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15-17 December 2008

Report of the
International Task Team on HIV-related Travel Restrictions:
Findings and Recommendations

Document prepared by the International Task Team

Additional documents for this item:

- i. The impact of HIV-related restrictions on entry, stay and residence: an annotated bibliography (*UNAIDS/PCB(23)/08.CRP.4*)
- ii. Mapping of restrictions on the entry, stay and residence of people living with HIV (*UNAIDS/PCB(23)/08.CRP.5*)
- iii. The impact of HIV-related restrictions on entry, stay and residence: personal narratives (*UNAIDS/PCB(23)/08.CRP.6*)

Action required at this meeting - the Programme Coordinating Board is invited to:

See decision paragraph 5

Cost implications for decisions: *none*

INTRODUCTION

1. At the sixteenth meeting of the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, held in November 2007, UNAIDS made a commitment to create a Task Team *“with the aim of eliminating policies and practices that restrict travel for HIV positive people”*:

“Board Action on the Right to Travel of People Living with HIV, Decision Point GF/B16/DP24: The Global Fund to Fight AIDS, Tuberculosis and Malaria will not hold Board or Committee Meetings in countries that restrict short-term entry of people living with HIV/AIDS and/or require prospective HIV positive visitors to declare their HIV status on visa application forms or other documentation required for entry into the country.

Acknowledgement of the UNAIDS Commitment to Create a Task Team on Travel Restrictions, Decision Point GF/B16/DP25: Following GF/B16/DP24 the Board strongly encourages all countries to move rapidly towards elimination of travel/entry restrictions, including waivers, for people living with HIV. The Board acknowledges UNAIDS commitment to create a task team with the aim of eliminating policies and practices that restrict travel for HIV positive people.”

2. The International Task Team on HIV-related Travel Restrictions was duly convened by UNAIDS under the co-chairmanship of the Government of Norway and the UNAIDS Secretariat. It comprises some 43 members including member States, associations and networks of people living with HIV, UN and inter-governmental organizations. The work of the Task Team is detailed in the attached Report and contains a number of recommendations some of which are directed specifically to the Boards of UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria.
3. As part of its work in producing evidence-informed recommendations, the Task Team asked the German AIDS Federation, the European AIDS Treatment Group, and the International AIDS Society, who together maintain the *Global Database on HIV-related Travel Restrictions* (<http://www.hivtravel.org>), to produce a document (see conference room paper UNAIDS/PCB(23)/08.CRP.5) *“Mapping of restrictions on the entry, stay and residence of people living with HIV”*. This document seeks to map countries, territories and areas in terms of whether they have restrictions on entry and residence based on HIV status, and if so, what type of such restrictions.
4. As the data from the *Global Database on HIV-related Travel Restrictions* had not been independently verified, Member States were requested, via an email from the Programme Coordinating Board Chair on 7 July 2008, to consider the draft mapping document and to indicate if they disagreed with the category in which they had been placed, referring to laws, regulations and policies as necessary in order to clarify the national situation. Some of the responses received confirmed the information as presented, and others provided corrections and clarifications. Replies were duly received from Cambodia, Canada, Chad (via the UNAIDS M&E Adviser), Colombia (via the Government of Brazil), Estonia, Fiji (via the UNAIDS Programme Officer and NZAID), Finland, France, Greece, Hungary, India, Italy, Japan, Kazakhstan (via the UNAIDS National Programme Officer), Malawi, Moldova, New Zealand, Paraguay (via the UNAIDS Country Coordinator), Romania, Sri Lanka, Switzerland, Tanzania (via the UNAIDS Country Coordinator), Togo, Turkey and Zambia (via the UNAIDS Country Coordinator). This information was put into the final document.

5. The Programme Coordinating Board is invited to:

- a. *Strongly encourage* all countries to eliminate HIV-specific restrictions on entry, stay and residence and ensure that people living with HIV are no longer excluded, detained or deported on the basis of HIV status;
- b. Mindful of PCB decision 8.2 taken at its twenty-first meeting, *agree* that no Programme Coordinating Board meeting will be held in a country with an HIV-specific restriction related to entry, stay or residence based on HIV status;
- c. *Request* UNAIDS to:
 - i. *Support* government efforts to review and eliminate laws, policies and practices related to HIV-specific restrictions on entry, stay and residence, through leadership, advocacy and appropriate partnerships at international, regional and national levels;
 - ii. *Ask* countries to report, as part of UNGASS reporting, on whether they have HIV-related restrictions on entry, stay and residence or have removed them during the reporting period;
 - iii. *Include* in its workplan the following elements:
 - *Support* leadership through the development of advocacy tools and a communications strategy; engagement of the broadest possible range of partners; and strategic support to civil society to take up the issue of HIV-specific restrictions on entry, stay and residence on a global, regional and national basis, including facilitation of dialogue between government and civil society.
 - *Provide* technical assistance and *develop* or *expand* guidance, in particular:
 - with WHO in the lead, in relation to public health and health economics regarding HIV-related restrictions on entry, stay and residence;
 - in relation to a review of the UNAIDS/IOM Statement on HIV-related Travel Restrictions (2004), in collaboration with IOM, civil society organizations and other relevant stakeholders, and drawing on the expert opinion of WHO and other relevant UN programmes and agencies;
 - with UNODC in the lead, on the inclusion of facilities used to detain immigrants in its work to promote comprehensive HIV prevention, treatment, care and support in prisons;
 - with ILO in the lead, involving actors in the world of work, on the protection of the rights of all workers in relation to HIV-related restrictions, including through global, regional and national coalitions;
 - with UNHCR in the lead, on the protection of refugees and asylum-seekers in the context of HIV-related restrictions on entry, stay and residence;

- through an invitation to the UN World Tourism Organization to address the issue of HIV-related restrictions on entry and stay on its agenda, and to include it as a specific topic in the study that is being carried out with a view to the adoption of a proposed declaration on facilitation of tourist travel;
- in collaboration with IOM, to countries to incorporate into their national HIV strategies and workplans, and through relevant national mechanisms, including the principles of the Three Ones, efforts to eliminate HIV-specific restrictions on entry, stay and residence, and include comprehensive HIV prevention, treatment and care programmes for all mobile populations within national AIDS responses in countries of origin and destination; and
- to the continued collection of information and evidence through strategic support to civil society efforts to develop and maintain a comprehensive, sustainable and publicly available global database on HIV-related restrictions on entry, stay and residence with references to laws, policies and practices, and the commissioning of necessary research on relevant economic, public health and human rights issues related to such restrictions.

[Report of International Task Team follows]

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



Findings and Recommendations

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Executive Summary

1. Since the beginning of the HIV epidemic, people living with HIV have been denied entry into or deported from some countries because of their positive HIV status. Over the years, laws and regulations that restrict the entry, stay or residence of HIV-positive people have come to be known in short-hand as “HIV-related travel restrictions”, though they can and do restrict a much broader range of mobility than the word “travel” implies. Such laws restrict the entry or stay of HIV-positive people who seek to engage in tourism, business travel, employment abroad, labour migration, study, and immigration. They can also restrict the entry or stay of those who seek asylum.
2. Governments have typically cited two reasons for such laws: one is to protect the public health by preventing the spread of HIV into a country, and the other is to avoid potential costs of care, treatment and support that might be associated with the stay of a person living with HIV. Early on, however, experts and advocates have stated that HIV-specific restrictions based on HIV status are discriminatory, do not protect the public health, and as blanket restrictions, are overly broad in terms of avoiding potential costs. Furthermore, since the introduction of such restrictions, the world has dramatically changed, making these restrictions even more anachronistic, ineffective and unnecessary. Of relevance is the fact that the world has learned a great deal regarding effective HIV prevention. Mobility has become a natural and necessary part of the lives of millions in a “globalized” world. The introduction of antiretroviral treatment has enabled positive people to live long and productive lives; and governments have made extensive commitments in the context of a major global response to HIV, including to strive to achieve universal access to HIV prevention, treatment, care and support and to protect the human rights of people living with HIV and their greater involvement in the response to HIV.
3. At the time of the writing of this Report, it appears that 63 countries, territories and areas still impose some form of restriction on the entry, stay and residence of people living with HIV based on their HIV status. Some eight countries basically declare all people living with HIV inadmissible for any reason or length of time; with an additional five countries denying visas for even short-term stays. Twenty-eight countries deport individuals once their HIV-positive status is discovered. One hundred and three (103) countries have no HIV-specific restrictions on entry, stay and residence.
4. In light of growing momentum of action and calls to eliminate restrictions on entry, stay and residence based on HIV status, including such a call by the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria in November 2007, the Joint United Nations Programme on HIV/AIDS (UNAIDS) created the International Task Team on HIV-related Travel Restrictions in January 2008. Its purpose 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 (GIPA) formed the core of the Task Team’s work and provided the context in which its efforts were set. The Task Team operated as an advisory/technical group, with representation from governments, international and inter-governmental organizations, the private sector and civil society, including representatives of networks of people living with HIV. The Task Team met, as a whole, three times (25-26 February 2008, Geneva; 31 March - 2 April 2008, Geneva; and 24-26 June 2008, Madrid).

5. The International Task Team on HIV-related Travel Restrictions focused its work on restrictions that are: (a) a part of formal law or regulation; (b) specify HIV as opposed to comparable chronic health conditions; and (c) are applied based on positive HIV status only. Such restrictions usually require a declaration of one's HIV status and/or a mandatory test for HIV to prove that one is HIV negative. It appears that the HIV testing that is conducted is often not done with appropriate pre- or post-test counselling, confidentiality or referral to any sort of HIV prevention, treatment, care or support services. Whether the person is denied entry or is allowed to apply for a waiver, their HIV-positive status is usually noted in immigration/visa records. In countries of destination that require those staying to be HIV-negative, persons already present must take an HIV test periodically to renew their visa and/or work permit. If found to be HIV-positive, they may be confined in immigration detention prior to deportation or they may be deported summarily.

6. The Task Team confirmed that HIV-specific restrictions on entry, stay and residence based on HIV status are discriminatory, do not protect the public health and do not rationally identify those who may cause an undue burden on public funds. In particular, the Task Team made the following findings:
 - The Task Team found no evidence that HIV-related restrictions on entry, stay and residence protect the public health and was concerned that they may in fact impede efforts to protect the public health.
 - All mobile populations – nationals and non-nationals alike – should benefit from access to evidence-informed HIV programmes as part of efforts to achieve universal access to HIV prevention, treatment, care and support and to implement effective responses to HIV, rather than be subjected to ineffective HIV-related restrictions on entry, stay and residence.
 - Restrictions on entry, stay and residence that specify HIV, as opposed to comparable conditions, and/or are based on HIV status alone are discriminatory.
 - Exclusion or deportation of HIV-positive people to avoid potential costs of treatment and support should be based on an individual assessment of the actual costs that are likely to be incurred, should not single out HIV, and should not override human rights considerations or humanitarian claims.
 - Restrictions on entry, stay or residence based on HIV status unreasonably restrict the participation of people living with HIV in major life activities and reduce their involvement in the response to HIV.
 - The implementation of HIV-related restrictions on entry, stay and residence can also interfere with the rights to life, privacy, liberty, work, the highest attainable standard of health, the rights of women, the rights of the child, the rights of migrants, and the rights to seek asylum and to protect the unity of the family.
 - HIV-related restrictions on entry, stay and residence should not result in the denial of the right to seek asylum, the right to be protected from *refoulement* or other rights applicable to refugees and asylum-seekers.
 - Political will, leadership and the commitment of governments, intergovernmental organizations and civil society are critical and necessary in order to eliminate restrictions on entry, stay and residence based on HIV status.

7. The International Task Team on HIV-related Travel Restrictions made recommendations to governments, the UNAIDS Programme Coordinating Board, the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and civil society, including people living with HIV. The Task Team urges all States with HIV-specific restrictions on entry, stay and residence, in the form of laws, regulations, and practices, including waivers, to review and then eliminate them, and ensure that all people living with HIV are no longer excluded, detained or deported on the basis of HIV status.

Introduction

The context and establishment of the International Task Team on HIV-related Travel Restrictions

1. The **International Task Team on HIV-related Travel Restrictions** (Task Team) was established by the Joint United Nations Programme on HIV/AIDS (UNAIDS) in January 2008. The purpose of the Task Team was to bring together stakeholders concerned with the continued implementation of restrictions on the entry, stay and residence of HIV-positive people who cross borders; examine the current context and impact of such restrictions; and create new energy and action towards their elimination. This is the **Report** of the Task Team presenting its **Findings and Recommendations**.
2. At the time of this report, some 63 countries, territories or areas have laws and policies which deny or restrict entry, stay or residence based on the HIV-positive status of those seeking to enter or remain.¹ Many of these restrictions were adopted in the early years of the epidemic when little was known about HIV, there was nothing that could be done to treat it, and there was great fear regarding its spread. At that time, governments who implemented such restrictions thought that they could protect the public health by preventing the spread of HIV into the country and/or could protect the public purse from possible claims for HIV-related treatment, care and support by HIV-positive foreigners. Very early on, however, as detailed below, experts and advocates stated that these restrictions were not effective in preventing the transmission of HIV and discriminatorily singled out people, based on their positive HIV status only, for unjustified differential treatment.
3. Over time, such restrictions have come to be referred to in shorthand as “HIV-related travel restrictions”, even though they can and do restrict a much broader range of mobility than implied by the word “travel”. They may restrict travel for short-term stays, such as for tourism, family visits, business trips or attending conferences; and they may deny longer-term stays or residence, such as in immigration, labour migration, study, refugee asylum and resettlement, family reunification, and diplomatic and consular postings. Because of the misleading nature of the term “travel restrictions”, the Task Team chose to use the more accurate phrase “HIV-related restrictions on entry, stay and residence”.

In the context of the work of the International Task Team on HIV-related Travel Restrictions and in this report, the term “HIV-related travel restrictions” refers only to restrictions on entry, stay and residence where:

- HIV is a *formal and explicit* part of the law or regulation;
- HIV is referred to *specifically*, apart from other comparable conditions; and
- Exclusion or deportation occurs because of *HIV-positive status only*.

¹ The data presented here is outlined in greater detail in the *Mapping of restrictions on the entry, stay and residence of people living with HIV* (2008), which was commissioned by the Task Team and available at www.unaids.org. This data is largely based on information collected by the German AIDS Federation and the European AIDS Treatment Group for the *Global Database on HIV-related Travel Restrictions*, available on-line at www.hivtravel.org. See also point 20 below. In July 2008, at the request of the Task Team Co-chairs, the draft mapping document was sent by the Chair of the UNAIDS Programme Coordinating Board to all governments through their Permanent Missions to the United Nations. Governments were invited to provide corrections and clarifications to the UNAIDS Secretariat by 1 September 2008. This information was used to verify and update data in the *Mapping* document, as well as in the Global Database.

4. It should be underlined that the work of the Task Team focused on *HIV-specific* laws or policies that restrict entry, stay or residence on the basis of *positive HIV status alone* and form a part of *formal law, regulation or policy*. The Task Team recognized that it is within the legitimate exercise of national sovereignty for States to exclude or deport people if they: (a) pose a threat to the *public order* by some aspect of their behaviour or because they are likely to become a public charge (e.g. have no resources to pay for health care or other support needs) or (b) they pose threat to the *public health* (e.g. have a disease that is contagious by casual contact). In this regard, countries might deny entry to someone obviously ill presenting for a visa or for entry. However, the Task Team focused on restrictions which single out HIV-positive status as the *only* condition by which the application of the restriction is triggered.
5. Over the years, the impact of restrictions on entry, stay and residence based on HIV status have been felt by thousands of people, some of whom knew they were positive when they sought to travel or migrate and some who found out in the country of destination. Their experience has been one of discrimination, exclusion and/or deportation based on HIV status; and sometimes their health and well-being have been threatened by the often harsh manner in which these restrictions have been implemented. Meanwhile, the world and the response to HIV have dramatically changed, making HIV-related restrictions on entry, stay and residence appear even more ineffective and discriminatory than they were when first adopted. For these reasons, UNAIDS decided to provide support to the growing movement of those who believe it is well past time to remove such restrictions. It did so by creating the **International Task on HIV-related Travel Restrictions**.
6. Throughout its deliberations, the Task Team was keenly aware of the current context in which HIV-related travel restrictions continue to exist. Firstly, HIV has long been present in every country in the world in the form of national epidemics; secondly, the world has “globalized”, with mobility becoming an increasingly necessary and natural part of the lives of millions of people; and thirdly, the world has rallied behind a major global response to HIV based on comprehensive HIV responses for all those in need and on protection of the human rights of those affected by or living with HIV.
7. According to the UN World Tourism Organization, the number of people who cross international borders rises every year, with many people viewing mobility as an integral part of their lives.² Countries also increasingly recognize the travel industry as a key component of their economies. In 2007 alone, international tourist arrivals reached 903 million, an increase of 6.6% from the previous year; while almost US\$ 900 billion were spent by these tourists in that one year.³ As of the end of 2005, there were an estimated 191 million migrants worldwide,⁴ many of whom, with today’s relatively accessible transportation, travel back and forth between their countries of origin and of destination.

² Some people even regard mobility as a “human right”. The *Global Code of Ethics for Tourism*, adopted by resolution A/RES/406(XIII) at the thirteenth World Tourism Organization General Assembly (Santiago, Chile, 27 September - 1 October 1999), addresses both the “right to tourism” (Article 7) and “liberty of tourist movements” (article 8). Available on-line at http://www.unwto.org/code_ethics/pdf/languages/Codigo%20Etico%20Ing.pdf

³ World Tourism Organization (2008), “Quick Overview of Key Trends”, *UNWTO World Tourism Barometer* 6(2). Available on-line at http://pub.unwto.org/WebRoot/Store/Shops/Infoshop/Products/1324/080707_unwto_barometer_02-08_engl_unprot_excerpt.pdf According to the UN World Tourism Organization, tourism is defined as the activities of persons “travelling to and staying in places outside their usual environment for not more than one consecutive year for leisure, business and other purposes not related to the exercise of an activity remunerated from within the place visited”.

⁴ United Nations (2006), *Trends in Total Migrant Stock: The 2005 Revision*. UN Document POP/DB/MIG/Rev.2005/Doc.

At the same time, there were some 11.4 million refugees driven across borders as of the end of 2007.⁵

8. In the last ten years, the world has built a global response to AIDS based on the extensive knowledge, experience and commitment that has been gained since the early days of the epidemic. Most importantly, the introduction of antiretroviral therapy has enabled people living with HIV to lead long and productive lives, making HIV a manageable health condition and reducing infectiousness when taken under optimal conditions. Solidifying the global response to AIDS, governments committed themselves in 2001 in the *Declaration of Commitment on HIV/AIDS*⁶ through a number of time-bound commitments to seriously scale up their efforts against HIV; and in 2006 in the *Political Declaration on HIV/AIDS*, they further committed themselves to strive to achieve *universal access* to HIV prevention, treatment, care and support by 2010.⁷ In both the *Declaration of Commitment* and the *Political Declaration*, Governments also made historic commitments to protect the human rights of people living with HIV, including their rights to non-discrimination and to greater involvement in the response.⁸
9. By the end of 2007, the World Health Organization reported that some three million people in low- and middle-income countries were receiving antiretroviral treatment, nearly 950,000 more than compared with the end of 2006 and a 7.5-fold increase during the past four years. With an estimated 6.7 million people still in need of treatment, ambitious efforts to further expand antiretroviral treatment programmes continue.⁹ HIV prevention is also a critical part of universal access, and though access to HIV prevention is still not available on the scale it should be, governments have recognized that the epidemic can only be stopped with much greater efforts to provide HIV prevention to all populations in need of it.¹⁰
10. In the present world of globalization and universal access, HIV-specific restrictions based on HIV-positive status are ever more anachronistic. Since such restrictions were first enacted, international organizations, governments and civil society have advocated

⁵ United Nations High Commissioner for Refugees (2008), *2007 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons*. Available on-line at <http://www.unhcr.org/statistics/STATISTICS/4852366f2.pdf>

⁶ UN Document A/RES/S-26/2. Available on-line at: <http://www.un.org/ga/aids/docs/aress262.pdf>

⁷ See para.20, UN Document A/RES/60/262. Available on-line at:

http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

⁸ For example, in the *Declaration of Commitment*, see para.58, where governments commit to “enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups [...]”. In the *Political Declaration*, see para.20, where governments commit to “pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, *with full and active participation of people living with HIV*, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010” (emphasis added).

⁹ World Health Organization, UNAIDS and UNICEF (2008), *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report 2008*. Available on-line at: http://www.who.int/hiv/pub/towards_universal_access_report_2008.pdf

¹⁰ In the *Political Declaration on HIV/AIDS* (2006), para.22, governments reaffirmed that “the prevention of HIV infection must be the mainstay of national, regional and international responses to the pandemic” and committed to intensifying efforts to ensure that a wide range of prevention programmes that take account of local circumstances, ethics and cultural values is available in all countries, particularly the most affected countries [...]”. See also United Nations (2008), “Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals; Report of the Secretary-General”. UN Document A/62/780. Available on-line at http://data.unaids.org/pub/Report/2008/20080429_sg_progress_report_en.pdf

against them as discriminatory obstacles to the equal access of HIV-positive people to international travel, labour migration, diplomacy, development and humanitarian endeavour, as well as to their greater involvement in international HIV conferences, strategic policy debates and governance of global and national health initiatives.¹¹ In the last few years, there has been increased momentum to overturn these restrictions. Examples of this momentum comprise action by the Government of Canada to revise its regulations to remove restrictions that would have made it difficult to hold the International AIDS Conference (2006) in Toronto;¹² a number of announcements and steps by the Government of the United States of America signalling its intention to remove such restrictions;¹³ and the commitment made by Government of the People's Republic of China in October 2007 to remove its own HIV-specific restrictions on entry, stay and residence.¹⁴

11. Furthermore, at its sixteenth meeting in November 2007, the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria decided not to hold Board or Committee meetings in countries that restrict the short-term entry of people living with HIV; and UNAIDS announced that it would create a Task Team with the aim of eliminating HIV-related travel restrictions. Subsequently, the International Task Team on HIV-related Travel Restrictions was constituted in January 2008.

¹¹ For example, the International AIDS Society (IAS) has addressed the issue of entry and stay restrictions against people living with HIV since 1989, when a Dutch HIV-prevention expert was jailed for four days in Minneapolis, United States of America, en route to the 1990 International AIDS Conference in San Francisco, after HIV medication was discovered in his suitcase. Public demonstrations followed, and it was subsequently decided that the 1992 International AIDS Conference would be moved from Boston to Amsterdam in protest of the United States entry ban for people living with HIV. The IAS has not hosted an International AIDS Conference in the United States since that time. See International AIDS Society (2007), *IAS Policy Paper – Banning Entry of People Living with HIV/AIDS*. Available online: http://www.iasociety.org/Web/WebContent/File/ias_policy%20paper_07%2012%2007.pdf

Similarly, the former “Global Programme on AIDS” of the World Health Organization had a policy on the “Non-sponsorship of international conferences on AIDS in countries with HIV/AIDS-specific short-term travel restrictions”. In 1993, the policy was endorsed by the then Administrative Committee on Coordination which recommended that all UN agencies adopt the policy. The policy was limited to international conferences on HIV in countries with HIV-specific short-term travel restrictions. It stated that the agencies would not sponsor, fund or participate in such meetings, unless such attendance was “deemed essential for promoting non-discrimination against people living with HIV”. Its purpose was to discourage use of such travel restrictions and support the involvement of people living with HIV.

¹² For a description of the changes that were made, and the process that led to them, see Canadian HIV/AIDS Legal Network (2005), *Recent changes to visitor visa process affecting entry into Canada for people living with HIV/AIDS*. Available on-line at <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=95>

¹³ See the United States of America White House (2006), *Fact Sheet: World AIDS Day 2006*. Available on-line at <http://www.whitehouse.gov/news/releases/2006/12/20061201-2.html>. The fact sheet details the announcement by the United States President on World AIDS Day (2006) that the Government of the United States would consider creating a categorical waiver for HIV-positive people seeking to enter the United States on short-term visas. Since that time the United States President's Emergency Plan for AIDS Relief (PEPFAR) reauthorization bill, signed into law on 30 July 2008, repealed the statutory basis for the United States HIV-related restrictions on entry and stay; the US Department of Homeland Security issued a new rule streamlining the process of processing waivers for HIV-positive people (see “Fact Sheet: Streamlined Process Announced for Otherwise Eligible HIV-Positive Individuals to Enter the United States”; available on-line at http://www.dhs.gov/xnews/releases/pr_1222704743103.shtm); and the Director of the US Centers for Disease Control Julie Gerberding underlined that the Department of Health and Human Services “has clearly stated our intent to remove HIV infection as an inadmissible condition for entering the United States. We are already preparing the revised rule.” (See “Removing the HIV Barrier”, *Washington Post*, 6 October 2008; available on-line at <http://www.washingtonpost.com/wp-dyn/content/article/2008/10/05/AR2008100501854.html>). However, at the time of the writing of this report, the HIV-related restrictions on entry and stay in the United States remain in effect by regulation.

¹⁴ This announcement was also widely reported in the media. See for example Lindsay Beck (2007), “China to ease travel restrictions on HIV-carriers”. *Reuters*, 8 November 2007. Available on-line at <http://www.alertnet.org/thenews/newsdesk/PEK29739.htm> The commitment was reiterated during the International AIDS Conference in Mexico City. See “China to lift HIV/AIDS travel ban – official”. *China Daily*, 6 August 2008. Available on-line at http://www.chinadaily.com.cn/china/2008-08/06/content_6906688.htm

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Scope of the work of the Task Team and its outputs

12. As a time-bound and action-oriented task team, the International Task Team on HIV-related Travel Restrictions worked from February to October 2008 to review evidence, discuss issues, make findings and develop recommendations towards the elimination of HIV-related restrictions on entry, stay and residence. During this period, it also commissioned the development of materials to support its work and utilized opportunities to encourage and support advocacy and action against such restrictions on national, regional and international agendas.
13. The Task Team operated as an advisory/technical group united around a common concern, with representation from governments, international and inter-governmental organizations, the private sector and civil society, including representatives of networks of people living with HIV. (See *Terms of Reference of the Task Team* attached as Annex 1.) UNAIDS and the Government of Norway served as Co-chairs. Members brought experience and expertise in public health, national responses to HIV, HIV-related advocacy and law, migration, and human rights. (See *Membership List* attached as Annex 2.) 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 elaborated.
14. The work of the Task Team was informed by plenary discussions, as well as by the deliberations of two working groups: the *Working Group on Short-term HIV-related Travel Restrictions* and the *Working Group on Long-term HIV-related Travel Restrictions*. The Task Team was supported by a Steering Committee comprised of the Task Team co-chairs (Government of Norway and UNAIDS), the Global Fund, and the Co-chairs of the Working Groups (*Short-term*: Government of Brazil and Communities Delegation-Global Fund/International AIDS Alliance); (*Long-term*: Government of the Philippines and CARAM Asia). The Task Team was also supported by a Secretariat, the International AIDS Society, which was selected after a competitive bidding process.
15. The Task Team met, as a whole, three times. The first meeting was held 25-26 February 2008 in Geneva; the second, 31 March - 2 April 2008 in Geneva; and the third and last, 24-26 June 2008 in Madrid. Two teleconferences of the Task Team Steering Committee were held between meetings (21 May 2008 and 20 June 2008), and Steering Committee members participating in the International AIDS Conference in Mexico City also met there.

16. All three meetings of the Task Team included plenary and working group sessions, with the Task Team acting in plenary to integrate the Working Groups' conclusions into a unified set of findings and recommendations. According to its Terms of Reference, the Task Team worked "based on consensus to the extent possible".¹⁵ In this regard, at its third and final meeting, the Task Team undertook a line-by-line review of the draft recommendations to agree and reach consensus on their formulation. Though it was felt important to preserve and honour the consensus reached, it was agreed that one further opportunity would be provided for Task Team members to provide comments to the draft findings and recommendations, based on consultations with respective governments or organizations.
17. On 5 August, the draft findings and recommendations were circulated to all Task Team members for a final opportunity to provide comments with the view that the Steering Committee would then meet to consolidate them into one report and finalize it. On 3 October, the Steering Committee met, reviewed the draft and the comments received, sought to incorporate those comments to the extent possible while maintaining the essential elements of the consensus achieved in the third meeting, and finalized the report. The report was distributed to all Task Team members on 16 October for an opportunity to express any dissenting views by 21 October. One dissenting view was received, and, as agreed in the Task Team's Terms of Reference, is noted in the footnote below.¹⁶
18. Task Team efforts were complemented by electronic discussions and engagement with key global and regional policy events. The Task Team also commissioned the development of advocacy and reference documents that could be used by national and international stakeholders to support the elimination of HIV-related restrictions on entry, stay and residence.
19. Key outputs of the Task Team include:¹⁷
 - Increased attention to and awareness of HIV-related restrictions on entry, stay and residence internationally, regionally and nationally by, among other things, members of the Task Team raising or supporting the issue at key events and high-level policy platforms in 2008 including: the Second Eastern Europe and Central Asia AIDS Conference (Moscow); the World Health Assembly (Geneva); the United Nations High Level Meeting on AIDS (New York); the International AIDS Conference (Mexico City); the Asia-Pacific Economic Cooperation workshop on HIV and mobility (Hanoi); and the Global Forum on Migration and Development (Manila). This included support to statements calling for the elimination of such restrictions made by the United Nations Deputy High Commissioner for Human Rights Kyung-wha Kang; and at the United Nations High Level Meeting on AIDS, held at the United Nations General Assembly, by President of the Republic of El Salvador, Elías Antonio Saca González; the United

¹⁵ See Terms of Reference "Working Principles" in Annex 1.

¹⁶ The Terms of Reference "Working Principles" also note that "if necessary, and on agreement of co-chairs, dissenting views will be footnoted and attributed in recommendations and outputs". See Annex 1. The Government of the United States requested that the following text be inserted into this report: **As of 16 October, the Government of the United States indicated that, while in agreement with many parts of the report, it is not able to support publication of this version of the Report of the International Task Team on HIV-related Travel Restrictions. The United States does not agree with certain aspects of text in the report and, noting its concerns with the late addition of new text without adequate opportunity for review and comment, does not agree with the presentation of conclusions in the report as those of the full Task Team.**

¹⁷ Available on request from UNAIDS Secretariat, Geneva, and via www.unaids.org.

Nations Secretary-General Ban Ki-moon; UNAIDS Executive Director Peter Piot; and several members of civil society and networks of people living with AIDS.

- Technical support towards the updating and reorganization of information on HIV-related restrictions on entry, stay and residence, which resulted in the *Global Database on HIV-related Travel Restrictions*, www.hivtravel.org, launched in July 2008.
- Commissioning of a document *Mapping of restrictions on the entry, stay and residence of people living with HIV*, describing the current situation related to HIV-related restrictions on entry, stay and residence and some of the various forms such restrictions take;
- Support to the production of the document *Entry Denied: Denying entry, stay and residence due to HIV status – ten things you need to know*, outlining key messages and actions regarding the entry, stay and residence of people living with HIV;¹⁸
- Commissioning a compilation of personal narratives comprising testimonies of individuals who have experienced HIV-related restrictions on entry, stay and residence;
- Commissioning a desk review and annotated bibliography of relevant research on the impact of HIV-related restrictions on entry, stay and residence.

20. Based on its commissioned research, discussions at its meetings and the collective experience and expertise of Task Team members, the International Task Team on HIV-related Travel Restrictions made the following findings.

Findings of the International Task Team on HIV-related Travel Restrictions

A. From existing data sources, it appears that HIV-related restrictions on entry, stay and residence remain in force in some 63 countries, territories or areas; take many and varied forms; and impact people who cross borders for both short and long stays.

21. During its work, the Task Team sought to ascertain the extent, nature and impact of HIV-related restrictions on entry, stay and residence. This was a considerable challenge as most of the lists of such restrictions were no longer being maintained;¹⁹ nor have many of the governments that have such restrictions published easily available information about them or publicly reported on their application or impact. Furthermore, such restrictions are often complex and arcane, differing widely among countries, territories or areas in terms of their form, content, application and implementation. The relative dearth of information about such restrictions made the work of the Task Team more difficult; and the Task Team concluded that it has also hampered general awareness of such restrictions, as well as advocacy and action against them by various stakeholders. Most importantly, the Task Team was concerned that lack of publicly available information on such restrictions has reduced the likelihood of HIV-positive travellers and migrants being forewarned about them.

¹⁸ This document was signed onto by the majority of Task Team members and was distributed, among other places, in some 24,000 delegate bags at the International AIDS Conference in Mexico City. It has been updated since the first printing and is available on-line at www.unaids.org and www.iasociety.org.

¹⁹ Notably those by Canada, AIDS Info Docu (Switzerland), and the United States of America. However, the United States Government has indicated to the Task Team that it is renewing its publicly available list of countries with HIV-specific travel restrictions and expects this to be available at www.state.gov by the end of 2008.

22. Unfortunately, it was beyond the scope or resources of the Task Team to collect and verify all national laws and policies that restrict entry, stay and residence based on HIV status, or to seek and examine the immigration records of countries which apply such restrictions. Thus, the Task Team sought to build its efforts and base its findings and recommendations on existing information on these laws and regulations. In this regard, the Task Team provided technical support to some members of the Task Team who had maintained a database on such restrictions since 1999.²⁰ Based on this support and a collaborative initiative of the German AIDS Federation, the European AIDS Treatment Group and the International AIDS Society, an updated and revised database – the *Global Database on HIV-related Travel Restrictions* (Global Database) – was launched in July 2008. This civil society-maintained database provides information on which countries, territories or areas employ HIV-related restrictions on entry, stay and residence, what forms they take, and how they are implemented.²¹ It is hoped that the *Global Database* will serve to inform those seeking to cross borders as well as inform further efforts to eliminate HIV-related travel restrictions.
23. In order to further address the general lack of awareness of HIV-related restrictions on entry, stay and residence, the Task Team also commissioned a document entitled *Mapping of restrictions on the entry, stay and residence of people living with HIV*, based on the information found in the *Global Database*.²² This document was an attempt to describe HIV-related travel restrictions and show in abbreviated form the nature, types and scope of these restrictions as they currently exist. Because the information in the *Global Database* had not been independently verified, the Task Team, through its Co-chairs, requested that all governments have the opportunity to review the draft mapping document. On 7 July 2008, the Chair of the UNAIDS Programme Coordinating Board sent out to all Permanent Missions of United Nations Member States a request that they validate the information in the document. The information received was inputted into the final version of the document and was also provided to those who maintain the *Global Database* to update and correct, if need be, its information.

As stated above, the work of the Task Team did not address policies or laws that are not HIV-specific and may result in the exclusion of HIV-positive people because of criteria other than their positive status. Nor was it in the scope of the Task Team to consider the many different forms of *practice* whereby border guards and/or immigration officials have, or utilize, broad discretion in determining who can enter or stay in a country, territory or area. Both situations may also involve the discriminatory application of laws or policies to HIV-positive people, but were beyond the scope of the work of the Task Team.

24. As of the time of this report and based on the information in the *Global Database* and the validation exercise described above, it appeared that 103 countries, territories or areas did not have any HIV-specific restrictions on entry, stay and residence based on HIV status. On the other hand, as stated, 63 countries, territories or areas did impose some form of such restrictions. Of these, it appeared that eight of these bar entry and stay for

²⁰ The German AIDS Federation (DAH) first sent out a questionnaire survey on travel and entry regulations for people living with HIV and AIDS to all German embassies abroad and all foreign embassies in Germany in 1999. Over the years, the data from this original survey was updated with information taken from various sources and other existing web sites. Another such survey was sent out in 2007/2008.

²¹ For details on the *Global Database on HIV-related Travel Restrictions*, see www.hivtravel.org.

²² Available via www.unaids.org.

any reason or any length of time (declare positive people generally “inadmissible”); with an additional five denying visas for even short-term stays.²³ Twenty-eight countries, territories or areas deported individuals once their HIV infection is discovered. For 21, the information was contradictory; and for 17, there was no available information.²⁴

25. The Task Team found that HIV-related restrictions on entry, stay or residence take many forms but generally require proof of negative HIV status, and thus are often based on mandatory HIV testing, that is, testing which must be undergone to procure a benefit. It appears that often the testing – required either by an immigration law or regulation and/or by an employer – is not linked to any health referral or therapeutic outcome or intervention.²⁵ The implementation of HIV-related restrictions appear to involve one or more of the following aspects:

- The applicant for a visa must declare his or her HIV status upon entry or show negative results of an HIV test.
- The applicant for a visa must submit to an HIV test before or at entry, or if in the country of destination, be tested for HIV in order to renew the visa or permit.
- If found to be HIV-positive in the context of entry, stay or residence, the person’s positive status is recorded on the passport and/or on some other immigration document, form or record.
- If found to be HIV-positive, the applicant is excluded from entry.
- If found to be HIV-positive while in the country of destination, the person is put into immigration detention pending deportation.
- If found to be HIV-positive, the person is deported.

26. In order to review the impact of the implementation of these elements of HIV-related restrictions on entry, stay and residence, the Task Team commissioned desk research and found that there appears to be relatively little official monitoring or published reports on impact, nor has much research been done on relevant economic, public health, and legal and human rights issues related to them. Critical missing information comprised, among other things, the number of travellers or migrants subject to HIV testing and referred, or not referred, to health services; the number of travellers or migrants excluded or deported on account of HIV status; the number of HIV prevention, care and treatment programmes for travellers and migrants; the number of HIV-related illness or deaths in immigration detention centres.²⁶

²³ This means that these five countries may allow entry of HIV-positive people, but deny visa applications based on HIV status for periods as short as 10 days up to 90 days, and beyond (depending on the country).

²⁴ For further information, see www.hivtravel.org as well as the document *Mapping of restrictions on the entry, stay and residence of people living with HIV* (2008), available on-line at www.unaids.org.

²⁵ There are exceptions, however. While advocating for fully voluntary HIV testing and counselling at the policy level, IOM does carry out HIV testing and counselling as part of its migration health assessment services for resettlement countries that require such testing under their national immigration legislation. IOM works to ensure that all HIV testing and counselling through its assessments is done under the following conditions: high quality pre- and post-test counselling by trained providers, understanding on the part of the migrant of the meaning and implications of the test result prior to undergoing it, protection of confidentiality to the fullest extent possible within the limitations imposed by some States, and referral to available treatment, care and support services. See the *IOM Guide for HIV Counsellors* (2006) for more information. Available on-line at [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](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)

²⁶ For a summary of published literature and other materials identified during the desk review, see *The impact of HIV-related restrictions on entry, stay and residence: an annotated bibliography*. Available via www.unaids.org.

27. Thus, the Task Team could not ascertain how many of the 33 million people that are currently living with HIV²⁷ have been affected by HIV-related restrictions on entry, stay or residence. It appears that such data are not being collected in any comprehensive fashion, and to do so would involve confronting a number of significant practical difficulties in generating an estimate. For example, it was recognised that some HIV-positive people who know that such restrictions are in place will not attempt to travel or migrate in the first place; whereas other positive people travel and manage to evade the restrictions, or are discovered later and deported. Many travellers or migrants may find out about their HIV status only through the application of restrictions while in the country of destination, but this may not be a part of publicly available immigration records. Other travellers or migrants may not be told that they are HIV-positive and that their status was the reason for the denial of entry or deportation. Those who do know why they were denied entry or deported may not reveal or report it in their country of origin.
28. It was also difficult to know how these restrictions impact vulnerable populations among migrants, including women and children. In this regard, the Task Team would have liked to explore the impact of these restrictions in gender terms, particularly as the Task Team was aware that such restrictions might have a differential impact on migrant women. For instance, many women find out their HIV status through prenatal testing which may make them more liable to be subject to such restrictions either when they seek to migrate or when already in the country of destination. Migrant women, including domestic workers, can also be vulnerable to sexual violence and its attendant risks of HIV transmission, leaving those infected to the further consequences of the application of HIV-specific restrictions. However, the data that does exist did not provide the Task Team with sufficient information to make a finding concerning gender issues.
29. The Task Team found that the studies that it did review (described below) indicated that the implementation of restrictions on entry, stay and residence based on HIV status can and do have serious negative consequences for the health, human rights and/or well being of the individual involved. The Task Team also acknowledged the important value of reported information comprising the experiences of people living with HIV who have faced such restrictions. In order to bring to light some of these experiences, the Task Team commissioned its Secretariat, the International AIDS Society, to call for personal narratives and collected these in a paper entitled *The impact of HIV-related Restrictions on Entry, Stay and Residence: Personal Narratives*.²⁸

B. The Task Team found no evidence that HIV-related restrictions on entry, stay and residence protect the public health and was concerned that they may in fact impede efforts to protect the public health.

30. As early as 1987, the World Health Organization issued the *Report of the Consultation on International Travel and HIV Infection* in which a panel of public health experts and senior officials from several countries stated that: "No screening programme of international travellers can prevent the introduction and spread of HIV infection."²⁹ The Task Team did

²⁷ UNAIDS (2008), *Report on the Global AIDS Epidemic 2008*. Available on-line at http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

²⁸ Available via www.unaids.org.

²⁹ "International travellers" were defined in this case as all people crossing international boundaries. See World Health Organization (1987), "Report of the Consultation on International Travel and HIV Infection", Geneva, 2-3 March 1987, WHO/SPA/GLO/87.1.

not find any evidence supporting a different public health conclusion from that set out in this consultation, except that restricting the entry of HIV-positive non-nationals is *even less likely in 2008 than it was in 1987* to significantly alter the course of a country's HIV epidemic.

31. Commenting on the United States' HIV-specific restrictions in 1991, the United States Centers for Disease Control stated: "The risk of (or protection from) HIV infection comes not from the nationality of the infected person, but from the specific behaviours that are practiced. Again, a careful consideration of epidemiological principles and current medical knowledge leads us to believe that allowing HIV-infected aliens into this country [the USA] will not impose a significant additional risk of HIV infection to the US population, where prevalence of HIV is already widespread."³⁰
32. The Task Team reiterated that restrictions on entry, stay and residence alone do not protect the public health in a country of destination, because the mere presence of an HIV-positive person in a country is not a threat to public health.³¹ HIV is transmissible, but it is not contagious in the sense of being spread by airborne particles or by casual contact. Instead, it must be transmitted by specific *behaviour*. Furthermore, this behaviour (most commonly unprotected sex or the use of contaminated injection equipment) can be made less risky by either the HIV-positive person or the HIV-negative person taking steps to prevent the transmission from occurring. There was no significant evidence supporting the notion that either HIV-positive travellers can be assumed to engage in risky behaviour or that their partners will also not use protection. In fact, there was evidence that HIV-positive people who know they are infected generally try to prevent the onward transmission of HIV.³² If such risky behaviour is a concern, it would appear to be better addressed by evidence-informed HIV prevention programmes to provide support to people to reduce risks of HIV transmission, as discussed below.
33. The Task Team also underlined that restricting the entry or stay of HIV-positive non-nationals as a so-called effective means to prevent the spread of HIV into a country has always been, and continues to be, counterintuitive when similar restrictions are not applied to the much greater numbers of nationals leaving and returning to their own country who might acquire HIV while abroad, return home and expose others.
34. HIV-related restrictions on entry, stay and residence also raise the issue of "whose public health?" Travellers and migrants may enter a country of destination uninfected and become infected with HIV while there. For example, a study of foreign-born people living with HIV in the United States concluded that most had been infected after arrival in the country.³³ To the degree that migrants or travellers are infected in countries of

³⁰ Public Health Service (1991), "Medical Examination of Aliens." 56 Fed. Reg. 2,484 (codified at 42 CFR §34). Cited in: MA Somerville, S Wilson (1998), "Crossing Boundaries: Travel, Immigration, Human Rights and AIDS", *McGill Law Journal* 43:781.

³¹ UNAIDS and International Organization for Migration (2004), *UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions*. Available on-line at http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/activities/health/UNAIDS_IOM_statement_travel_restrictions.pdf

³² For example, see R Bunnell et al (2006) "Changes in sexual risk behaviour and risk of HIV transmission after antiretroviral therapy and prevention interventions in rural Uganda", *AIDS* 20(1):85-92, and Gary Marks et al (2005), "Meta-analysis of high-risk sexual behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs", *Journal of Acquired Immune Deficiency Syndromes* 39(4):446-53.

³³ 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.

destination and carry their infection back to countries of origin, countries of origin have justifiably as much concern about their “public health” as countries of destination do.³⁴ Yet the Task Team found that few governments of countries of origin appear to raise with governments of countries of destination, as a matter of diplomatic concern, the infection of their nationals abroad and/or the denial of HIV prevention, treatment, care and support services to these nationals while in countries of destination.³⁵

35. Furthermore, as stated in various documents such as the IOM/UNAIDS *Statement on HIV-related Travel Restrictions* (2004), the Task Team was also concerned that HIV-related restrictions on entry, stay and residence might be harmful to the public health of nationals and non-nationals in the country of destination because they: (a) misdirect resources into intimidating screening and enforcement activities versus using these resources to expand voluntary HIV counselling and testing, prevention, treatment and care; (b) drive HIV prevention and care issues, as well as those living with HIV, underground, with negative outcomes for both individual and public health; and (c) pressure HIV-positive people to leave their medicines behind when travelling, with the result that they become ill and/or develop drug resistance.³⁶
36. Research conducted in 2006 among HIV-positive travellers to the United States found that a significant minority (11.3%) stopped their medication in an unplanned manner at the time of travel, risking the development of drug resistance and other negative health outcomes. Several study participants reported that they did so because they were “entering a country with an official travel ban for HIV positive subjects” and were afraid of being searched by immigration authorities or had a “fear of being found out”.³⁷ Similar findings were reported from a study amongst HIV-positive people attending an HIV clinic in a tertiary care hospital in Canada.³⁸ An analysis of public policies that affect primary HIV prevention and access to HIV care for Mexican migrants residing in California found that 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 become aware of their HIV infection.³⁹
37. The Task Team emphasized the need for all countries to recognize the potential danger posed by HIV-related restrictions in terms of undermining gains made by HIV treatment at individual and public health levels. When people who have been receiving antiretroviral therapy in one country travel to another country, it is extremely important for them to

³⁴ K.A 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. See also recent media reports regarding new infections among Australian men travelling overseas and engaging in unprotected sex. “6 Cairns businessmen contract HIV in [Papua New Guinea]”. *ABC News (Australia)*, 16 September 2008. Available on-line at <http://www.abc.net.au/news/stories/2008/09/16/2366479.htm>

³⁵ However, in 2006, senior officials from the governments of Denmark, Sweden and Norway sent a joint letter to the Government of the United States, expressing concern about travel restrictions affecting HIV-positive people travelling to the country. See <http://www.norwaystand.mfa.no/Policies/Travel+Restrictions/Travel+restrictions.htm>

³⁶ UNAIDS and International Organization for Migration (2004), *UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions*. Available on-line at http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/activities/health/UNAIDS_IOM_statement_travel_restrictions.pdf; see also Alana Klein (2001), *HIV/AIDS and Immigration: Final Report*. Montreal: Canadian HIV/AIDS Legal Network. Available on-line at <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=853>

³⁷ M Mahto, K Ponnusamy, M Schuhwerk, J Richens, N Lambert, E Wilkins, DR Churchill, RF Miller, RH Behrens (2006), “Knowledge, attitudes and health outcomes in HIV-infected travellers to the USA”, *HIV Medicine* 7(4):201-4.

³⁸ 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* 172:884-888.

³⁹ SF 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 Syndrome* 37 Suppl 4:S252-S259.

continue taking their medications. Interruptions in antiretroviral treatment without physician supervision can have harmful individual and public health consequences because missing even a small number of doses may lead to the emergence of drug resistant strains of HIV, undermine effectiveness of treatment and ultimately lead to treatment failure.⁴⁰ If drug-resistant strains of HIV are transmitted to other people, those people will also fail to benefit from the class of drugs that the virus has mutated to evade. Serious negative public health consequences include the rebound of viral load with increased infectiousness; increased likelihood of transmission of drug resistant strains of HIV; illness and increased health care costs due to late reporting and/or the need to switch to more expensive second line therapies.⁴¹

38. The Task Team underlined that people who continue taking their antiretroviral medications are both safeguarding their health, minimizing the likelihood of developing HIV drug resistance and, if taking antiretrovirals under optimal conditions, decreasing their infectiousness.⁴² In the era of universal access to HIV, prevention, treatment, care and support, travellers taking antiretroviral therapy can be expected to grow as countries move closer to achieving universal access. Repeal of laws and policies restricting entry, stay and residence of people living with HIV based on HIV status would remove the incentives to conceal HIV-positive status and medication and/or stop taking medication while travelling.
39. As raised by others before it, the Task Team also expressed concern that HIV-related restrictions on entry, stay and residence appear to create a false sense of security among the populace and discourage mutual responsibility for protecting sexual health. Such restrictions appear to encourage nationals to consider HIV a “foreign problem” that has been “dealt with” by keeping out HIV-positive foreigners, which is not only wrong but also can increase stigma against foreigners.⁴³ A study on HIV knowledge, attitudes, and educational needs among Arab university students in the United Arab Emirates – a country that requires HIV testing of foreign workers – found that many students had misconceptions about HIV and feelings of invulnerability, perceiving “others” to be at risk. The authors point out that students may mistakenly believe that universal testing for foreigners would stop transmission of the virus in the country.⁴⁴ In the United States, a 2007 report published by the Centre for Strategic and International Studies stated that “the current inadmissibility policy may in fact provide a false sense of security to United

⁴⁰ See for example R Hogg, K Heath, DR Bangsberg et al. (2002), “Intermittent use of triple combination therapy is predictive of mortality at baseline and after one year of follow-up AIDS”, *AIDS* 16: 1051–1058; JH Oyugi, J Byakika-Tusiime, K Ragland et al. (2007), “Treatment interruptions predict resistance in HIV-positive individuals purchasing fixed-dose combination antiretroviral therapy in Kampala, Uganda”, *AIDS* 21: 965–971; JJ Parienti, V Massari, D Descamps et al. (2004), “Predictors of virologic failure and resistance in HIV-infected patients treated with nevirapine or efavirenz-based antiretroviral therapy”, *Clinical Infectious Diseases* 38: 1311–1316; E Wood, RS Hogg, B Yip et al. (2003), “Effect of medication adherence on survival of HIV-infected adults who start highly active antiretroviral therapy when the CD4+ cell count is 0.200 to 0.350 × 10(9) cells/L”, *Annals of Internal Medicine* 139: 810–816.

⁴¹ K Ponnusamy et al. (2003), “A study of knowledge attitudes and health outcomes in HIV positive patients following travel to the United States of America”, Abstract 10.1/2, presented at the 9th European AIDS Clinical Society Conference, 25-19 October 2003.

⁴² On this last point, see note 46 below.

⁴³ UNAIDS and International Organization for Migration (2004), *UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions*; Alana Klein (2001), *HIV/AIDS and Immigration: Final Report*. Montreal: Canadian HIV/AIDS Legal Network.

⁴⁴ The study reported that 97 per cent of students felt that all people entering the United Arab Emirates should be tested for HIV. 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* 40:572-578.

States citizens by implying that their risk of contracting HIV through sex is associated primarily with sexual activity with noncitizens.”⁴⁵ The Task Team was concerned that, by perpetuating such misperceptions, HIV-related restrictions discourage countries to “know their epidemic” and develop HIV prevention, treatment and support interventions that truly respond to it.

40. In light of public health considerations that come into play in connection with increased access to antiretroviral therapy – including potentially positive developments, such as decreased HIV transmissibility,⁴⁶ and potentially negative developments, such as increased drug resistance – and in light of the fact that no conclusive research has been conducted with regard to the impact of HIV-related restrictions on public health, the Task Team asked WHO to update and provide guidance in relation to the public health impacts of such restrictions.

C. All mobile populations – nationals and non-nationals alike – should benefit from access to evidence-informed HIV programmes as part of efforts to achieve universal access to HIV prevention, treatment, care and support and to implement effective responses to HIV, rather than be subjected to ineffective HIV-related restrictions on entry, stay and residence.

41. In 1988, WHO stated that: “HIV screening of international travellers would be ineffective, impractical and wasteful.... Rather than screening international travellers, resources must be applied to preventing HIV transmission among each population, based on information and education, and with the support of health and social services.”⁴⁷ Since that time, the Task Team found that there is much greater knowledge of what constitutes effective, evidence-informed HIV prevention measures. Furthermore, there is much greater political commitment to the proposition that, in order for prevention to be both effective and equitable, all populations at risk of HIV should have access to HIV prevention measures. Finally, in the age of antiretroviral therapy, there is recognition that effective prevention programmes are those that build upon synergies with effective treatment programmes and vice versa.

42. In the *Declaration of Commitment on HIV/AIDS* (2001), States committed themselves to “By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile

⁴⁵ P Nieburg, JS Morrison, K Hofler, H Gayle (2007), *Moving Beyond the U.S. Government Policy of Inadmissibility of HIV-infected Non-citizens*. Washington: Center for Strategic and International Studies. Available on-line at <http://www.csis.org/media/csis/pubs/movingbeyondinadmissibility.pdf>

⁴⁶ The Swiss National AIDS Commission (EKAF) released a statement on risk of HIV transmission while under antiretroviral treatment and in the absence of other sexually-transmitted infections. The Commission states that “an HIV-infected person on antiretroviral therapy with completely suppressed viraemia (‘effective ART’) is not sexually infectious, i.e. cannot transmit HIV through sexual contact.” However, the Commission qualifies its statement, noting that it is considered valid only so long as: (a) the person adheres to antiretroviral therapy, the effects of which must be evaluated regularly by the treating physician, and (b) the viral load has been suppressed (< 40 copies/ml) for at least six months, and (c) there are no other sexually transmitted infections. See P Vernazza et al (2008), “Les personnes séropositives ne souffrant d’aucune autre MST et suivant un traitement antirétroviral efficace ne transmettent pas le VIH par voie sexuelle”, *Bulletin des médecins suisses* 89:165-169. Available on-line at http://www.saez.ch/pdf_f/2008/2008-05/2008-05-089.PDF In response to the statement, UNAIDS and the World Health Organization have reiterated the importance of a comprehensive approach to HIV prevention, including correct and consistent use of condoms. The joint UNAIDS/WHO statement acknowledges that research suggests that when the viral load is undetectable in blood the risk of HIV transmission is significantly reduced, but goes on to note that it has not been proven to completely eliminate the risk of transmitting the virus. See “Antiretroviral therapy and sexual transmission of HIV” (1 February 2008). Available on-line at http://data.unaids.org/pub/PressStatement/2008/080201_hivtransmission_en.pdf

⁴⁷ World Health Organization (1988), “Statement on screening of international travellers for infection with Human Immunodeficiency Virus”. WHO/GPA/INF/88.3.

workers, including the provision of information on health and social services.”⁴⁸ In 2006, in the *Political Declaration on HIV/AIDS*, governments called for the scaling up of “comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector towards the goal of universal access to comprehensive prevention programmes, treatment care and support by 2010.”⁴⁹ In the *Political Declaration*, governments also “reaffirmed that the prevention of HIV infection must be the mainstay of national, regional and international responses to the pandemic.”⁵⁰

43. In its 2005 policy position paper on *Intensifying HIV prevention*, UNAIDS stated that “For key populations experiencing rapidly rising or high HIV infection rates (for example, injecting drug users, sex workers, economic migrants, prisoners and men who have sex with men), HIV treatment access provides significant new opportunities for HIV prevention as a result of the increased accessibility of these hitherto hard-to-reach groups. These opportunities must not be lost if a significant impact on the HIV epidemic is to be made.”⁵¹ The UNAIDS *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*, published in 2007, underlined the importance of including programmes for migrant workers and mobile populations within national HIV responses.⁵²
44. In light of these commitments and relevant policy and technical guidance, the Task Team found that ensuring the access of mobile populations – nationals and non-nationals – to HIV prevention, treatment, care and support would likely be more effective in preventing HIV transmission and protecting the public health than are HIV-related restrictions on entry, stay and residence. Such access would empower all people, national and non-nationals, in the context of travel and migration, to be able to avoid becoming infected with HIV and to avoid infecting others. Furthermore, increased access to treatment would maintain productivity, avoiding the need for costly health care, while likely reducing infectiousness if taken under optimal conditions. Thus, the Task Team found that much greater efforts should be made to expand access to evidence-informed HIV programmes and services that have proven to be effective to travellers and migrants; in contrast to application of ineffective and discriminatory measures to deny entry or stay based on HIV status.

D. Restrictions on entry, stay and residence that specify HIV, as opposed to comparable conditions, and/or are based on HIV status alone are discriminatory.

45. The Task Team recognized that States may impose immigration and visa restrictions as a valid exercise of their national sovereignty. However, the Task Team also considered that States must be mindful of their international human rights commitments and obligations,

⁴⁸ Para. 50, UN Document A/RES/S-26/2. Available on-line at <http://www.un.org/ga/aids/docs/aress262.pdf>

⁴⁹ Para. 20, UN Document A/RES/60/262. Available on-line at http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

⁵⁰ *Ibid.*, para. 22.

⁵¹ UNAIDS (2005), *Intensifying HIV prevention: a UNAIDS policy position paper*, at p.10. Available on-line at http://data.unaids.org/Publications/IRC-pub06/jc585-prevention%20paper_en.pdf

⁵² Available on-line at http://data.unaids.org/pub/Agenda/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf See also UNAIDS, International Labour Organization and International Organization for Migration (2008), *Policy Brief: HIV and International Labour Migration*. Available on-line at http://data.unaids.org/pub/Manual/2008/20080716_jc1513_policy_brief_labour_migration_en.pdf

including those relating to non-discrimination and equality before the law.⁵³ The Task Team found that restrictions on entry, stay and residence based on HIV status alone amount to differential and discriminatory treatment of HIV-positive people and inequality before the law. As such, these restrictions represent limitations on the right to non-discrimination and the right to equality before the law. The Task Team was of the view that States which felt that it was necessary and justified to limit these rights through HIV-related restrictions in order to “protect the public health” should, in line with the *Siracusa* principles, show compelling reasons for these limitations and show that they have chosen the least restrictive means to rationally achieve their public health goals.⁵⁴ The Task Team thus felt that the burden is on States that have enacted such restrictions to demonstrate that they are justified and rational (not on others to demonstrate that they are irrational and wrong). However, the Task Team felt that no State has yet done that.

46. As previously stated, the Task Team found no evidence that HIV restrictions on entry, stay and residence based on positive HIV status alone serve to protect the public health and was concerned that they may indeed harm the public health. The differential treatment of HIV-positive people based on status alone is therefore not justified. Nor is the *blanket* exclusion or deportation of all people living with HIV the least restrictive means possible to achieve any public health goal. A blanket measure does not serve to rationally identify those who may or may not actually pose a threat to public health.
47. In 1988, the World Health Assembly urged Member States “to protect the human rights and dignity of HIV-infected people....and to avoid discriminatory action against and stigmatization of them in the provision of services, employment and *travel* (emphasis added).⁵⁵ In 1995, the former United Nations Commission on Human Rights (now the Human Rights Council) confirmed that “discrimination on the basis of AIDS or HIV status, actual or presumed, is prohibited by existing international human rights standards, and that the term ‘or other status’ in non-discrimination provisions in international human rights texts can be interpreted to cover health status, including HIV/AIDS”.⁵⁶ Since the beginning of the HIV epidemic, it has been repeatedly recognized that it is essential to protect the rights and dignity of people living with HIV and to involve them in national responses to HIV not only because it is right but also because it leads to the most effective responses to HIV. This has been confirmed by governments in the *Declaration of Commitment on HIV/AIDS* (2001) and *Political Declaration on HIV/AIDS* (2006).⁵⁷ The Task Team finds that one of the essential ways to protect the rights and dignity of people living with HIV and fulfill these commitments is by rescinding restrictions on entry, stay and residence based on HIV status.

⁵³ United Nations Human Rights Committee (1989), “International Covenant on Civil and Political Rights, General Comment No. 18: Non-discrimination”. Available on-line at

[http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/3888b0541f8501c9c12563ed004b8d0e?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/3888b0541f8501c9c12563ed004b8d0e?Opendocument)

⁵⁴ “Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights” (1984), UN Document E/CN.4/1984/4.

⁵⁵ “Avoidance of discrimination in relation to HIV-infected people and people with AIDS” (1988), WHA Resolution 41.24.

⁵⁶ “The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)”, Commission on Human Rights resolution 1995/44. Available online:

http://ap.ohchr.org/Documents/E/CHR/resolutions/E-CN_4-RES-1995-44.doc

⁵⁷ See notes 6, 7 and 8.

E. Exclusion or deportation of HIV-positive people to avoid potential costs of treatment and support should be based on an individual assessment of the actual costs that are likely to be incurred, should not single out HIV, and should not override human rights considerations or humanitarian claims.

48. States have long excluded persons on the bases of lack of self-sufficiency, public charge or undue burden/excessive demand on public monies/services. There are many chronic health conditions, as well as conditions not related to health, that might result in someone becoming a public charge or requiring support by public monies or services. The Task Team recognized that a person living with HIV, like anyone with a chronic health condition, might incur significant health care costs and might be in need of health care assistance and social support, and that it might be legitimate for a State to deport or exclude that person if indeed the person was a public charge or was likely to become one or make excessive demands on public funds.⁵⁸ However, the Task Team found that laws and policies that single out HIV, as opposed to comparable conditions, and use HIV-positive status only as a basis for exclusion or deportation to avoid possible costs are discriminatory and overly-broad.⁵⁹ Such laws and policies appear to *presume* that people living with HIV would become “an undue burden” on the State and/or are “medical migrants” seeking to enter or stay to benefit from publicly available health care. Such presumptions are objectionable.
49. Increasing access to antiretroviral therapy has resulted in more and more HIV-positive people living long lives, supporting themselves fully, and contributing productively to society. The drive towards universal access to HIV prevention, treatment, care and support should also result in less need to “medically migrate” to other countries to receive life-saving drugs.⁶⁰ The Task Team heard no evidence that countries without HIV-related restrictions and with free provision of HIV treatment have experienced significant numbers of HIV-positive foreigners entering or staying to use State-sponsored medical benefits.
50. In their 2004 *Statement on HIV/AIDS-related Travel Restrictions*, UNAIDS and the International Organization for Migration recommended that countries not single out HIV or treat it differently from similar conditions, and that countries perform individual

⁵⁸ HIV screening carried out during immigration procedures may not always be associated with exclusion. A 2008 news article in Canada cited information from Citizenship and Immigration Canada, which stated that of the 2,567 immigration applicants who tested positive for HIV from January 2002 to December 2006, only 126 were refused. The spokesperson for the government agency was quoted as saying such applicants aren't considered an excessive burden on the medical system – “the medical cost considered during a five to 10-year period generally isn't considered untoward... Given that Canada accepted 1.2 million immigrants in the 2002-2006 time frame, [the number of immigrants with HIV is] a very small number.” See Bill Kaufmann (2008), “Canada welcomes HIV immigrants: Sun learns thousands who have the virus causing AIDS allowed to come to Canada”. *Calgary Sun*, 20 March 2008.

⁵⁹ In one of the only published cost analyses relating to HIV-related restrictions on entry, stay and residence, the authors sought in 1992 to compare costs associated with HIV and other diseases with regard to immigration policy in Canada. Notable is the authors' conclusion: “The economic impact of HIV infection in immigrants to Canada is similar to that of [coronary heart disease]. This comparison identifies an important shortcoming in current immigration policy: economic considerations can be arbitrarily applied to certain diseases, thereby discriminating against specific groups of immigrants.” See H Zowall, L Coupal, RD Fraser, N Gilmore, A Deutsch, SA Grover (1992), “Economic impact of HIV infection and coronary heart disease in immigrants to Canada”, *Canadian Medical Association Journal* 147(8):1163-72.

⁶⁰ WHO, UNAIDS and UNICEF (2008), *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector – progress report 2008*. Available on-line at http://www.who.int/hiv/pub/towards_universal_access_report_2008.pdf

assessments regarding issues of self-sufficiency.⁶¹ The Task Team found that this recommendation proposes a process that would seem to address legitimate government concerns as well as avoid discriminatory and overly-broad treatment.

51. Thus, the Task Team reiterated that individual assessments are a more rational means by which to identify potential “public charge” cases and a less restrictive approach than blanket exclusions which automatically exclude all HIV-positive people. Such an assessment should ascertain that the person requires health and social assistance; is likely in fact to use it in the relatively near future; has no other means of meeting such costs (e.g. through private or employment-based insurance, private resources, support from community groups); “and that these costs will not be offset through benefits that exceed them, such as specific skills, talents, contribution to the labour force, payment of taxes, contribution to cultural diversity, and the capacity for revenue or job creation.”⁶²
52. In line with human rights commitments and valid humanitarian considerations, the Task Team also strongly felt that the implementation of restrictions on entry, stay and residence to avoid potential costs to public funds should not prevail over national obligations to protect individual human rights and address humanitarian concerns.⁶³ (See further discussion under findings G and H.)

F. Restrictions on entry, stay or residence based on HIV status unreasonably restrict the participation of people living with HIV in major life activities and reduce their involvement in the response to HIV.

53. The Task Team found that restrictions on entry, stay and residence based on HIV status deny to people living with HIV an equal opportunity to participate in major life activities. These major life activities can include: conducting business travel and personal or tourist visits in other countries; attending meetings; studying abroad; migrating for labour; participating in international humanitarian and development efforts; serving in consular services abroad; seeking or receiving asylum; and moving to unite with family members.
54. HIV-related restrictions can also prevent or hinder HIV-positive people from participating in international conferences and meetings that shape global HIV policy. This prevents them from being able to effectively influence and shape the HIV response based on their considerable experience and knowledge. It contravenes the human rights principles of participation and inclusion as well as the principle of the Greater Involvement of People Living with HIV (GIPA). The principle of GIPA was originally adopted by 42 governments in the Paris Declaration at the Paris AIDS Summit in 1994,⁶⁴ and has been reaffirmed in the *Declaration of Commitment on HIV/AIDS (2001)* and the *Political Declaration on HIV/AIDS (2006)*. For example, paragraph 33 of the *Declaration of Commitment* begins: “Acknowledging the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects and recognizing that their full involvement and participation in design,

⁶¹ UNAIDS and International Organization for Migration (2004), *UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions*.

⁶² *Ibid.*

⁶³ *Ibid.*

⁶⁴ Available on-line at http://data.unaids.org/pub/ExternalDocument/2007/the-paris-declaration_en.pdf

planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic.”⁶⁵

55. The Task Team discussed the impact on GIPA of HIV-related restrictions on entry, stay and residence, as highlighted by the choice of the venue of the annual/biennial International AIDS Conference. The International AIDS Society, with the support of many of those participating in the International AIDS Conference, has refused since 1990 to hold the conference in countries that restrict the entry of people living with HIV.⁶⁶ The Task Team acknowledged the efforts of the HIV community to honour GIPA in this regard. It also acknowledged, however, that there continue to be other situations where people living with HIV cannot cross borders to participate in conferences that most concern them. This was dramatically underlined by the holding of the United Nations General Assembly Special Session on HIV/AIDS (2001) and the two High Level Meetings on HIV/AIDS (2006, 2008) at that United Nations Headquarters in New York, United States of America. With regard to the 2008 High Level Meeting on AIDS, the Task Team, through its Co-chairs, wrote to the Civil Society Task Force to the High Level Meeting⁶⁷ to express its concern about the holding of the High Level Meeting on HIV/AIDS in a country with HIV-related restrictions on entry, stay and residence.⁶⁸

56. The Task Team acknowledged that some countries employ waiver programmes which provide a means for HIV-positive people to engage in many of the activities and events described in this section. The Task Team found, however, that waivers to allow entry into a country that maintains restrictions on entry, stay and residence based on HIV status is not an acceptable way to deal with such restrictions; rather, such restrictions themselves should be removed. Of particular concern to the Task Team was that such waivers require disclosure of HIV status and result in loss of confidentiality concerning HIV status.

G. The implementation of HIV-related restrictions on entry, stay and residence can also interfere with the rights to life, privacy, liberty, work, the highest attainable standard of health, the rights of women, the rights of the child, the rights of migrants, and the rights to seek asylum and to protect the unity of the family.

57. The Task Team found that, according to the information before it, in many if not most instances the implementation of HIV-related restrictions on entry, stay and residence appeared to contravene international standards regarding HIV testing and counselling. HIV testing and counselling is internationally recognized as the “gateway to treatment”, as well as an important entry point for supporting prevention of HIV transmission. In the *UNAIDS/WHO Policy Statement on HIV Testing*, UNAIDS and WHO state that all HIV testing

⁶⁵ With regard to the 2006 *Political Declaration*, see for example para. 20, where governments commit “to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010 (emphasis added);”

⁶⁶ On this point, see note 11 above.

⁶⁷ The Civil Society Task Force was convened at the request of the Office of the President of the United Nations General Assembly to support effective and meaningful participation of civil society organizations and the private sector in the High Level Meeting on AIDS. For more information about the Task Force, see <http://www.un.org/ga/aidsmeeting2008/civilsociety.shtml>

⁶⁸ E-mail exchange between the Task Team Co-chairs and the Co-chair of Civil Society Task Force, February 2008. A number of civil society organizations expressed similar concerns. For an example of the letter sent by the European AIDS Treatment Group to United Nations Secretary-General Ban Ki-moon and the President of the 62nd session of the United Nations General Assembly, Srgjan Kerim, see http://www.eatg.org/view_file.php?file_id=133

should be conducted under conditions of the “3 Cs”: “such testing of individuals must be confidential, be accompanied by counselling and only be conducted with informed consent, meaning that it is both informed and voluntary.”⁶⁹ The Policy Statement goes on to say that: “WHO and UNAIDS do not support mandatory or compulsory testing of individuals on public health grounds.... Recognizing that many countries require HIV testing for immigration purposes on a mandatory basis ...UNAIDS/WHO recommend that such testing be conducted only when accompanied by counselling for both HIV-positive and HIV-negative individuals and referral to medical and psychosocial services for those who receive a positive test result”.⁷⁰ Furthermore, the *ILO Code of practice on HIV/AIDS and the world of work* (2001) (sections 4.6. and 8) provides guidance on HIV testing in the context of work. It states that screening for purposes of exclusion from employment or work processes should not be required of job applicants or persons in employment, nor for insurance purposes.⁷¹

58. However, it appears that in the implementation of the majority of HIV-related restrictions, HIV testing is not used as a screening tool to promote health, but rather as a mandatory means by which to identify, deny entry and/or deport people on the basis of their health status, or to pre-screen them for employment and/or labour. In countries of origin or destination, travellers or migrants are usually unable to benefit from national laws and policies that otherwise protect nationals against compulsory or mandatory HIV testing, including for employment purposes.⁷² It does not appear that many migrants, either prospective or already in destination countries – either tested for HIV before going to a country or tested while in the country – are told why they are being tested; are provided counselling and informed consent; are provided the test results or benefit from full confidentiality. It appears that individuals are seldom referred to any HIV services, including, if found to be HIV-positive, to treatment and other forms of support.⁷³ The Task Team found that HIV testing under these conditions is a violation of medical ethics, and can constitute an interference with the rights to privacy, the highest attainable standard of health, life and to rights found under ILO conventions relating to migrants.⁷⁴

⁶⁹ UNAIDS/WHO Policy Statement on HIV Testing (2004). Available on-line at http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf

⁷⁰ *Ibid.* See also WHO and UNAIDS (2007), *Guidance on Provider-initiated Testing and Counselling in Health Facilities*. Available on-line at http://www.who.int/hiv/pub/guidelines/9789241595568_en.pdf

⁷¹ International Labour Organization (2001), *ILO code of practice on HIV/AIDS and the world of work*. Available on-line at http://www.ilo.org/public/english/protection/trav/aids/code/languages/hiv_a4_e.pdf

⁷² Concern has also been expressed by the Committee on Migrant Workers, which monitors implementation of the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*. It issued the following concluding observations in 2007 after reviewing the State report of Egypt and meeting with a national delegation: “The Committee expresses its concern that foreign migrant workers seeking permission to work in Egypt must provide a certificate proving that they do not carry HIV/AIDS. It recalls that, according to the [International Labour Organization] Code of Practice on HIV/AIDS and the World of Work, HIV testing should not be required at time of recruitment. The Committee recommends that medical tests of migrant workers be in conformity with the [Code of Practice] and the *International Guidelines on HIV/AIDS and Human Rights*.” UN Document CMW/C/EGY/CO/1, paras. 32-33. Available online: http://www2.ohchr.org/english/bodies/cmw/docs/cmw_c_egy_co1.doc

⁷³ CARAM Asia (2007), *State of Health of Migrants 2007 – mandatory testing*. Available on-line at http://www.caramasia.org/reports/SoH2007/SoH_Report_2007-online_version.pdf However, see also note 25 above.

⁷⁴ In particular, see *Migration for Employment Convention (Revised)*, 1949 (no.97), and *Migrant Workers (Supplementary Provisions) Convention*, 1975 (no.143). Also of relevance are the four key ILO equality Conventions: the 1958 Discrimination Convention (no.111), the 1951 Equal Remuneration Convention (no.100), the 1981 Workers with Family Responsibilities Convention (no.156) and the 2000 Maternity Protection Convention (no.183). The rights codified in these instruments include the rights of migrant workers to social security, non discrimination, equality before the law, the right to work, the right to the highest attainable standard of physical and mental health, the protection of the family unit, the right to freedom of movement and the right to a healthy and safe working environment. For further detail and to access other ILO conventions, see ILOLEX (ILO Database of International Labour Standards), available on-line at <http://www.ilo.org/ilolex/english/convdisp1.htm>.

59. Upon detection of a foreigner's HIV-positive status through mandatory HIV testing, the *Global Database on HIV-related Travel Restrictions* indicates that some 28 countries have policies calling for the deportation of the HIV-positive foreigner.⁷⁵ Some of these people are confined in immigration detention pending deportation, and there have been reports of HIV-positive people dying while being held in immigration detention where treatment was denied, or upon being deported back to a situation where they could not receive, or continue, treatment.^{76,77}
60. HIV-positive migrants who are deported may not receive their full wages or compensation, and commonly must pay the cost of the return air ticket home.⁷⁸ Upon return, migrants can face severe economic consequences: families commonly go 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. Furthermore, as testimony has shown, when a migrant worker prematurely returns home empty-handed, community and family members may become suspicious. Research by CARAM Asia has shown that, because migrants often come from the same source communities, the community is likely to find out that the migrant was deported. Driven by fear of the impact that disclosure of HIV status may have, some deported migrants have avoided returning to their home communities.⁷⁹ Other migrants may manage to hide their status due to despair, self-stigma or fear of discrimination, not only threatening their own health but also increasing their partner's/spouse's vulnerability to HIV.⁸⁰
61. The Task Team also acknowledged that the implementation of HIV-related restrictions may impact the protection of the family and the rights of the child. International human rights law has recognized that respect for family life should be considered as a basis for allowing a non-national to enter or reside in country.⁸¹ However, families seeking to migrate or seeking asylum and/or resettlement may be denied family unity if one member of the family is HIV-positive and therefore blocked from entry and residence. (For further discussion on the impact of HIV-related restrictions on refugees and asylum-seeker, see finding H.) Prospective adoptive parents may also not be able to adopt an HIV-positive child from another country. Experiences of families seeking to adopt HIV-positive children illustrate how HIV-related restrictions against the entry, stay and residence of children living with HIV are discriminatory, increase emotional and financial costs, and in some cases can cause delays that result in the child not having timely access to treatment.⁸²

⁷⁵ See www.hivtravel.org. See also Mapping of restrictions on the entry, stay and residence of people living with HIV.

⁷⁶ Daniel M. Bernstein, Vishal Trivedi, Cecelia Volk, Felix Lopez (2008), *HIV and lawful permanent residency: an analysis of the HIV bar, waivers, and prospects for change*. New York: Gay Men's Health Crisis. Available on-line at http://www.gmhc.org/policy/federal/2008_residency.pdf Human Rights Watch (2007), *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*. Available on-line at

<http://www.hrw.org/reports/2007/us1207/us1207webwcover.pdf> See also "Open letter protesting death of Victoria Arellano in detention", 11 September 2007. Available on-line at <http://www.aidsinfonyc.org/tag/activism/arellanoltr.html>

⁷⁷ For an example of a case where the deportation of a person living with HIV was blocked by the European Court of Human Rights, see *D v. United Kingdom*, no. 30240/96, ECHR 1997-III. However, the Court will not prevent deportation when treatment is likely available in the country of return. See *N v. United Kingdom*, no. 26565/05, ECHR 2008 (27 May).

⁷⁸ CARAM Asia (2007), *State of Health of Migrants 2007 – mandatory testing*.

⁷⁹ *Ibid.*

⁸⁰ See *The impact of HIV-related restrictions on entry, stay and residence: personal narratives*, available at www.unaids.org.

⁸¹ For example, see United Nations Human Rights Committee (1986), "International Covenant on Civil and Political Rights: General Comment No. 15 on the position of aliens under the Covenant." Available on-line at

[http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/bc561aa81bc5d86ec12563ed004aaa1b?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/bc561aa81bc5d86ec12563ed004aaa1b?OpenDocument). See also UNAIDS and International Organization for Migration (2004), *UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions*.

⁸² See note 80.

62. Another concern raised by the Task Team was that relating to trafficked persons. The Task Team was concerned that persons trafficked into countries of destination and infected by HIV during the course of their exploitation should not be subject to HIV-related restrictions if it is in their best interest not to be returned to their country of origin.

H. HIV-related restrictions on entry, stay and residence should not result in the denial of the right to seek asylum, the right to be protected from *refoulement* or other rights applicable to refugees and asylum-seekers.

63. The Task Team found that refugees and asylum-seekers are uniquely affected by HIV-related restrictions on entry, stay and residence. Information provided to the Task Team⁸³ indicated that some countries, which otherwise apply HIV-related restrictions to the entry, stay and residence of foreign nationals, exempt refugees and asylum-seekers from these restrictions. A number of countries issue waivers for refugees under certain conditions. Several countries, however, in particular those with no specific asylum laws or which are not party to the 1951 Convention relating to the Status of Refugees, apply the same HIV-related restrictions to refugees and asylum-seekers as to all other foreigners. In these cases, the restrictions may result in the automatic denial of entry or deportation of HIV-positive asylum-seekers or refugees.

64. Furthermore, access to asylum procedures in several countries appears to be procedurally connected with mandatory HIV testing. Some countries require mandatory HIV testing for persons applying for asylum, although a positive test does not have any adverse impact on the asylum decision but rather takes place with the purpose to facilitate access to antiretroviral treatment and medical facilities. In other countries, however, mandatory testing may have severe implications for those who test positive, including the denial of access to asylum procedures and/or automatic removal from the country of asylum. Some countries also require mandatory testing if recognized refugees seek work permits or change their residency status. This may lead to *refoulement* if the refugee tests HIV positive.

65. The Task Team encouraged further review of the impact of HIV-related restrictions on the entry, stay and residence on asylum-seekers and refugees as part of steps toward the elimination of such restrictions. The Task Team reiterated the importance of recognizing that refugees and asylum-seekers enjoy all human rights and have specific rights as set forth by the 1951 Refugee Convention, including the right to be protected against *refoulement*, which is also considered customary international law.⁸⁴ The Task Team underlined that the application of HIV-related restrictions on entry, stay and residence, and/or HIV status, should not result in the human rights of refugees or asylum-seekers from being abridged, should not be a ground for any exception to the principle of *refoulement*, and should not be a ground for expulsion of a refugee to a third country.

66. The Task Team welcomed the fact that the evolving interpretation of the refugee definition contained in the 1951 Refugee Convention has included increasing recognition

⁸³ This information was provided to the Task Team by UNHCR and was based on internal documents of UNHCR, including Annual Protection Reports.

⁸⁴ Under the *1951 Convention relating to the Status of Refugees*, as well as under customary international law, States are prohibited from returning a refugee to a country where his or her life or freedom would be threatened on account of his or her race, religion, nationality, membership of a particular social group or political opinion.

of valid HIV-related asylum claims by various jurisdictions, although few cases have been recognized on grounds of HIV status alone. It was also pleased to note that some States have introduced provisions in their immigration laws which allow for residence or stay permits to be issued on valid humanitarian medical grounds.

I. Political will, leadership and the commitment of governments, intergovernmental organizations and civil society are critical and necessary in order to eliminate restrictions on entry, stay and residence based on HIV status.

67. The Task Team underlined that the leadership of governments is critical if restrictions on entry, stay and residence based on HIV status are to be removed. Some 103 countries, territories, and areas do not employ such restrictions, and in this regard, are providing leadership on this issue.⁸⁵ Similarly, countries that had such restrictions and decided to get rid of them are providing leadership. At the High Level Meeting on AIDS (2008), the President of El Salvador, Elías Antonio Saca González, stated that:

We cannot accept the burden imposed on HIV-positive people due to discriminatory practices when travelling. In this era of globalisation, restricting the travel of people living with HIV does not have any impact whatsoever on public health, however it does have a discriminatory effect on the lives of those living with this virus... I urge the international community, as well as the leaders of the world, to bring down walls and restrictions which hamper the free movement of persons living with HIV... Four years ago, El Salvador eliminated those restrictions which were discriminatory for those living with HIV/AIDS.⁸⁶

68. At the time of this report, both China and the United States of America were working to improve the situation with regard to their own restrictions based on HIV status.⁸⁷ In both the *Declaration of Commitment on HIV/AIDS* and the *Political Declaration on HIV/AIDS*, governments committed themselves to eliminate all forms of discrimination against people living with HIV. In the spirit of these Declarations, the Task Team found that governments with restrictions on entry, stay and residence based on HIV status should eliminate them, and governments whose citizens are subjected to such restrictions should raise these issues on a bilateral basis, urging that discriminatory restrictions be lifted and that their citizens be protected from harmful and discriminatory practices.⁸⁸ The leadership of lawmakers in parliaments across the world will be essential toward the elimination of these restrictions.

69. The Task Team also urged international and intergovernmental organizations to provide leadership against HIV-related restrictions on entry, stay and residence. In the past, IOM, the Global Fund, UNAIDS, UNDP, WHO and others have spoken out forcefully against them. The Task Team welcomed the leadership by the United Nations Secretary-General at the June 2008 High Level Meeting on AIDS, where he called for “a change in laws that uphold stigma and discrimination – including restrictions on travel for people living with

⁸⁵ See *Mapping of restrictions on the entry, stay and residence of people living with HIV*, available at www.unaids.org, and the Global Database on HIV-related Travel Restrictions, www.hivtravel.org.

⁸⁶ Elías Antonio Saca González, President of the Republic of El Salvador, United Nations High Level Meeting on AIDS, June 2008. Webcast of statements made at the High Level Meeting are available on-line at

<http://www.un.org/webcast/aidsmeeting2008/index.asp>, for examples of other statements see *Entry Denied: Denying entry, stay and residence due to HIV status – ten things you need to know*.

⁸⁷ For further details see paragraph 10 and notes 13 and 14 above.

⁸⁸ For an example of such practice, see note 35 above.

HIV”. HIV-positive United Nations staff members, a group potentially very affected by such restrictions, have also spoken out against them.⁸⁹ Such leadership must continue, and the momentum of such efforts maintained.

70. Civil society partners have played, and continue to play, a lead role in global advocacy and pressing for government accountability on non-discrimination and the elimination of HIV-related restrictions on entry, stay and residence.⁹⁰ The Canadian HIV/AIDS Legal Network, CARAM Asia, Ecumenical Advocacy Alliance, European AIDS Treatment Group, Gay Men’s Health Crisis, International AIDS Society, International Council of AIDS Service Organizations, Lutheran World Federation Council, National AIDS Trust, Physicians for Human Rights, World AIDS Campaign, and others, a number of whom are members of the Task Team, have advocated strongly against such restrictions.⁹¹ Civil society organizations also assumed a leadership role at the June 2008 United Nations High Level Meeting on AIDS by advocating with governments to eliminate restrictions based on HIV status through the Civil Society Task Force;⁹² at the Interactive Civil Society Hearing entitled *Action for Universal Access 2010: Myths and Realities*; at a side event entitled “Entry Denied”; and through strategic engagement of the media. Civil society actively advocated for attention to HIV-related restrictions in the meeting of G8 leaders in Japan in June 2008. In their outcome declaration, the G8 stated that they “support ongoing work to review travel restrictions for HIV positive people with a view to facilitating travel” and are committed to follow the issue.⁹³
71. As HIV-related restrictions are a national phenomenon - with international impact, the Task Team found that the next step in their elimination will necessarily involve the formation of national coalitions to advocate and work against them in national settings. The Task Team discussed the need for support of such coalitions, comprised of AIDS service organizations, migrant support groups, networks of people living with HIV, and legal and parliamentary advocates. The Task Team worked to produce materials that would assist such efforts.

⁸⁹ UN+, the United Nations System HIV-positive Staff Group, have made travel and mobility one of their priority issues, and have raised their concerns in meetings with the United Nations Secretary-General. Their position papers are available on-line at http://www.unplus.org/index.php?option=com_docman&task=doc_download&gid=9

⁹⁰ For example, the following civil society organizations have served on the Task Team: Bolivian Network of People Living with HIV; Cameroon Network of Associations of PLWHA; Canadian HIV/AIDS Legal Network; Coalition to Lift the Bar; Ecumenical Advocacy Alliance; European AIDS Treatment Group; Ford Foundation; Gay & Lesbian Health Norway; German AIDS Federation; Global Network of People Living with HIV; Global Business Coalition on HIV/AIDS, TB and Malaria; Human Rights Watch; International AIDS Society; International Community of Women Living with HIV; International Council of AIDS Service Organizations; Terrence Higgins Trust; UN+; and World AIDS Campaign.

⁹¹ Additionally, most Task Team members – including civil society – signed-on to the document, *Entry Denied: Denying entry, stay and residence due to HIV status – ten things you need to know*. See inside back cover for endorsements.

Available on-line at www.unaids.org and www.iasociety.org.

⁹² A letter supported by 350 non-governmental organizations was sent to all Heads of States and their Ambassadors to the United Nations, urging that countries that impose HIV-related restrictions should lift them. For more information, including the text of the letter and list of signatories, see <http://www.ua2010.org/en/UA2010/Universal-Access/Travel-Restrictions/CS-letter-on-HIV-related-travel-restrictions> and http://www.icaso.org/resources/HLMTravel_restriction_letter.pdf.

⁹³ G8 Hokkaido Toyako Summit Leaders Declaration, 8 July 2008, para.46(e). Available on-line at http://www.g8summit.go.jp/eng/doc/doc080714_en.html

Recommendations of the International Task Team on HIV-related Travel Restrictions

1. The International Task Team on HIV-Related Travel Restrictions urges all States with HIV-specific restrictions on entry, stay and residence, in the form of laws, regulations, and practices, including waivers, to review and then eliminate them, and ensure that all people living with HIV are no longer excluded, detained or deported on the basis of HIV status.
2. The International Task Team on HIV-Related Travel Restrictions urges all States to ensure the full protection of the human rights of people living with HIV in the context of mobility, under the international human rights framework.
3. The International Task Team on HIV-related Travel Restrictions urges civil society organizations, including people living with HIV, at global, regional and national levels to promote awareness of how HIV-related restrictions on entry, stay and residence based on HIV status are discriminatory, can interfere with human rights principles, and propagate HIV stigma, and call for their urgent removal.
4. In the context of increasing globalization, the International Task Team on HIV-related Travel Restrictions urges the private sector to support and participate in efforts to eliminate HIV-specific restrictions on entry, stay and residence, as part of respect for and protection of the human rights of people living with HIV.
5. The International Task Team on HIV-related Travel Restrictions encourages the relevant international, regional and national human rights mechanisms and institutions to monitor the impact of HIV-specific restrictions on entry, stay and residence.

THE INTERNATIONAL TASK TEAM ON HIV-RELATED TRAVEL RESTRICTIONS RECOMMENDS THAT THE UNAIDS PROGRAMME COORDINATING BOARD:

6. Strongly encourage all countries to eliminate HIV-specific restrictions on entry, stay and residence and ensure that people living with HIV are no longer excluded, detained or deported on the basis of HIV status;
7. Mindful of PCB decision 8.2 taken at its twenty-first meeting, to agree that no Programme Coordinating Board meeting will be held in a country with an HIV-specific restriction on entry, stay or residence based on HIV status.

THE INTERNATIONAL TASK TEAM ON HIV-RELATED TRAVEL RESTRICTIONS RECOMMENDS THAT THE UNAIDS PROGRAMME COORDINATING BOARD REQUEST UNAIDS TO:

8. Support government efforts to review and eliminate laws, policies and practices related to HIV-specific restrictions on entry, stay and residence, through leadership, advocacy and appropriate partnerships at international, regional and national levels;
9. Ask countries to report, as part of UNGASS reporting, on whether they have HIV-related restrictions on entry, stay and residence or have removed them during the reporting period;

10. Include in its workplan the following elements:

- a. Support leadership through the development of advocacy tools and a communications strategy; engagement of the broadest possible range of partners; and strategic support to civil society to take up the issue of HIV-specific restrictions on entry, stay and residence on a global, regional and national basis, including facilitation of dialogue between government and civil society.
- b. Provide technical assistance and develop or expand guidance, in particular:
 - 1) With WHO in the lead, in relation to public health and health economics regarding HIV-related restrictions on entry, stay and residence;
 - 2) In relation to a review of the UNAIDS/IOM Statement on HIV-related Travel Restrictions (2004), in collaboration with IOM, civil society organizations and other relevant stakeholders, and drawing on the expert opinion of WHO and other relevant UN programmes and agencies;
 - 3) With UNODC in the lead, on the inclusion of facilities used to detain immigrants in its work to promote comprehensive HIV prevention, treatment, care and support in prisons;
 - 4) With ILO in the lead, involving actors in the world of work, on the protection of the rights of all workers in relation to HIV-related restrictions, including through global, regional and national coalitions;
 - 5) With UNHCR in the lead, on the protection of refugees and asylum-seekers in the context of HIV-related restrictions on entry, stay and residence;
 - 6) Through an invitation to the UN World Tourism Organization to address the issue of HIV-related restrictions on entry and stay on its agenda, and to include it as a specific topic in the context of the adoption of a proposed declaration on facilitation of tourist travel;
 - 7) In collaboration with IOM, to countries to incorporate into their national HIV strategies and workplans, and through relevant national mechanisms, including the principles of the Three Ones, efforts to eliminate HIV-specific restrictions on entry, stay and residence, and include comprehensive HIV prevention, treatment and care programmes for all mobile populations within national AIDS responses in countries of origin and destination;
 - 8) To the continued collection of information and evidence through strategic support to civil society efforts to develop and maintain a comprehensive, sustainable and publicly available global database on HIV-related restrictions on entry, stay and residence with references to available laws, policies and practices, and the commissioning of necessary research on relevant economic, public health and human rights issues related to such restrictions.

THE INTERNATIONAL TASK TEAM ON HIV-RELATED TRAVEL RESTRICTIONS RECOMMENDS THAT THE GLOBAL FUND BOARD:

11. Agrees that no Board, Committee meeting, or Partnership Forum will be held in a country with an HIV-specific restriction related to entry, stay or residence based on HIV status;
12. Supports work toward country efforts to review and eliminate laws, policies and practices related to HIV-specific restrictions on entry, stay and residence, through leadership, advocacy and appropriate partnerships at international, regional and national levels;
13. Works toward the elimination of HIV-specific restrictions on entry, stay and residence by:
 - a. Encouraging, through its policies and processes, countries to apply for funding for interventions that support the elimination of HIV-related restrictions, which may include operational research on relevant economic, public health and human rights issues, as well as proposals that expand the access of mobile populations to comprehensive HIV prevention, treatment, care and support, including legal support; and
 - b. Working with partners to ensure countries have access to the latest guidance and information from normative agencies on this issue.

THE INTERNATIONAL TASK TEAM ON HIV-RELATED TRAVEL RESTRICTIONS RECOMMENDS THAT CIVIL SOCIETY, INCLUDING PEOPLE LIVING WITH HIV, AT GLOBAL, REGIONAL AND NATIONAL LEVELS:

14. Promotes and supports the leadership of communities most affected by such restrictions;
15. Monitors the progress towards full removal of HIV-specific entry, stay and residence restrictions, and encourages further documentation of how such restrictions affect diverse groups of people;
16. Builds and strengthens coalitions through the active engagement of a wide range of partners, including migrant organizations, law and human rights groups, and trade unions.

Annexes

ANNEX I: International Task Team on HIV-related Travel Restrictions – Terms of Reference

DESCRIPTION

An advisory/technical group whose role is to galvanize attention to HIV-related travel restrictions on national, regional and international agendas, calling for and supporting efforts toward their elimination

COMPOSITION

1. Steering Committee (Co-chairs of Task Team, Co-chairs of Working Groups, Global Fund representative)
2. Working Group on Long-Term Travel Restrictions
3. Working Group on Short-Term Travel Restrictions
4. Secretariat (International AIDS Society)

BROAD DELIVERABLES

1. Strategies for advocacy, communication and awareness-raising against HIV-related travel restrictions.
2. Policy recommendations on HIV-related travel restrictions (short-term and long-term) and update of UNAIDS/IOM statement.
3. Recommendations on programmatic implications regarding the needs and rights of mobile populations (including populations in humanitarian settings), with attention to gender, including rights and needs of women, girls, and sexual minorities.
4. Identification of tools and strategies to address HIV-related restrictions and suggested means for promoting their use and dissemination.
5. Review evidence – public health, human rights, and cost data – on the impact of HIV-related travel restrictions; map case studies, research gaps and include specific analysis of existing programs and policies.

GUIDING PRINCIPLES

1. Non-discrimination and other relevant human rights
2. Greater Involvement of People Living with HIV
3. Evidence-informed policies and programmes

WORKING PRINCIPLES

1. Advisory, strategic and technical, not executive or decision-making
2. Short time-frame and time-limited (substantive work to be concluded largely by July 2008)
3. Broad-based and diverse: representation from governments, civil society, private sector and inter-governmental organizations
4. Interactive and informal
5. Constructive and bold in approach, while respectful of different viewpoints
6. Based on consensus to the extent possible (if necessary, and on agreement of co-chairs, dissenting views will be footnoted and attributed in recommendations and outputs).

ROLE OF THE STEERING COMMITTEE

1. Facilitate and support the work of the Working Groups according to agreed timelines
2. Support necessary communication between the Working Groups

3. Bring outputs of Working Groups together and promote coherence of recommendations and outputs
4. Prepare consolidated draft recommendations based on Working Group outputs and present to the Task Team for consideration
5. Take any necessary decisions on behalf of the Task Team between meetings
6. Support the promotion of the Task Team's recommendations at the Global Forum on Migration and Development (Manila, October 2008), the Global Fund board meeting (November, 2008), and the UNAIDS Programme Coordinating Board (December, 2008).

ROLE OF WORKING GROUP CO-CHAIRS

1. Facilitate a consultative process that enables all Task Team members to provide input into Working Group outputs, including draft recommendations
2. Work with the Task Team Secretariat, as necessary, between meetings to ensure that the views and inputs of Task Team members are appropriately reflected in Working Group outputs
3. Liaise with each other to facilitate communication between the two Working Groups
4. Bring the views and outputs of the Working Group to the Steering Committee
5. Bring feedback from the Steering Committee to the Working Group and guide work towards the overall objectives of the Task Team

POSSIBLE SPECIFIC DELIVERABLES OF TASK TEAM

1. Recommendations to the UNAIDS Programme Coordinating Board (November, 2008) and Global Fund board (December, 2008) on supporting the elimination of HIV-related travel restrictions in short-term and long-term contexts
2. Recommendations and support regarding action, strategies and advocacy at country and regional levels to remove HIV-related travel restrictions
3. Updated mapping of short- and long-term HIV-related travel restrictions packaged in user-friendly form
4. Development of advocacy pieces relating to case studies, impact of people, impact on national HIV responses^
5. Identification of Best Practice regarding regulations and law regarding entry/stay relating to health and health conditions comparable to HIV
6. Input at the High Level Meeting on HIV, 10-11 June; the International AIDS Conference (Mexico, 3-8 August) and the Global Forum on Migration and Development (Philippines, 27-30 October)
7. Desk review of existing data and current studies on the impact of HIV-related travel restrictions and identification of research gaps
8. Input into updated UNAIDS/IOM statement and support to production of short advocacy version

SECRETARIAT (based on contract with UNAIDS)

1. Support Task Team meetings, including writing draft meeting reports
2. Do necessary research between meetings
3. Prepare papers for Task Team meetings
4. Prepare draft recommendations of Task Team, based on Working Group outputs
5. Provide for wider consultation beyond Task Team Members, as necessary and desirable

ANNEX II: Members of the International Task Team on HIV-related Travel Restrictions

CO-CHAIRS

Sissel Hodne Steen Counsellor	Government of Norway Permanent Mission of Norway to the United Nations in Geneva
Susan Timberlake Senior Human Rights and Law Adviser	UNAIDS Secretariat

GOVERNMENTS

Marie Ahouanto Head of Mission, AIDS, Tuberculosis and Malaria	Government of France Ministry of Foreign and European Affairs
Sakyi Awuku Ainoa Director-General	Government of Ghana Ghana AIDS Commission
Emmanuel Gikoro Minister of Health	Government of Burundi Ministry of Health
Djama Guirreh Technical Adviser on HIV/AIDS, Tuberculosis and Malaria	Government of Djibouti Ministry of Health
Mathieu Kohio Legal Adviser to the Minister of Health	Government of Burkina Faso Ministry of Health
Colin McIff Multilateral Organizations Officer	Government of the United States of America US Department of State Office of the US Global AIDS Coordinator
Grace Relucio Princesa Executive Director	Government of the Philippines Ministry of Foreign Affairs Office of United Nations and Other International Organizations
Rodrigo Siman Siri El Salvador AIDS Ambassador	Government of El Salvador Ministry of Public Health and Social Assistance
Mariangela Simao Director, Brazil National AIDS Programme	Government of Brazil National AIDS Programme
Vijay K. Trivedi Counsellor	Government of India Permanent Mission of India to the United Nations in Geneva
Fia van der Klugt Assistant to the AIDS Ambassador	Government of the Netherlands Ministry of Foreign Affairs, Health and HIV/AIDS Division
Ran Wei Senior Programme Officer	People's Republic of China Ministry of Health, Department of International Cooperation

CIVIL SOCIETY AND PRIVATE SECTOR

Joseph Amon Director, Health and Human Rights Program	Human Rights Watch
Brian Brink Group Medical Consultant, Anglo American plc	Global Business Coalition on HIV/AIDS, TB and Malaria
Richard Elliott Executive Director	Canadian HIV/AIDS Legal Network
Kim Fangen Project manager	Gay & Lesbian Health Norway
Deborah Glejser Spokesperson	Groupe Sida Genève
David Haerry	European AIDS Treatment Group
Beri Hull Global Advocacy Officer	International Community of Women Living with HIV
James Clovis Kayo	Cameroon Network of Associations of PLWHA (RECAP)
Craig McClure Executive Director	International AIDS Society
Terry McGovern Program Officer, HIV/AIDS Human Rights Unit	Ford Foundation
Shaun Mellors Senior Technical Adviser, Human Rights	International HIV/AIDS Alliance
Per Miljeteig President, HIV Norway	Global Network of People Living with HIV (GNP+)
Lillian Mworeko Regional Coordinator	International Community of Women Living with HIV
Nancy Ordovery	Coalition to Lift the Bar
Lisa Power Corporate Head of Policy	Terrence Higgins Trust
Brahm Press Convener, State of Health Taskforce	CARAM Asia
Peter Prove Assistant to the General Secretary for International Affairs and Human Rights, Lutheran World Federation	Ecumenical Advocacy Alliance
Gracia Violeta Ross Quiroga National Chair	REDBOL, the Bolivian Network of People with HIV/AIDS
Mary Ann Torres Senior Policy Advisor	International Council of AIDS Service Organizations
Marcel van Soest Executive Director	World AIDS Campaign
Peter Wiessner	German AIDS Federation / Münchner Aids-Hilfe

UN PROGRAMMES AND AGENCIES and INTERGOVERNMENTAL ORGANIZATIONS

Islene Araujo Migration Health Programme Coordinator	International Organization for Migration
Andrew Ball Senior Strategy and Operations Adviser Department of HIV/AIDS	World Health Organization
James Jennings Secretary of the Advisory Group on HIV/AIDS	Inter-Parliamentary Union
Anastasia Kamlyk	UN Plus – the UN System HIV Positive Staff Group
Thierry Mertens Director, Strategic Planning and Innovation	World Health Organization
Davide Mosca Director, Migration Health Department	International Organization for Migration
Béchir N’Daw Human Rights Adviser	United Nations Development Programme
Abigail Noko Human Rights Officer, HIV/AIDS	Office of the UN High Commissioner for Human Rights
Helena Nygren-Krug Health and Human Rights Adviser	World Health Organization
Bruce Plotkin Technical Officer, International Health Regulations Coordination Programme	World Health Organization
Pallavi Rai Technical Specialist ILO Global Programme on HIV/AIDS	International Labour Organization
Taleb Rifai Deputy Secretary-General	World Tourism Organization
Marian Schilperoord Public Health and HIV Section	UN High Commissioner for Refugees
Dianne Stewart Head, Board and Donor Relations	Global Fund to Fight AIDS, Tuberculosis and Malaria
Ibrahim Wani Chief, Development and Economic and Social Issues Branch	Office of the UN High Commissioner for Human Rights

The **International Task Team on HIV-related Travel Restrictions** was established by UNAIDS in January 2008 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.

This is the **Report** of the Task Team, presenting its **Findings** and **Recommendations**. The Task Team affirmed that HIV-specific restrictions on entry, stay and residence based on HIV status are discriminatory, do not protect the public health and are overly broad in terms of rationally identifying those whose entry or stay might result in an undue burden on public monies. According to the Task Team, such restrictions have always been ineffective but have become even more inappropriate in the age of globalization, increased travel, treatment for HIV, and national and international commitments to universal access to HIV prevention, treatment, care and support and the protection of the human rights of people living with HIV.



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