department of State summaries of immigrant and non-immigrant visa ineligibilities, one very rough upper limit approximation is that between 2002 and 2005, well below 500 people per year were denied admission to the United States because of HIV.

The report notes that the public health rationale for restrictions, if ever valid, is no longer valid. Recent studies involving HIV-positive immigrants in the United States concluded that many, if not most, had been infected after arrival (see also Harawa *et al* below). The authors also note that a quarter of US residents with HIV are unaware of their infection, and current inadmissibility policy may provide a false sense of security. Immigrants already legally in the United States may be reluctant to seek HIV testing or care because they believe they would be subject to deportation if immigration authorities became aware of their HIV infection (see Morin *et al* above).

Concerning potential cost: "Assuming that current immigrant visa categories remain essentially unchanged, and assuming that affidavits of support and public charge tests continue to be required, it is difficult to envision a large additional economic burden resulting from a more open admission policy for HIV-infected people" (p.13).

Concerning leadership: "There is an emerging consensus that the current policy of excluding otherwise eligible HIV-infected visa applicants is counterproductive, rooted in discrimination, and damaging to U.S. HIV/AIDS credibility and leadership" (p.11).

### *Assessments of immigrant detention practices and facilities*

People living with HIV who have had their HIV status discovered upon entry into a country with HIV-related restrictions, or through periodic testing administered during their stay, may be placed in detention centres while awaiting deportation. A thorough review of the impact of such detention is beyond the scope of this bibliography, but two recently published reviews provide a starting point for further exploration of the subject. Both documents describe lamentable conditions for immigrants held in detention, including lack of appropriate health care in general, as well as an absence of HIV-related care more specifically.

**Human Rights Watch (2007), "Chronic Indifference – HIV/AIDS Services for Immigrants Detained by the United States",** ***Human Rights Watch*** **19(5G).**

***Subjects covered:*** *Detention of immigrants in the United States; immigrant detention facilities and conditions; accountability; legal standards; access to HIV and AIDS treatment in detention centres; recommendations.*

***Location:*** *United States of America*

***Methodology:*** *Interviews with current and former detainees, and Department of Homeland Security and detention facility officials; independent medical review of treatment provided.*

**Key findings:** At the time of the report's publication, the United States was holding nearly 28,000 immigrants in federal detention centres, privately run prisons, and county jails. These included undocumented persons, legal permanent residents, asylum seekers, families, and unaccompanied children. Mandatory detention had been expanded to include perpetrators not only of crimes designated as "aggravated felonies" but of any crime involving "moral

turpitude", a phrase interpreted to justify the detention and deportation of persons guilty of shoplifting, drunk driving and minor drug offences.

Persons subject to the United States' "HIV ban" may also be detained while awaiting decision on an application for waiver. Persons not eligible for waiver may be detained pending removal proceedings.

The investigation of HIV and AIDS care for detained immigrants found that detention facilities failed to:

- Deliver complete antiretroviral regimens in a consistent manner (thus creating a risk of drug resistance that endangers the health of the detainee and that can impact public health);
- Adequately monitor detainees' clinical condition;
- Prescribe prophylactic medications when medically indicated;
- Ensure continuity of care as detainees are transferred between facilities, including access to necessary specialty care; and
- Ensure confidentiality of medical care, thus exposing detainees to discrimination and harassment.

Policies and procedures were found to be conflicting, confusing and incomplete, and to fail to conform to national and international guidelines for HIV/AIDS care in correctional settings.

**See also:** American Civil Liberties Union of New Jersey (2007), Behind Bars: The Failure of the Department of Homeland Security to Ensure Adequate Treatment of Immigration Detainees in New Jersey. http://www.aclu-nj.org/downloads/051507DetentionReport.pdf

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**Treatment Action Campaign (2008), "Special Report on Systematic Abuse of Immigrants", *Equal Treatment* 25: 4-27.**
http://www.tac.org.za/community/files/file/et25.pdf

A special issue of the Treatment Action Campaign newsletter, *Equal Treatment*, published in June 2008, documented systematic abuse of immigrants in South Africa detention centres as well as highly inadequate health care and sanitary conditions.

## C. Research indirectly related to impact

The two previous sections have described studies directly related to the impact of HIV-related restrictions on entry, stay and residence, as well as expert reviews addressing the impact of such restrictions more indirectly. As already noted, very few studies have directly examined the impact of such restrictions. This section thus turns to studies on other matters which may be relevant to an assessment of the impacts.

Since the earliest efforts to analyse HIV-related restrictions and their impacts, although variously formulated the main arguments against them[8] have been that they are:

- Ineffective
- Counter-productive, and
- Costly.

This section presents research that relates to such arguments. Each of the themes could be the object of a specific study or extensive review of the literature. The material presented is not exhaustive, but is meant to suggest points of departure and stimulate reflection.

### ***Travel restrictions are ineffective***

Several reasons have been put forward to suggest that travel restrictions are ineffective, in particular that:

- HIV is already in every country. Annual UNAIDS/WHO epidemiological reports have shown this for some time now. Studies of the spread of HIV subtypes give a data-driven means of examining the distribution of the virus globally.
- People to whom travel restriction are *not* applied (e.g. returning nationals or tourists) bring HIV into countries. Ever since the beginning of the epidemic, it has been shown that HIV may be carried across borders by nationals returning home after working abroad, as well as by people who are mobile for other reasons. A growing number of studies are examining tourism in relation to HIV. However, given the importance of tourism revenues, few countries prohibit the entry of prospective tourists.
- Immigrants are infected after they arrive in destination countries. HIV vulnerability associated with migration has been described in a number of publications. Some studies addressing issues of where migrants may have been infected and under what circumstances are included below.

*Studies on the spread of HIV subtypes*

**MM Thomson and R Najera (2001), "Travel and the introduction of human immunodeficiency virus type 1 non-B subtype genetic forms into Western countries", *Clinical Infectious Diseases* 32(12): 1732-1737.**

**L Perrin, L Kaiser and S Yerly (2003), "Travel and the spread of HIV-1 genetic variants", *Lancet Infectious Diseases* 3(1): 22-27.**

[8] See *Report of the International Task Team on HIV-related Travel Restrictions: Findings and Recommendations*, available at www.unaids.org, for relevant references.

**JM Achkar, ST Burda, FA Konings, MM Urbanski, CA Williams, D Seifen, MN Kahirimbanyi, M Vogler, M Parta, HC Lupatkin, S Zolla-Pazner and PN Nyambi (2004), "Infection with HIV type 1 group M non-B subtypes in individuals living in New York City",** ***Journal of Acquired Immune Deficiency Syndromes*** **36(3): 835-844.**

**L Buonaguro, M Tagliamonte, M Tornesello and F Buonaguro (2007), "Genetic and phylogenetic evolution of HIV-1 in a low subtype heterogeneity epidemic: the Italian experience",** ***Retrovirology*** **4:34.**

***Subjects covered:*** *Distribution of viral subtypes*

***Location:*** *global*

***Methodology:*** *Reviews (Thomson and Najera; Perrin et al); gene analysis of patients likely to have non-B subtype (Achkar et al)*

**Key findings:** "The spread of the HIV-1 pandemic worldwide is essentially a travel story whose episodes can be traced by epidemiology and molecular tools" (Perrin *et al,* p.22). All articles document the presence of a wide variety of genetic subtypes in countries throughout the world, with new forms of HIV carried by travellers infected in other regions.

The two review articles note that some groups of travellers may be at risk of transporting HIV subtypes to new areas, thus increasing the diversity of HIV-1 worldwide. Apart from immigrants, these include military personnel, tourists, seafarers, truck drivers, expatriates, diplomats, and businesspeople. In addition, Perrin *et al* note that in large countries such as Russia, China, India, Brazil, and South Africa, internal migrants contribute largely to the spread of HIV-1 diversity. Of particular interest here is that most of the above groups are difficult to affect by HIV-related restrictions on entry, stay and residence.

Both reviews note, in addition, that in Cuba new strains of HIV were probably introduced by Cuban troops who served in large numbers in Angola in the 1970s and 1980s, and by advisers and other aid workers who served in several countries in sub-Saharan Africa. More recently, Cuba has become a preferred destination for tourists from Western Europe, creating other possibilities for mixing subtypes if effective HIV prevention is absent.

### *Travellers and HIV*

**BJ Ward and P Plourde (2006), "Travel and sexually transmitted infections",** ***Journal of Travel Medicine*** **13(5): 300-317.**

"From the Huns and Vikings to the current day, unscrupulous military and paramilitary commanders have used sex to motivate men to march across deserts, row open boats across oceans, and face all manner of other perils... there has been a remarkable democratization of travel: exotic itineraries are now accessible to a large majority of those living in the developed world including both genders and the extremes of age. Sex is still sex, however, and many will still do remarkably silly things in its pursuit" (Ward and Plourde, p.300).

***Subjects covered:*** *sexual risk-taking behaviour in the context of travel and mobility*
***Location:*** *global*
***Methodology:*** *Extensive review article (178 item bibliography)*

**Key findings:** The anonymity of travel, a sense of isolation brought on by unfamiliar surroundings, and the desire for unique experience all encourage travellers to shed social and sexual inhibitions. Across various studies, reports of casual sexual experiences during travel vary between 5% and 51%. Females as well as males now report casual sex while travelling, though with quantitative and qualitative differences in behaviour.

Individuals who acquire new sexual partners while travelling, especially those who pay for sex or have multiple casual partners overseas, are at risk for a wide range of sexually-transmitted infections. According to the literature review, travellers who may be at particular risk include: expatriates, travellers returning to their countries of origin to visit family and relatives, military personnel, seafarers and men who have sex with men.

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**MA Schuhwerk, J Richens, and JN Zuckerman (2006), "HIV and travel", *Travel Medicine and Infectious Disease* 4(3-4):174-183.**

These UK authors state that there is a high demand for travel among HIV-positive individuals. They note that those who have benefited from advances in antiretroviral therapy are living longer, have a better quality of life, and are at reduced risk of opportunistic infections. Another reason posited by the authors is that those with advanced disease may experience a strong desire to take a last chance to travel.

*Returning expatriates*

There are numerous studies referring to HIV brought home to Western countries by returning expatriates, starting with Vittecoq's 1987 mention of 17 French patients infected in Central Africa.[9] See for example:

**F Kane, M Alary, I Ndoye, AM Coll, S M'Boup, A Gueye, PJ Kanki, and JR Joly (1993), "Temporary expatriation is related to HIV-1 infection in rural Senegal", *AIDS* 7(9): 1261-1265.**

**R de Graaf, G van Zessen, H Houweling, RJ Ligthelm and R van den Akker (1997), "Sexual risk of HIV infection among expatriates posted in AIDS endemic areas", *AIDS* 11(9): 1173-1181.**

**ME Jones (1999), "HIV and the returning expatriate", *Journal of Travel Medicine* 6(2): 99-106.**

[9] D Vittecoq, T May, RT Roue, M Stern, C Mayaud, P Chavanet, F Borsa, P Jeantils, M Armengaud and J Modai (1987), "Acquired immunodeficiency syndrome after travelling in Africa: an epidemiological study in seventeen Caucasian patients", *Lancet* 1(8533):612-615.

*Truck drivers*

A large number of studies have addressed HIV risk and vulnerability among long-distance truck drivers. See for example:

**Synergy Project (2000), *Putting on the brakes*.**
http://www.synergyaids.com/documents/Submoduletruckers.pdf

**D Stratford, TV Ellerbrock, JK Akins and HL Hall (2000), "Highway cowboys, old hands, and Christian truckers: risk behavior for human immunodeficiency virus infection among long-haul truckers in Florida", *Social Science and Medicine* 50(5): 737-749.**

**IOM and UNAIDS (2005), *HIV and Mobile Workers: A review of risks and programmes among truckers in West Africa*. Geneva: IOM.**
http://siteresources.worldbank.org/INTTSR/Resources/462613-1135099994537/MIL6010070.pdf

**SA Lippman, J Pulerwitz, M Chinaglia, A Hubbard, A Reingold and J Diaz (2007), "Mobility and its liminal context: exploring sexual partnering among truck drivers crossing the Southern Brazilian border", *Social Science and Medicine* 65(12): 2464-2473.**

*Immigrants, migrants and HIV*

**NT Harawa, TA Bingham, SD Cochran, S Greenland, and WE Cunningham (2002), "HIV prevalence among foreign- and US-born clients of public STD clinics", *American Journal of Public Health* 92(12): 1958-1963.**

***Subjects covered:*** *Differences in HIV seroprevalence and likely timing of HIV infection by region of birth*

***Location:*** *Los Angeles county, United States of America*

***Methodology:*** *Analysis of unlinked HIV antibody data on 61,120 specimens drawn for routine syphilis testing among attendees of seven public STD clinics, 1993-1999.*

**Key findings:** 38% (n=23,310) of the patients were foreign-born, 62% (n=37,810) were US-born. The largest percentage of foreign-born clients (87%, n=20,208) were from Central America and Mexico.

HIV-positive clients from all but two regions had immigrated in their late teens or very early 20s and had lived in the United States for an average of 12 years. Since the median time between HIV infection and AIDS diagnosis in untreated cases is 10 to 12 years, and the largest proportion of documented AIDS cases are reported in persons aged 30 through 39 years (generally indicating HIV infection during the clients' 20s), the data therefore suggests that most of the HIV-positive clients of the sexually-transmitted disease (STD) clinics in the study were infected after immigration to the United States.

In contrast to the other foreign-born clients, clients born in sub-Saharan Africa had immigrated at older ages and had spent fewer years in the United States. These divergent

patterns probably resulted from the US Immigration Act of 1990, which fuelled large increases in African immigration during the 1990s.[10] It seems reasonable to assume that a majority of the HIV-positive clients from this region were infected in their countries of origin. (Note, however, that the article does not address how the immigrants with HIV were admitted to the US. They may have undergone the mandatory testing but been granted permission to enter regardless of their status.)

**See also:**

**TM Painter (2008), "Connecting the dots: when the risks of HIV/STD infection appear high but the burden of infection is not known—the case of male Latino migrants in the southern United States", *AIDS and Behavior* 12(2): 213-226.**

This article reviews the literature on HIV risk factors for Latino immigrants to six southern US states, which have recently been seeing a rapid rise in the number of young, foreign-born males who arrive in destination communities without female partners.

**MG Shedlin, E Drucker, CU Decena, S Hoffman, G Bhattacharya, S Beckford and R Barreras (2006), "Immigration and HIV/AIDS in the New York Metropolitan Area", *Journal of Urban Health* 83(1): 43-58.**

This paper focuses on three different immigrant populations in New York city (new Hispanic immigrants from the Dominican Republic, Mexico and Central America; immigrants from Jamaica, Trinidad/Tobago and other English-speaking Caribbean nations; and South Asian immigrants from India), discussing the differences and commonalities in the social, attitudinal and behavioural factors contributing to increased vulnerability to HIV and AIDS.

**EE Foley (2005), "HIV/AIDS and African immigrant women in Philadelphia: structural and cultural barriers to care", *AIDS Care* 17(8): 1030-1043.**

The author of this study points out that unlike settled refugees or asylum seekers, international visitors who obtain tourist, student or business visas to enter the United States are not required to undergo HIV testing as part of their application process.[11] Pregnant women are eligible to receive free pre-natal consultations in Philadelphia if they are residents. HIV testing is now a routine part of pre-natal care, and it is often in this context that the African women test positive.

This qualitative study revealed a number of problems for such women, including several that are pertinent for this review. These include fear of the American health system; AIDS-risk denial; stigma both from HIV and from being an African; and lack of cultural understanding – tinged with racism – on the part of caregivers. On the other hand, the study described other caregivers who find ways to assist both documented and undocumented patients without

[10] AP Lobo (2001), "US diversity visas are attracting Africa's best and brightest", *Population Today* 29:1–2, cited in Harawa *et al*.

[11] This statement demonstrates one of the difficulties in applying – and also examining the impact of – HIV-related restrictions on entry, stay and residence. While at the time the study was carried out such visitors were not routinely required to be tested for HIV to obtain their visas, they were required to answer a specific screening question about having a 'communicable disease of public health significance'. Those who knew they had HIV could apply for a 'waiver of HIV-related inadmissibility'. Such waivers may (or may not) have been granted on a discretionary and case-by-case basis (see Nieburg *et al*, 2007, for a description of rules and procedures for various types of applicant). Those who had HIV but were not aware of it could simply have entered the country.

health insurance. The women's attitudes to testing and treatment in the United States were shaped by the lack of antiretroviral treatment and high mortality rates in their home countries.

**L Doyal and J Anderson (2005), "'My fear is to fall in love again...' how HIV-positive African women survive in London", *Social Science and Medicine* 60(8): 1729-1738.**

These authors, who have published several papers describing their research with women under HIV treatment in London, describe remarkably similar experiences in the United Kingdom.

**FF Hamers, I Devaux, J Alix and A Nardone (2006), "HIV/AIDS in Europe: trends and EU-wide priorities", *Euro Surveillance* 11(11): E061123.**

The European Centre for Disease Control documents that an increasing proportion of new heterosexual HIV infections reported in Europe are diagnosed in immigrants, and recommends increasing voluntary HIV testing and providing specific services for migrant communities.

*Studies showing a relation between migration – often circular migration – and the spread of HIV in different regions of Africa*

**JR Glynn, J Ponnighaus, AC Crampin, F Sibande, L Sichali, P Nkhosa, P Broadbent, and PE Fine (2001), "The development of the HIV epidemic in Karonga District, Malawi", *AIDS* 15(15): 2025-2029.**

This study of sociodemographic risk factors for HIV infection during the early stages of the epidemic used a strategy comparable to the Harawa *et al* study above. In this case, blood samples drawn between 1981 and 1989 for a different purpose (a leprosy study) were analysed. The study was carried out in a rural area with one small town and two nearby international borders. A main road was built through the district in 1988, and there is also a small port on Lake Malawi. Two total population surveys had been carried out at the time the blood samples were drawn for the leprosy study, including information on previous areas of residence and socioeconomic variables.

Retrospective analysis showed that in the early 1980s, eight out of the 11 HIV-positive individuals were either new immigrants to the district or had recently returned there. In the late 1980s, immigration, and having spent time outside the district, continued to be major risk factors for HIV. HIV prevalence was higher among those of higher socioeconomic status, those who lived in the best houses, and those in occupations other than subsistence farming – in other words among those whose economic resources had allowed them to travel. The other groups with increased HIV risk were casual labourers and those living in temporary shelters, both of whom are likely to be itinerant.

**E Lagarde, M Schim van der Loeff, C Enel, B Holmgren, R Dray-Spira, G Pison, JP Piau, V Delaunay, S M'Boup, I Ndoye, M Curet-Pellicer, H Whittle and P Aaby for the MECORA group (2003), "Mobility and the spread of human immunodeficiency virus into rural areas of West Africa", *International Journal of Epidemiology* 32(5): 744-752.**

**C Kishamawe, DC Vissers, M Urassa, R Isingo, G Mwaluko, GJ Borsboom, HA Voeten, B Zaba, JD Habbema, and SJ de Vlas (2006), "Mobility and HIV in Tanzanian couples: both mobile persons and their partners show increased risk", *AIDS* 20(4):601-608.**

**M Lurie (2006), "Migrant labour and AIDS: Challenging Common Assumptions. Mobility and HIV/AIDS", in B Dodson and J Crush, *Southern African Migration Project* 6.**

Lurie and colleagues, who have carried out a number of studies of circular migrants over the years in southern Africa, have challenged the often-held assumption that it is male migrant workers who become infected while away, then return home to infect their partners. In studies of HIV-discordant couples in high prevalence regions and at advanced stages of the epidemic, it is in fact often the woman who has remained at home who is HIV-positive. One possible explanation is that some women are left with no alternative other than to exchange sex for subsistence, or for pleasure.

*Studies discussing risk of infection to migrants or others returning to visit high prevalence home countries, territories or areas*

**KA Fenton, M Chinouya, O Davidson and A Copas (2001), "HIV transmission risk among sub-Saharan Africans in London travelling to their countries of origin", *AIDS* 15(11): 1442-1445.**

**MA Kramer, A van den Hoek, RA Coutinho and M Prins (2005), "Sexual risk behaviour among Surinamese and Antillean migrants travelling to their countries of origin", *Sexually Transmitted Infections* 81(6): 508-510.**

**CC O'Connor, LM Wen, C Rissel and M Shaw (2007), "Sexual behaviour and risk in Vietnamese men living in metropolitan Sydney", *Sexually Transmitted Infections* 83(2): 147-150.**

The main point in the above three studies is that HIV may be carried from one location to another by people who are not likely to be affected by HIV-related restrictions on entry, stay and residence, including immigrants infected after they have legally entered a destination country, circular migrants (including those who do not necessarily cross international boundaries), and migrants returning home for visits.

***<u>Travel restrictions are counter-productive</u>***

It has also been suggested that HIV-related restrictions on entry, stay and residence are counter productive: they create mistrust, increase stigma of migrants or foreigners, drive people underground where they become more vulnerable, and create a false sense of security for nationals who are encouraged to think that AIDS is a "foreign" problem.

To address the role of mistrust and fear in delaying care, the review incorporates studies beyond HIV and conducted in the context of tuberculosis and sexually transmitted infections, specifically discussing the experience of migrants.

Numerous examples of studies addressing HIV risk among populations out of the range of formal controls are available; the review focuses on a recently published study in Bangladesh, where movement of two or three different hidden populations across borders between regions with varying HIV prevalence creates a situation of potentially explosive risk.

This subsection of the review concludes with a striking example of the false sense of security that can be created when young people think that such restrictions will have kept HIV out of their country, and that AIDS is thus not a problem that concerns 'us'.

### *Immigrants and care for tuberculosis and sexually transmitted infections*

**S Asch, B Leake and L Gelberg (1994), "Does fear of immigration authorities deter tuberculosis patients from seeking care?",** ***Western Journal of Medicine*** **161(4):373-376.**

**S Asch, S Rulnick, C Todoroff and G Richwald (1996), "Potential impact of restricting STD/HIV care for immigrants in Los Angeles County",** ***International Journal of STD and AIDS*** **7(7): 532-535.**

**S Asch, B Leake, R Anderson and L Gelberg (1998), "Why do symptomatic patients delay obtaining care for tuberculosis?"** ***American Journal of Respiratory and Critical Care Medicine*** **157(4 Pt1): 1244-1248.**

***Subject covered:*** *Access to care among TB and STI patients frequenting public facilities in a county with a high proportion of immigrants*

***Location:*** *Los Angeles, United States of America*

***Methodology:*** *survey of 313 patients with active tuberculosis (1994); survey of 234 STD clinic patients (1996); interviews among 313 TB patients (1998)*

**Key findings:**

- Illegal immigrants may delay seeking care for tuberculosis symptoms because of fear of immigration authorities (1994).
- If measures to bar illegal immigrant residents from receiving non-emergency health services were implemented, such residents would be more likely to either forgo treatment or to seek treatment from sources providing inadequate care for STDs. The consequent untreated STDs would lead to preventable morbidity from pelvic inflammatory disease, perinatal infections, poor birth outcomes and spread of the disease (1996).
- Among TB patients, self-reported delay in seeking care of more than 60 days from symptom onset was strongly associated with fear of immigration authorities. During the delay, patients exposed an average of eight contacts to tuberculosis (1998).

### *Migrant populations and trust of health authorities*

As with many of the other sections of the bibliography, the section on trust and public health as it affects immigrant or minority populations would require a far more thorough review than could be carried out here. A good starting point, however, would be the well-known Tuskegee study of untreated syphilis that seriously damaged the credibility of public health authorities among African-Americans, and has ramifications for HIV prevention and access to care even a generation later.[12]

[12] See SB Thomas and SC Quinn (1991), "The Tuskegee Syphilis Study, 1932 to 1972: implications for HIV education and AIDS risk education programs in the black community", *American Journal of Public Health* 81(11): 1498-1505.

Several of the studies already presented in this bibliography have addressed trust issues, as have European reviews concerning AIDS and migration. A good starting point on the subject is:

**Audrey Prost (2005), *A Review of Research Among Black African Communities Affected by HIV in the UK and Europe*. Glasgow: Medical Research Council, Social and Public Health Sciences Unit. Occasional Paper No. 15.**
http://www.sphsu.mrc.ac.uk/files/File/library/occasional/OP015.pdf

*Mobile populations outside the range of formal controls*

**R Gazi, A Mercer, T Wansom, H Kabir, NC Saha and T Azim (2008), "An assessment of vulnerability to HIV infection of boatmen in Teknaf, Bangladesh", *Conflict and Health* 2:5.**

***Subjects covered:*** *Risk behaviours among boatmen moving between Myanmar and Bangladesh.*

***Location:*** *A small town at the southern tip of Bangladesh, separated from Myanmar by the river Naf. The river serves as a primary crossing point for people travelling back and forth between Bangladesh and Myanmar. The town of about 23,000 inhabitants is a burgeoning tourist spot.*

***Methodology:*** *Initial rapport-building with community members; mapping; in-depth interviews with key informants and members of other vulnerable groups (spouses of boatmen, female sex workers, and injecting drug users); oral questionnaires with 433 boatmen.*

**Key findings:** About 22,000 Burmese refugees live in camps on the Bangladeshi side, but many others are undocumented and live in squalid conditions, attempting to make a living in activities such as fishing, boating, smuggling of goods and sex work. Bangladesh recognizes neither the official nor the unofficial refugees as citizens, rendering the vast majority of the permanent population in this border area stateless.

There has also been an increase in the numbers of people moving back and forth between Bangladesh and Myanmar. The border remains very porous despite efforts at regulation on both sides. Over 40% of the boatmen interviewed had visited Myanmar during the course of their work. 17% of these had commercial sex while abroad; 19% of all boatmen surveyed had sex with another man within the previous year; 14% of boatmen had participated in group sex, with groups ranging in size from three to fourteen people. Condom use was rare, irrespective of type of sex partners.

Only three boatmen reported any past history of injecting drug use, but injecting drug users reported in interviews that they occasionally shared injecting equipment with boatmen. Knowledge regarding HIV transmission and personal risk perception for contracting HIV was low.

The authors conclude that there is great potential for boatmen infected with the virus to spread HIV to their spouses and other sexual partners (both male and female) in their

See also VS Freimuth, SC Quinn, SB Thomas, G Cole, E Zook and T Duncan (2001), "African Americans' views on research and the Tuskegee Syphilis Study", *Social Science and Medicine* 52(5): 797-808.

communities. Local sex workers who have boatmen among their clients are at even higher risk. They are often undocumented migrants from Myanmar who are extremely marginalized and have very little power to negotiate condom use.

*Travel restrictions and public perceptions: false sense of security*

**M Ganczak, P Barss, F Alfaresi, S Almazrouei, A Muraddad and F Al-Maskari (2007), "Break the silence: HIV/AIDS knowledge, attitudes, and educational needs among Arab university students in United Arab Emirates", *Journal of Adolescent Health* 40(6): 572-578.**

***Subjects covered:*** *Students HIV knowledge and attitudes*
***Location:*** *Al Ain, United Arab Emirates*
***Methodology:*** *Written knowledge/attitudes/practices/behaviours questionnaire, 267 first year university students (2005)*

**Key findings:** Students demonstrated many incorrect beliefs about HIV transmission (e.g. could become infected by eating "HIV-infected food", sharing a comb), and attitudes toward people living with HIV were neither friendly nor tolerant. Concerning entry restrictions, 97% of the respondents felt that all people entering the United Arab Emirates should be tested.

HIV testing is mandatory for all foreign workers entering the United Arab Emirates, although tourists and sex workers who enter on tourist visas are excluded from such testing.[13] The authors point out that students may mistakenly believe that universal testing for foreigners would stop transmission of the virus in their own society.

The article notes several potential risk factors for young people in the United Arab Emirates: recent rapid development, with opening of the society to workers or tourists who bring new perspectives and values; increasing ease of international transportation and communication; influence of media; large differences in incomes; and decreased influence of family and religion, which is engendering rapid change in family, cultural, and religious values. Conflict in other countries and related displacement has been associated with the trafficking of young females into the United Arab Emirates and elsewhere. In addition to these factors, the authors observe that citizens of the United Arab Emirates may engage in risk behaviour during travel to higher-prevalence destinations. Injecting drug use, which is not currently believed to be frequent in the United Arab Emirates, is expected to increase because it is highly prevalent in some neighbouring countries.

**See also:** KMA Al Mulla, RNH Pugh, MM Hossain and RH Behrens (1996), "Travel-Related AIDS Awareness among Young Gulf Arab Men", *Journal of Travel Medicine* 3(4): 224-226.

***<u>Discussions of costs and benefits</u>***

Arguments about the costs and benefits of barring the entry, stay and residence of non-nationals with HIV are extremely complex, for a number of reasons. For example, not all costs are costs borne by States; the cost of an HIV test conducted in the screening process is usually

[13] The authors note that mandatory HIV testing of sex workers would be difficult to implement without legalizing a forbidden occupation.

borne by the potential traveller or immigrant. In addition, estimating the potential cost of health care for immigrants, whether HIV-infected or not, is highly dependent on the health care system in the destination country, notably whether services are predominantly publicly-funded, or whether there is greater use of private insurance schemes. In addition, the picture is shifting rapidly as costs for first-line antiretroviral medications are decreasing (although to differing extents depending on the country).

Covering the growing literature on the cost of HIV care was beyond the scope of this review, but one article about the cost of health care for immigrants in the United States was reviewed as an example and starting-point, after which other directions for inquiry are suggested.

*Health-related costs and benefits of immigration*

**SA Mohanty, S Woolhandler, DU Himmelstein, S Pati, O Carrasquillo and DH Bor (2005), "Health care expenditures of immigrants in the United States: a nationally representative analysis", *American Journal of Public Health* 95(8): 1431-1438.**

***Subjects covered:*** *Medical expenditures (immigrants compared with US-born)*

***Location:*** *United States of America*

***Methodology:*** *Analysis of 1998 data on expenditures for health care, emergency department visits, office-based visits, hospital-based outpatient visits, inpatient visits, and prescription drugs concerning 18,398 US-born persons and 2,843 immigrants*

**Key findings:** In their work, the authors cite a comprehensive analysis on the costs and benefits of immigrants to the United States economy, in which the National Research Council concluded that immigrants add as much as US$ 10 billion to the American economy each year, and that over their lifetimes, they will pay an average of US$ 80,000 per capita more in taxes than they use in government services.[14] This study finds that health care expenditures for immigrants are substantially lower than for US-born persons. In 1998, immigrants accounted for a total of US$ 39.5 billion in healthcare expenditure, of which about US$ 25 billion was reimbursed by private health insurers, US$ 12 billion was reimbursed by government programmes, and the remaining – just under US$ 3 billion – was paid out-of-pocket by immigrants.

After multivariate adjustment, the total health care expenditure of immigrants was 55% lower than that of US-born individuals. For example in 1998, Latino immigrants spent an average of US$ 962 each on health care, compared with US$ 1,870 for US-born Latino Americans. Expenditure among uninsured and publicly-insured immigrants was about half that of their US-born counterparts. The findings cannot be explained by "free care", and remained robust even after adjustment for health insurance status.

Overall, the lower health care expenditures by immigrants suggest important disparities in health care use. Alarmingly, disparities are even greater concerning immigrant children, for whom there are low outpatient and office-based visit health expenditures, and higher emergency department expenditures, probably reflecting poor access to primary care.

[14] JP Smith, B Edmonston (1997), *The New Americans: Economic, Demographic, and Fiscal Effects of Immigration.* Washington, DC: National Academy Press.

In sum, the study refutes the widely held assumption that immigrants represent a disproportionate financial burden on the United States health care system. The authors find that the lower expenditures have nothing to do with limiting access to the country, but instead suggest that immigrants face access barriers once they are there, including cultural and linguistic barriers. Fear of deportation is an additional barrier among the 5–10 million undocumented immigrants residing in the United States.

**See also:**

**DP Goldman, JP Smith, and N Sood (2006), "Immigrants and the cost of medical care",** ***Health Affairs (Millwood)*** **25(6): 1700-1711.**

This study employed data on health status and use of services, place of birth, and legal status concerning a representative sample of residents of Los Angeles County, USA, in 2000 to estimate service use and costs of care for non-elderly adults by nativity and type of immigrant, including the undocumented. Foreign-born adults constituted 45% of the population aged 18 to 64, but were found to account for only 33% of health spending. Similarly, the undocumented constituted 12% of the non-elderly adult population, but accounted for only 6% of spending. For the county studied, and also when extrapolating to the national level, the foreign-born (especially the undocumented) were found to use disproportionately fewer medical services and to contribute less to health care costs in relation to their population share. Among other factors, the authors posit that this is due to lack of health insurance.

**A Fowler, L Collins, N Larbalestier, R Kulasegaram, A de Ruiter and V Micunovic (2006), "HIV, HAART and overseas visitors",** ***Sexually Transmitted Infections*** **82(6): 516.**

This article reports on the case of a newly diagnosed HIV-positive patient for whom antiretroviral treatment for HIV was delayed because she was not eligible for treatment in the National Health Service (NHS) and was unable to fund the cost of treatment herself. The patient became severely ill, spent 11 days in intensive care then had a lengthy convalescence period. In the clinical opinion of her physicians, the patient would have avoided both of these negative outcomes had highly-active antiretroviral treatment been started earlier. They conclude that the consequences of delaying treatment may in fact place a greater cost burden on the NHS.

### *Other perspectives on costs and benefits*

Properly assessing costs and benefits associated with entry, stay and residence of people living with HIV may require broader contextualization of the issue, including implications which go beyond the context of HIV. Some examples of articles that illustrate these contextual factors include the following:

**G Brumfiel (2003), "Visa rules leave US colleges facing semester of discontent",** ***Nature*** **423 (6943): 906.**

This article predicted that tightening of visa regulations in the United States (unrelated to HIV) would have negative consequences for universities. The new regulations would keep many foreign students and academic staff out of the country, causing "classes to be cancelled, and

educational and research opportunities to be lost". The author predicted that some students and staff would head for other countries such as Britain, France and Australia.

**M Rice (2004), "New visa 'will attract scientists to Europe'", *European Journal of Cancer* 40(10): 1461.**

The Chief Executive of the European Biomedical Research Association noted that the European Union announced the introduction of a 'scientific visa' to aid the movement of third country researchers both to and within the European Union.

**NJ Gay and WJ Edmunds (1998), "Developed countries could pay for hepatitis B vaccination in developing countries", *BMJ* 316(7142): 1457.**

A World Health Organization publication on migration, health and human rights[15] made the following intriguing observation: "Investing in improving health in poor countries is not a question of altruism but of long-term self-interest. For example, it has been shown by mathematical modelling for hepatitis B that the resources needed to prevent one carrier in the United Kingdom could prevent 4,000 carriers in Bangladesh of whom, statistically, four might be expected to migrate to the UK." Based on this logic, it would be four times more cost effective for the United Kingdom to sponsor a vaccination programme against hepatitis B in Bangladesh than to introduce its own universal vaccination programme.

**DW Light (2007), *Toward an Economic Sociology of Compassionate Charity and Care. Development Working Paper Series.* Princeton: Center for Migration and Development.**

In a discussion paper about use-of-time and what makes people do generous things, Light notes that, rather than prioritize themselves and their pleasures, millions of people give away scarce time and valued resources that they worked to earn. He discusses "compassionate care", defined as the time that health professionals give *pro bono* to people who need it, including irregular migrants and others in vulnerable situations.

**A Pécoud and P de Guchteneire (2006), "International Migration, Border Controls and Human Rights: Assessing the Relevance of a Right to Mobility", *Journal of Borderlands Studies* 21(1): 69-86.**

The authors of this text underline that controlling migration is costly: the 25 richest countries in the world are reported to spend US$ 25 to 30 billion per year on enforcing immigration laws. The costs come from controlling borders, but also from issuing visas and residence permits; prosecuting, detaining and removing undocumented migrants; carrying out labour inspections and implementing sanctions on employers; treating asylum-seekers' claims; resettling refugees; and searching for undocumented migrants. They state that tight migration policies risk generating undocumented migration, smuggling, and human trafficking, which then prompt calls for more control.

Towards a solution, they suggest unpacking "citizenship" and distributing its different components (political, civil, social, family and cultural rights) in a differentiated way. Migrants would receive entitlements related to a first set of rights (civil rights and fundamental social rights), but only later receive full welfare entitlements or political rights in a progressive manner. By avoiding the binary logic of inclusion/exclusion, this approach would ensure that

[15] World Health Organization (2003), *International migration, health and human rights*. Geneva: WHO, at p.8.

migrants are not seen as without rights (as undocumented migrants tend to be) while at the same time enabling high mobility and addressing the reluctance of nationals and long-term residents to extend privileges to temporary residents or newcomers.

## D. Possible approaches to monitoring restrictions on entry, stay and residence, with a view to mitigating their impacts

A selection of reports and handbooks are presented in this final section, as potential models for how HIV-related restrictions might be monitored and their impacts mitigated. The first is a review carried out by the European AIDS & Mobility project, which monitored the way in which the press in 12 European countries discussed migration and HIV. The review was carried out in the aim of assessing potential stigma. The second is a presentation of national policy audits concerning HIV and migration, carried out in four South East Asian countries. A similar process might be used to raise awareness about HIV-related restrictions on entry, stay and residence issues among policy makers and other relevant stakeholders, and to promote positive change.

Finally, there is no doubt that comprehensive and evidence-informed information about HIV, accompanied by access to voluntary counselling and testing, are critical elements in support of HIV prevention and enabling timely access to treatment, care and support. In parallel with efforts to stop mandatory HIV testing and HIV-related travel restrictions, and in acknowledgement that policy change can take time and a great deal of social mobilization, a third document is presented in a spirit of "harm reduction". This element of the annotated bibliography returns to the concept of "migrant friendly testing" discussed in the first section, to discuss the way in which HIV testing and counselling might be carried out in a positive way in the context of immigration health assessments, and promote beneficial health outcomes as people cross borders for various reasons.

### *Media monitoring*

**J del Amo, A Caro, C Martínez, V Field, G Bröring and Press Analyses working group (2005), *HIV/AIDS and migration in European printed media: An analysis of daily newspapers.* Woerden, the Netherlands.**

> ***Subjects covered:*** *information on HIV and migrants being published; how migration and HIV is portrayed by the major newspapers in Europe; misuse of information; stigma; how press stories may promote xenophobia and racism.*
>
> ***Location:*** *Europe*
>
> ***Methodology:*** *48 daily newspapers selected from across 12 countries; identification of all news stories about HIV/AIDS in migrants and/or ethnic minorities, published in any section of the selected newspapers from 1 January to 31 December 2004; pre-defined data collection forms in English were completed by a research team from each country; country teams usually consisted of one person from an NGO and another from a government agency.*

**Key findings:** 150 news stories were considered eligible for the study. The United Kingdom had the highest number of articles (57) followed by Spain (27) and Portugal (22). Poland and Slovenia had no news. The number of articles meeting the eligibility criteria was lower than initially expected. Neither of the two major AIDS events of the year (Bangkok AIDS

conference, World AIDS Day) seemed to have a significant impact on the amount of HIV and migration news. Articles of more than one page were very uncommon.

No author was credited in nearly one-quarter of the articles. Discriminatory messages towards HIV-infected migrants were more common in anonymous articles. Press agency news stories were found to be the least discriminating. Epidemiological/statistical data was present in six out of ten articles, with substantial differences between countries. Discriminatory messages towards HIV-infected people were not found to be more common in news items using epidemiological data.

In all, three out of ten articles were judged to contain discriminatory messages against HIV-infected migrants or ethnic minorities. Clear differences were identified by country, with Lithuania, the United Kingdom and Greece showing the highest proportions of discriminatory messages. The discriminatory messages were closely related with the content of the news, which blamed HIV-infected migrants for costing tax payers large sums of money and bringing HIV into the country. In the United Kingdom, migrants originating from Sub-Saharan Africa were most targeted. For other countries, especially those from the Baltic States, the fear concerned HIV infections originating in Russia.

Content published by conservative newspapers was found to be two-and-a-half times more likely to contain discriminatory content, but discrimination was also detected in two out of ten articles in newspapers whose political orientation was deemed to favour the rights of the disadvantaged. In contrast, 1.5 out of ten contained messages of solidarity towards HIV-positive migrants and ethnic minorities, arguing that all people should have equal rights to HIV treatment and calling for changes in attitudes towards HIV-positive people.

The most common theme in the articles related to European enlargement and the fear of HIV infections coming from “the East”. This concern was much more common in the Baltic States. The United Kingdom was a very distinct case: in comparison with other countries, messages were more often inflammatory in tone; politically-sensitive themes such as "health tourism” and asylum were treated harshly.

This report confirms the importance of the print media as a health communication tool, and the urgent need for HIV and migration specialists to work with and sensitize journalists and newspaper editors.

**Canada South East Asia Regional HIV/AIDS Programme (CSEARHAP) (2006), *Cambodia, Lao PDR, Thailand, Vietnam: Consolidated National Policy Self Audits 2006. Mobility and HIV Vulnerability Reduction in the Greater Mekong Subregion*. Bangkok: CSEARHAP.**

| ***Subjects covered:*** *Compliance with signed agreements related to reduction of mobile populations' HIV vulnerability*<br>***Location:*** *Cambodia, Lao People's Democratic Republic, Thailand, Viet Nam*<br>***Methodology:*** *Development of a regional Strategy on Mobility and HIV Vulnerability Reduction; national capacity-building workshops to present and discuss the international and regional policy instruments relevant to HIV and mobility; development of an audit tool to measure national government perceptions of compliance with the relevant instruments[16]; Reports prepared in each country (supervised by a multisectoral working groups on HIV and mobility) which included representatives of international organizations, NGOs, groups of people living with HIV, donors and other partners.* |
|---|

**Key findings:** In some cases the policy audits caused officials to become aware of their Government's position on issues relating to HIV and mobility for the first time. The first National Policy Self Audit:

- Increased awareness concerning relevant international and regional instruments and respective national commitments among Government officials, policy advisors working on issues relating to HIV and mobility, and other relevant partners;
- Created an opportunity for discussion of critical policy issues;
- Provided a baseline for the evaluation of a country's progress.

*Quality standards: HIV testing and counselling for migrants*

**International Organization for Migration (2006), *IOM Guide for HIV Counsellors: HIV counselling in the context of immigration health assessments*. Geneva: IOM.**
http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/published_docs/brochures_and_info_sheets/HIV%20counselors%20GUIDE%20FINAL_Apr2006%20(4).pdf

| ***Subjects covered:*** *HIV counselling and testing procedures for immigration health assessments*<br>***Location:*** *global*<br>***Methodology:*** *Manual developed programme specialists and reviewed by field workers* |
|---|

[16] For example:

- The Strategy on Mobility and HIV Vulnerability Reduction in the Greater Mekong Subregion, 2002-2004;
- The 2001 United Nations General Assembly Special Session on HIV/AIDS 'Declaration of Commitment on HIV/AIDS';
- The International Convention on the Protection of the Rights of All Migrant Workers and their Families;
- The Memorandum of Understanding for Joint Action to Reduce HIV Vulnerability Related to Population Movement 2004-2009;
- Bilateral memorandums which address migrant workers.

**Key findings:** The International Organization for Migration has been carrying out health assessments according to the admission requirements of resettlement countries for over five decades. Since the beginning of the AIDS epidemic some countries have required HIV testing. While IOM promotes voluntary HIV testing and counselling as opposed to mandatory HIV testing for travel purposes, the organization nevertheless carries out HIV testing for migrants going to countries that require it. In doing so, IOM follows a "harm reduction model", attempting to ensure that high quality counselling is offered. Although not necessarily sought-after, the HIV test may provide an opportunity to provide applicants information on HIV and AIDS, help them learn how to protect themselves and their partners, and provide referral services and appropriate support.

The Guide, designed with the support of the United States Department Bureau of Population, Refugees and Migration, focuses on HIV counselling within the context of resettlement. It discusses the nature of effective HIV counselling; how, in a group setting, to effectively give pre-test information about HIV and AIDS and about what is involved in testing for immigration purposes; and conducting post-test HIV counselling, both when the test is negative and when it is positive.

**See also:**

**J Weekers and H Siem (1997), "Is compulsory overseas medical screening of migrants justifiable?"** ***Public Health Reports*** **112(5): 396-402.**

This article discusses some of the complex and sensitive issues related to mandatory screening of migrant populations, including conflicting objectives, epidemiological concerns, uncertain economic benefit, ethical dilemmas, and the need to formulate medically-sound screening mechanisms that meet the needs of receiving countries while at the same time responding to the epidemiology of disease, the rights of individuals, and the public health concerns of the community.

**V Keane, G Hammond, H Keane and J Hewitt (2005), "Quantitative evaluation of counseling associated with HIV testing",** ***Southeast Asian Journal of Tropical Medicine and Public Health*** **36(1): 228-232.**

A study carried out in one IOM site for health assessments, comparing passive and more active information-giving, demonstrated that interactive and culturally-sensitive information-giving in the context of comprehensive health assessments can be relatively easy to accomplish and can lead to increased knowledge.

**UNESCO and UNHCR (2007),** ***Educational Responses to HIV and AIDS for Refugees and Internally Displaced*** **Persons*****: Discussion Paper for Decision-Makers***.

This discussion paper notes that in 2005, more than 44 million people, primarily in low-income countries, were forcibly displaced by conflict, violence, crisis or persecution due to race, religion, nationality, political opinion or membership in a particular social group. Although the number of refugees has fallen in recent years, the number of internally displaced persons – people who have been obliged to flee but who have not crossed a recognized border – continues to rise as states have closed their borders to refugees or adopted restrictive admission policies. Focusing on the education sector, the document outlines the policy and programmatic measures required to address the prevention, treatment, care and support needs of refugees and internally displaced persons. The need to address stigma and discrimination is particularly noted.

A final reference is given as a starting point for going beyond the issue of HIV-related restrictions, to addressing the policy and programmatic implications of addressing migrant health more broadly. This is an article published in a special issue dedicated to "health and foreign policy" in the *Bulletin of the World Health Organization*.

**DW Macpherson, BD Gushulak and L Macdonald (2007), "Health and foreign policy: influences of migration and population mobility", *Bulletin of the World Health Organization* 85(3): 200-206.**

The authors point out that the underlying health threats associated with international population movements have long driven the development of national and international border control health policies. Even before the concepts of germ theory and transmissible diseases were properly understood, foreign-born migrants, returning traders, explorers, and military forces were perceived as potential public health threats, a fear that has been tempered by competing demands for trade, economy, exploration, exploitation and conquest.

Although in recent years efforts have been made to bridge the policy gaps between migration and economic outcomes, labour-force movements and international humanitarian issues, the article notes that policy-makers have as yet failed to adequately address migration health. The authors call upon policy-makers to intensify efforts to address the complex challenges in this area, and provide a 48 item bibliography of key references.

***The impact of HIV-related restrictions on entry, stay and residence: an annotated bibliography*** was commissioned by the International Task Team on HIV-related Travel Restrictions. The Task Team was established by UNAIDS in January 2008 as an advisory/technical group whose role was to galvanize attention to such restrictions on national, regional and international agendas, calling for and supporting efforts toward their elimination. The principles of non-discrimination and the Greater Involvement of People Living with HIV formed the core of the Task Team's work and provided the context in which its efforts were set.

The **Report** of the Task Team, presenting its **Findings** and **Recommendations**, can be found at www.unaids.org.

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