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

1. This bibliography was commissioned by the *International Task Team on HIV-related Travel Restrictions.*[1] It is a based on a desk review of the research and reports available concerning the impact of such restrictions. The first section presents the studies found to focus specifically on the impact of HIV-related restrictions on entry, stay and residence. The second section of the bibliography presents a number of reviews and reports that focus less directly on the subject. The third section presents research that is relevant but more indirectly related to these restrictions. The final section of the bibliography presents some examples of models for addressing these restrictions.

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

Studies that specifically focus on impact of restrictions on entry, stay and residence

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

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

Migrants and their families

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

   Subjects covered

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

   Regional analysis of policies and practices.

   CARAM proposes that, if such testing is to be done, it should be “migrant friendly”.

[1] See *Final Report* of the International Task Team on HIV-related Travel Restrictions, available at www.UNAIDS.org. This bibliography was prepared by Mary Haour-Knipe.

Location

Asia: Countries of origin, territories or regions of origin: Bangladesh, Cambodia, India, Indonesia, Nepal, Pakistan, Philippines, Sri Lanka, Vietnam

Countries, territories or regions of destination: Bahrain, Hong Kong Special Administrative Region of the PRC, Japan, Malaysia, Republic of Korea, Thailand, UAE (Dubai)

Methodology

Participatory research, development of a common framework for each country studied

In-depth interviews with migrants and other stakeholders, focus group discussions, participatory learning and action methods (e.g. mapping, priority ranking)

Key findings

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

Problems for migrant workers include:

Pre-departure: costs (including cost of travel to medical exam sites), poor quality exams, lack of counselling or poorly adapted counselling (e.g. not in migrant's language), exams carried out in ways that abuse dignity, lack of information about results. As the official exam will leave a permanent record on the worker's passport, the report documents a practice of 'pre-medicals' carried out before an official exam, so that potential migrants can make sure they will pass the latter. In at least one country, a CARAM researcher posing as a migrant with a problem documented that it can be possible to bribe an official to 'fix' a negative test result.

At destination: necessity to repeat medical exams (thus additional cost), fear of results, lack of explanations, long waits between various elements of the check-up. Generally better exam conditions than in some countries pre-departure, although with language problems (including need to sign consent forms in a language the migrant does not understand).

Those found 'unfit' are simply asked to leave. They may receive no information about test results, no counselling, and no referral. Deportation is often immediate, or the migrant is placed in detention until deported.

Some workers who are ill return home for treatment to avoid having 'deported' stamped on their passports.

Undocumented workers have no health checks, and little or no access to care and support.

In some instances, countries do not require HIV testing, but employers or recruitment agencies do. Many migrants had misconceptions about who was requiring tests.

Tests may create a false sense of security for the migrant: some interpreted passing the medical exam as a sign that they are healthy, thus can engage in risk behaviours.

On the other hand, well done health checks can be reassuring.

On return migrants deported for health reasons face severe economic consequences: families had often gone heavily into debt to send a worker abroad, and premature return means loss of that investment, as well as loss of the remittances the worker would have sent home. Returnees also experience stigma, discrimination, lack of referral and of support, inadequate links with national or local treatment and support facilities, exploitation by quacks offering false cures for AIDS.

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

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

   "…behind good policies and intentions the realities may be different" (Wolffers, p ix)

   Subjects covered

   Health and labour migration from the Philippines, pre-departure, while abroad, on reintegration.

   Point of view of a sending country in which national epidemiology reports that 34% of HIV cases are among people who have been working overseas.

   Location
   Philippines

   Methodology
   Literature review

   Focus group discussions

   Interviews with migrant workers and other relevant stakeholders

   Key findings

   Although Philippine AIDS Law prohibits HIV testing as a requirement for employment, migrant workers may be required to undergo such testing by the Governments of their countries of destination.

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

   At destination health is not usually a priority for migrant workers; symptoms are ignored until it is not possible to do so any more. Migrant workers may not know where to go for care. They may not have health insurance, or may be insured but not know that they are, or what is covered by their insurance. Workers in difficulty abroad may be afraid to contact the Philippines embassy for assistance because of fear that they will be sent back home.

   Migrant workers diagnosed HIV positive abroad will most likely be deported immediately, without counselling and with no chance to organize their possessions or claim their salaries and other benefits. Those who cannot be deported immediately may be detained. Impacts are psychological (discovering HIV status, fear, frustration), loss of income, and possibly exposure to other infections while in detention.

Migrant workers who return home ill are not followed in any way, and no data is available concerning what happens to them. Embassies are not informed thus cannot assist, and workers are unaware of the services the embassies might have been able to provide.

The heavy impact of HIV infection among migrant workers is economic: an HIV positive result in the medical examination automatically disqualifies a person from further overseas employment, and unemployment is high in the Philippines.

A migrant worker's HIV infection also affects families and communities. Workers may infect their spouses. The family's income is further compromised when medical expenses rise, and when children's education is sacrificed to meet medical expenses.

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

The report concludes that, while laws and policies are important to guarantee that rights are promoted and protected, having laws and policies does not necessarily guarantee that health care and services are accessible. Existing laws and policies may not be sufficiently strong, they may not be strictly implemented, or they may be too easy to circumvent.

See also:

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

   All available from:
   http://www.caramasia.org/index.php?option=com_content&task=section&id=29&Itemid=347
10. **S. F. Morin, H. Carrillo, W. T. Steward, A. Maiorana, M. Trautwein, and C. A. Gomez. Policy perspectives on public health for Mexican migrants in California**. J Acquir.Immune.Defic.Syndr. 37 Suppl 4:S252-S259, 2004.

    Subjects covered

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

    Location
    USA

    Methodology
    Review

Key findings

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

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

See also:

11. **Zencovich, M., Kennedy, K., MacPherson, D. W., & Gushulak, B. D. 2006**, ***Immigration medical screening and HIV infection in Canada***, *Int.J.STD AIDS*, vol. 17, no. 12, pp. 813-816. Paper in JLICA files

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

Travellers

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

    Subjects covered
    Travel to US by HIV positive individuals

    Whether or not US visa and waiver regulations were followed

    Effect of travel restrictions on adherence to ARV regime

    Location
    UK urban centres
    Methodology
    Questionnaires filled out by patients attending HIV clinics in 2004: Manchester (n=408) Brighton (n=346) London (n=359) (overall response rate 67%)

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

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

    69% (n=212) were on ARV, of whom 27 (11%) stopped their medication. Twenty eight mailed their medication in advance, of whom 25 received it on time.

Of those who discontinued treatment, 44% did so without seeking medical advice. Several reported that they did so because they were 'entering a country with an official travel ban for HIV positive subjects', were afraid of being searched by immigration authorities or had a 'fear of being found out'.

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

13. **E. Salit, M. Sano, A. K. Boggild, and K. C. Kain. *Travel patterns and risk behaviour of HIV-positive people travelling internationally***. CMAJ. 172 (7):884-888, 2005.

Subjects covered
Travel activities and pre-travel precautions of HIV-positive people

Burden of illness and risk exposure during travel

Location
Toronto, Canada
Methodology
Anonymous survey among 290 HIV-positive people attending a tertiary care hospital HIV clinic

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

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

Five of the 119 respondents taking antiretroviral therapy reported that they had been harassed crossing borders; 4 attributed this to their antiretroviral medication or their HIV status.

Other reviews that touch on impact

14. A number of documents over the years have discussed the public health, cost, and ethical and human rights arguments concerning HIV-related restrictions on entry, stay and residence[2]. This section of the bibliography focusing on impact presents some

[2] C.f.

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

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

N. Gilmore, A. J. Orkin, M. Duckett, and S. A. Grover. International travel and AIDS. *AIDS* 3 Suppl 1:S225-S230, 1989.

L. O. Gostin, P. D. Cleary, K. H. Mayer, A. M. Brandt, and E. H. Chittenden. Screening immigrants and international travelers for the human immunodeficiency virus. *N.Engl.J Med.* 322 (24):1743-1746, 1990.

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

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

relatively recent reports or analyses that, although they do not attempt to directly assess the impact of travel restrictions, do evoke the subject. The first is an extensive review of population mobility and HIV in Asia, in which a 10 page section discusses the premature return of people who had gone abroad to work.

15. Three secondary sources are also presented. These are the results of expert reviews in countries considering changing their regulations concerning travel restrictions (Canada, UK and US). Although quite different from each other, the three reviews give a comprehensive picture of the issues, including of the problems associated with restrictions.

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

Overviews and discussions

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

Subjects covered
Extensive review of population mobility and HIV in Indonesia

Contains ten pages on migrants returning before end of their contracts, possibly for health reasons. This is one of the rare studies to identify the issue of return migration.

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

Irregular workers do not have health checks.

Contracts are usually for three years, but substantial numbers of workers return early, usually for health reasons (from 12 to 60% of all workers, depending on the study). A study from West Java showed that only half returned because they had completed their contract, 9% because they were sick.

Negative effects of premature return include the experience itself for the worker; financial losses, especially when the worker had gone into debt to be able to travel; and creating a poor image for Indonesian workers.

Data collected in 1998-99 at the Jakarta airport among returning workers, mostly from the Middle East, found that a 1/3 were returning prematurely: 1/4 after less than a year, 1/10 after less than 3 months. About 5% returned for health reasons, although some returnees giving other reasons may in fact have failed medical exams at destination (data concerning HIV status was not requested).

B Hoffmaster and T Schrecker. An ethical analysis of the mandatory exclusion of immigrants who test HIV-positive. Anonymous. Anonymous. Toronto: Canadian HIV/AIDS Legal Network. 2000.

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

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

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

Subjects covered
History of restrictions meant to protect the public health and the public purse, internationally and in Canada

Canadian laws and policies

Recommended changes

Location
Canada
Methodology
Research regarding legal issues

Key informant interviews

Workshop for discussion

Extensive consultation on first draft of report

Key findings
At the time it was written, this was the most thorough review to date, and, although specific to Canada, is a basic reference document. For reference, the report concluded (inter alia) that:

- The possible benefits of mandatory testing of immigrants are outweighed by its potential for harm.
- Any exclusion of a prospective immigrant with HIV on public health grounds is discriminatory and inconsistent with current, commonly accepted public health practice.
- When assessing whether a prospective immigrant with HIV/ would create "excessive demands" on health and social services, each person's individual circumstances must be taken into account, and demands should be considered "excessive" only when the expected cost of government services estimated over a short period (of a few years at most) exceeds the estimated financial contribution that the applicant will make over the same period, and also outweighs the potential social contributions that the individual is expected to make.
- Prospective immigrants with HIV who have compelling compassionate and humanitarian reasons for being in Canada should be granted permanent resident status, rather than being issued [more precarious] permits.
- All medical barriers to admission of refugees should be removed.

Concerning the potential impact, the report proposed that:

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

It also proposed that excluding immigrants with HIV could:

• cause personal hardship, including possibly encouraging families to leave HIV-positive family members behind, where they may suffer without care, treatment, and family support

• constitute unlawful discrimination since many would be excluded even though they would not engage in exposure-producing activities with the nationals of the excluding country

• be grossly disproportionate to any benefit, marginal if any, to be gained in protecting the public health

• constitute an unjustified generalization, and discriminate against those who would not place excessive demands on health or social services by assuming that persons with HIV would all place excessive demands on health or social services

• constitute a slippery slope to further exclusion of persons more likely to need health or social services, for example of people over 50 years of age, or of people who have been shown by genetic screening to be at risk of developing genetic conditions that are expensive to treat.

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

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

Subjects covered
(Inter alia): current difficulties of migrants living with HIV in UK, potential impact of mandatory HIV testing

Location
United Kingdom
Methodology
Series of hearings, expert testimony
Key findings
Re. potential cost: National Health Services in the UK are under strain, but for reasons unrelated to migration.

Clinicians are frequently faced with an ethical dilemma: whether to treat an individual with HIV in need, or to deny treatment if the patient's immigration status does not entitle her to care.

As HIV prevalence rises globally, it is logical that the number of individuals coming to the UK with HIV will also rise: there is an intrinsic link between what is happening at the national level and what is happening at the global level, and:

"… We will be dealing with this challenge in the most effective way when we can ensure that those who do come to the UK with HIV are treated in a timely and effective manner while at the same time working in international partnerships to develop sustainable health systems and access to treatment at the global level" (p 6).

Some elements of asylum and immigration policies - in particular issues around non-citizens' access to health care (so-called 'treatment tourism') - have been developed in response to media agendas, led more by prejudice and fear than by factual assessment.

A culture of blame surrounding HIV, in particular when it is linked to groups viewed as potential carriers, discourages people from being tested or revealing their status, with serious implications for prevention and care.

"Calls for mandatory testing compound the fear and stigma associated with migrants and HIV by giving credence to the idea that these groups are a danger which society must be protected from and further perpetuates the discrimination against them" (para 30).

Such a climate of hostility contributes to driving people with HIV underground, where they become increasingly vulnerable.

Testing migrants for HIV upon entry sends out a false sense of security to the general public. They conclude that they are not at risk of acquiring HIV, and that only immigrants and asylum seekers carry this risk.

By actively singling out HIV as an illness which they would like to keep out of the UK, officials risk discouraging people already in the country to test. This undermines a very significant component of HIV prevention, which rests on individuals feeling comfortable enough to seek out testing.

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

20. Nieburg, P., Morrison, J. S., Hofler, K., & Gayle, H. 2007, *Moving beyond US government* policy *of inadmissability of HIV-infected non-citizens*, Center for Strategic and International Studies, Washington, D.C.

Subjects covered
United States ban on entry of people with HIV: issues and rationale at the time the policy was established in 1987, and subsequent efforts to change the policy

Current procedures: visa application and HIV waiver process for various categories of entrants.

Policy options

Includes extensive footnotes and basic reading list for US issues

Location
United States
Methodology
Expert panel review
Key findings
This panel review touches on several elements related to the impact of travel restrictions:

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

The public health rationale is no longer valid. In fact recent data reviews among HIV-infected immigrants to the United States concluded that many, or even most, had probably become infected after arrival (c.f. Harawa et al below).

A quarter of US residents with HIV are unaware of their infection, and current inadmissibility policy may provide a false sense of security.

Immigrants already legally in the US 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 (c.f. Morin et al above).

Concerning potential cost:

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

And concerning leadership:

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

References concerning immigrant detention

21. People living with HIV who have been discovered to enter countries with HIV travel restrictions may be placed in detention centres while awaiting deportation. A thorough review of the impact of such detention is beyond the scope of this bibliography, but two recently published reviews provide a starting point for further exploration of the subject. Both document lamentable conditions for immigrants held in detention, including lack of appropriate health care in general, and lack of care for HIV disease in specific.

22. **Human Rights Watch 2007, *Chronic Indifference - HIV/AIDS Services for Immigrants Detained by the United States***, Human Rights Watch, New York, Volume 19, No. 5(G).

Subjects covered
Detention of immigrants in the United States, including changes in reaction to terrorist attacks on 11 September 2001

Immigrant detention facilities and conditions, accountability, legal standards

Access to HIV and AIDS treatment in detention centres

Recommendations

Location
United States
Methodology
Interviews with current and former detainees, and Department of Homeland Security and detention facility officials

Independent medical review of treatment provided

Key findings
At the time of writing the US was holding nearly 28,000 immigrants in federal detention centres, privately run prisons, and county jails. These included undocumented persons, legal permanent residents, asylum seekers, families, and unaccompanied children. Mandatory detention had been expanded to include perpetrators not only of crimes designated as "aggravated felonies" but of any crime involving "moral turpitude" a phrase interpreted to justify the detention and deportation of persons guilty of shoplifting, drunk driving and minor drug offences.

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

The investigation of HIV and AIDS care for detained immigrants found that detention facilities failed to: deliver complete anti-retroviral regimens in a consistent manner (thus creating a risk of drug resistance that endangers the health of the detainee and can impact public health); adequately monitor detainees' clinical condition; prescribe prophylactic medications when medically indicated; ensure continuity of care as detainees are transferred between facilities, including access to necessary specialty care; ensure confidentiality of medical care, thus exposing detainees to discrimination and harassment.

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

See also: American Civil Liberties Union of New Jersey: Behind Bars: The Failure of the Department of Homeland Security to Ensure Adequate Treatment of Immigration Detainees in New Jersey

23. **Treatment Action Campaign. *Special Report on Systematic Abuse of Immigrants*. Equal Treatment** 25, 4-27. 2008. Cape Town, TAC.
Detention centres for immigrants also exist in other countries throughout the world. Concerning South Africa, a special issue of the Treatment Action Campaign newsletter, published in June 2008, documented systematic abuse of immigrants in detention centres in that country, as well as highly inadequate health care and sanitary conditions in some.

Research indirectly related to impact

24. The two previous sections have described studies directly related to the impact of HIV restrictions on entry, stay and residence, as well as some recent expert reviews related in some way to the impact of HIV travel restrictions. As already noted, very few studies have directly examined the impact of such restrictions. This section thus turns to studies focusing on other matters, but the findings of which may be relevant.

25. Since the beginning of discourse around the subject, and although variously formulated, the main arguments have always been[3] that HIV travel restrictions are:

- Ineffective
- Counter productive
- Costly

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

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

- HIV is already in every country. Annual UNAIDS epidemiological reports have shown this for some time now. Studies of the spread of HIV subtypes give an intriguing lead for examining hard data about the distribution of the virus.
- People to whom travel restriction are not applied (e.g. returning nationals or tourists) bring HIV into countries. Ever since the beginning of the epidemic, it has been shown that HIV may be carried across borders by nationals returning home after working abroad, as well as by people who are mobile for professional reasons. A growing

[3] See references listed in footnote 1.

number of studies, in addition, are examining tourism in relation to HIV. HIV-related restrictions on entry, stay and residence are not applied to nationals of countries (although in certain instances mandatory testing may) and, given the importance of tourism revenues, few countries prohibit the entry of prospective tourists.

- Immigrants are infected after they arrive in destination countries. The HIV vulnerabilities related to the migration process have been described in other publications. Some studies addressing the extremely sensitive question of where migrants may have been infected are listed below.

Travel restrictions are ineffective

Studies of spread of HIV subtypes

28. **M. M. Thomson and R. Najera. Travel and the introduction of human immunodeficiency virus type 1 non-B subtype genetic forms into Western countries**. Clin.Infect.Dis. 32 (12):1732-1737, 2001.
29. **L. Perrin, L. Kaiser, and S. Yerly. Travel and the spread of HIV-1 genetic variants.** Lancet Infect.Dis. 3 (1):22-27, 2003.
30. **J. M. Achkar, S. T. Burda, F. A. Konings, M. M. Urbanski, C. A. Williams, D. Seifen, M. N. Kahirimbanyi, M. Vogler, M. Parta, H. C. Lupatkin, S. Zolla-Pazner, and P. N. Nyambi. Infection with HIV type 1 group M non-B subtypes in individuals living in New York City**. J Acquir.Immune.Defic.Syndr. 36 (3):835-844, 2004.
31. **L. Buonaguro, M. Tagliamonte, M. Tornesello and f. Buonaguro. Genetic and phylogenetic evolution of HIV-1 in a low subtype heterogeneity epidemic: the Italian experience. Retrovirology**, 2007 (4):34, 2007.

Subjects covered
Distribution of viral subtypes as linked to travel

Location
World wide

Methodology
Thomson & Najera; Perrin et al: Reviews
Achkar et al: Gene analysis of New York city patients likely to have non-B

Key findings

"The spread of the HIV-1 pandemic worldwide is essentially a travel story whose episodes can be traced by epidemiology and molecular tools" (Perrin et al, p 22).

All three articles document the presence of a wide variety of genetic subtypes in countries throughout the world, with new forms of HIV carried by travellers infected in other regions.

The two reviews, especially, note that some groups of travellers may be at risk of transporting HIV subtypes to new areas, thus increase the diversity of HIV-1 worldwide. Apart from immigrants, these include military personnel, tourists, seamen, truck drivers, expatriates, diplomats, and businessmen. In addition, Perrin et al note that in large countries such as Russia, China, India, Brazil, and South Africa internal migrants contribute largely to the spread of HIV-1 diversity.

Of particular interest here is that the above are difficult to affect by HIV restrictions on entry, stay and residence.

Both reviews note, in addition, that in Cuba new strains of HIV were probably introduced by Cuban troops who served in large numbers in Angola in the 1970s and 1980s, and by advisers and other aid workers who served in several countries in sub-

Saharan Africa. More recently, Cuba has become a preferred destination for tourists from Western Europe, raising yet other possibilities for mixing subtypes.

Travellers and HIV

32. **B. J. Ward and P. Plourde. *Travel and sexually transmitted infections***. *J Travel.Med.* 13 (5):300-317, 2006.

Subjects covered

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

Location
World

Methodology
Extensive review article, 178 item bibliography

Key findings

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

Individuals who acquire new sexual partners while travelling, especially those who pay for sex or have multiple casual partners overseas, are at risk for a wide range of STIs.

Travellers who may be at particular risk include: expatriates, travellers returning to their countries of origin to visit family and relatives, military personnel and seamen and men who have sex with men.

See also re travellers:

33. **M. A. Schuhwerk, J. Richens, and J. N. Zuckerman. *HIV and travel*.** Travel.Med.Infect.Dis. 4 (3-4):174-183, 2006.

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

Re. returning expatriates:

34. There are numerous studies mentioning HIV brought home to Western countries by returning expatriates, starting with Vittecoq's 1987 mention of 17 French patients infected in Central Africa[4]. See for example:

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

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

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

37. **M. E. Jones. HIV and the returning expatriate**. J Travel.Med. 6 (2):99-106, 1999.

Re. truck drivers:

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

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

40. **D. Stratford, T. V. Ellerbrock, J. K. Akins, and H. L. Hall. *Highway cowboys, old hands, and Christian truckers: risk behavior for human immunodeficiency virus infection among long-haul truckers in Florida***. *Soc Sci.Med.* 50 (5):737-749, 2000.

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

42. **S. A. Lippman, J. Pulerwitz, M. Chinaglia, A. Hubbard, A. Reingold, and J. Diaz. *Mobility and its liminal context: exploring sexual partnering among truck drivers crossing the Southern Brazilian border***. *Soc.Sci.Med.* 65 (12): 2464-2473, 2007.

Immigrants, migrants and HIV

43. **N. T. Harawa, T. A. Bingham, S. D. Cochran, S. Greenland, and W. E. Cunningham. *HIV prevalence among foreign- and US-born clients of public STD clinics***. Am J Public Health 92 (12):1958-1963, 2002.

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

Location
Los Angeles county, US

Methodology
Analysis of unlinked HIV antibody data on 61,120 specimens drawn for routine syphilis testing among attendees of 7 public STD clinics, 1993-1999.

Key findings

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

HIV-positive clients from all but 2 regions had immigrated in their late teens or very early 20s and had lived in the United States for an average of 12 years. Since the median time between HIV infection and AIDS diagnosis in untreated cases is 10 to 12 years, and the largest proportion of documented AIDS cases are reported in persons aged 30 through 39 years (generally indicating HIV infection during the clients' 20s), the data therefore suggests that most of the HIV-positive STD clients in the study were infected after immigration to the United States.

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

divergent patterns probably resulted from the US Immigration Act of 1990, which fuelled large increases in African immigration during the 1990s[5]. It seems reasonable to assume that a majority of the HIV-positive clients from this region were infected in their countries of origin. NOTE: The article does not address how the immigrants with HIV were admitted to the US. They may have undergone the mandatory testing but been granted permission to enter anyway.

See also

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

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

45. **Shedlin, M. G., Drucker, E., Decena, C. U., Hoffman, S., Bhattacharya, G., Beckford, S., & Barreras, R. 2006, *Immigration and HIV/AIDS in the New York Metropolitan Area***, *J Urban.Health*, vol. 83, no. 1, pp. 43-58.

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

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

    The author of this study points out that unlike settled refugees or asylum seekers, international visitors who obtain tourist, student or business visas to enter the US are not required to undergo HIV testing as part of their application process[6]. Pregnant women are eligible to receive free pre-natal consultations in Philadelphia if they are residents. HIV testing is now a routine part of pre-natal care, and it is often in this context that the African women test positive.

    This qualitative study revealed a number of problems for such women, including several that are pertinent for this review. These include fear of the American health system; AIDS-risk denial; stigma both from HIV and from being an African; and lack of cultural understanding - tinged with racism - on the part of caregivers. On the other hand, the study described other caregivers who find ways to assist both documented and undocumented patients without health insurance. The women's attitudes to testing and treatment in the US were shaped by lack of ARV treatment and high mortality rates in their home countries.

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

[5] Lobo AP. *US diversity visas are attracting Africa's best and brightest*. Popul Today. July 2001;29:1–2 cited in Harawa et al.

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

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

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

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

Some studies showing a relation between migration, often circular migration, and the spread of HIV in different regions of Africa

49. **J. R. Glynn, J. Ponnighaus, A. C. Crampin, F. Sibande, L. Sichali, P. Nkhosa, P. Broadbent, and P. E. Fine. *The development of the HIV epidemic in Karonga District, Malawi*.** *AIDS* 15 (15):2025-2029, 2001.

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

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

50. **E. Lagarde, Loeff M. Schim van der, C. Enel, B. Holmgren, R. Dray-Spira, G. Pison, J. P. Piau, V. Delaunay, S. M'Boup, I. Ndoye, M. Coeuret-Pellicer, H. Whittle, and P. Aaby. *Mobility and the spread of human immunodeficiency virus into rural areas of West Africa*.** *Int J Epidemiol.* 32 (5):744-752, 2003.

51. **C. Kishamawe, D. C. Vissers, M. Urassa, R. Isingo, G. Mwaluko, G. J. Borsboom, H. A. Voeten, B. Zaba, J. D. Habbema, and S. J. de Vlas. *Mobility and HIV in Tanzanian couples: both mobile persons and their partners show increased risk***. *AIDS* 20 (4):601-608, 2006.

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

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

Some studies discussing risk of infection to migrants or people from ethnic minorities returning to visit high prevalence home countries

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

54. **M. A. Kramer, Hoek A. van den, R. A. Coutinho, and M. Prins. *Sexual risk behaviour among Surinamese and Antillean migrants travelling to their countries of origin***. *Sex Transm.Infect.* 81 (6):508-510, 2005.

55. **C. C. O'Connor, L. M. Wen, C. Rissel, and M. Shaw. *Sexual behaviour and risk in Vietnamese men living in metropolitan Sydney*.** *Sex Transm.Infect.* 83 (2):147-150, 2007.

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

Travel restrictions are counter-productive

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

57. To discuss the role of mistrust and fear in delaying care the review engages in some lateral thinking, drawing on studies of tuberculosis and sexually transmitted infections, then lists some studies discussing the same for migrants.

58. Numerous examples could be given of studies of HIV risk among populations out of the range of formal controls: the review uses the example of a recently published study in Bangladesh, where movement of two or three different hidden populations across borders between regions of different HIV prevalence creates a situation of potentially explosive risk.

59. The section then returns to HIV restrictions on entry, stay and residence per se, ending with a striking example of the false sense of security that can be created when young people think that such restrictions will have kept HIV out of their country, and that AIDS is thus not a problem that concerns ‘us’

Immigrants and care for tuberculosis and sexually transmitted infections

60. **S. Asch, B. Leake, and L. Gelberg. *Does fear of immigration authorities deter tuberculosis* patients from seeking care?** West J Med. 161 (4):373-376, 1994.

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

62. **S. Asch, B. Leake, R. Anderson, and L. Gelberg. Why do symptomatic patients delay obtaining care for tuberculosis?** Am J Respir.Crit Care Med. 157 (4 Pt 1):1244-1248, 1998.

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

Location
Los Angeles, USA

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

Key findings

1994: Illegal immigrants may delay seeking care for tuberculosis symptoms because of fear of immigration authorities.

1996: If measures to bar illegal immigrant residents from receiving non-emergency health services were implemented, such residents would be more likely to either forgo treatment or to seek treatment from sources providing inadequate care for STDs. The consequent untreated STDs would lead to preventable morbidity from pelvic inflammatory disease, perinatal infections, poor birth outcomes and spread of the disease.

1998: Among TB patients, self-reported delay in seeking care of more than 60 days from symptom onset was strongly associated with fear of immigration authorities. During the delay, patients exposed an average of eight contacts to tuberculosis.

See also:

Migrant populations and trust of health authorities

63. As with certain other sections of the bibliography, the section on trust and public health as it affects immigrant or ethnic minority populations would require a far more thorough review than could be carried out here. A good starting point would be the well-known Tuskegee study of untreated syphilis that seriously damaged credibility of public health authorities among African-Americans, hindering efforts for HIV prevention and access to care even a generation later[7].

64. Several of the studies already presented in this bibliography have also touched upon trust, as have European reviews concerning AIDS and migration. A good starting point is:

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

Clandestine mobile populations out of range of formal controls

65. **R. Gazi, A. Mercer, T. Wansom, H. Kabir, N. C. Saha, and T. Azim. *An assessment of vulnerability to HIV infection of boatmen in Teknaf, Bangladesh***. *Confl.Health* 2:5, 2008.

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

    Location

[7] C.f. S. B. Thomas and S. C. Quinn. The Tuskegee Syphilis Study, 1932 to 1972: implications for HIV education and AIDS risk education programs in the black community. *Am J Public Health* 81 (11):1498-1505, 1991.

V. S. Freimuth, S. C. Quinn, S. B. Thomas, G. Cole, E. Zook, and T. Duncan. African Americans' views on research and the Tuskegee Syphilis Study. *Soc Sci.Med.* 52 (5):797-808, 2001.

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

Methodology
Initial rapport building with community members

Mapping

In-depth interviews with key informants and members of other vulnerable groups (spouses of boatmen, female sex workers, and injecting drug users)

Oral questionnaires with 433 boatmen

Key findings

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

There has also been an increase in the numbers of people moving back and forth between Bangladesh and Myanmar. The border remains very porous despite efforts at regulation on both sides.

Over 40% of the boatmen had visited Myanmar during the course of their work. 17% of these had commercial sex while abroad. In the past year, 19% of all boatmen surveyed had sex with another man. 14% of boatmen had participated in group sex, with groups ranging in size from three to fourteen people. Condom use was rare, irrespective of type of sex partners.

Only three boatmen reported any past history of injecting drug use, but injecting drug users reported in interviews that they occasionally shared injecting equipment with boatmen.

Knowledge regarding HIV transmission and personal risk perception for contracting HIV was low.

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

Local sex workers who cater to the needs of clients, including boatmen, are at even higher risk. They are often undocumented migrants from Myanmar, who are extremely marginalized and have very little power to negotiate condom use.

Travel restrictions create a false sense of security

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

Subjects covered
Students HIV knowledge and attitudes

Location
Al Ain, United Arab Emirates

Methodology
Written KAPB questionnaire, 267 first year university students, 2005

Key findings

Students demonstrated many items of false knowledge about HIV transmission (e.g. eating HIV-infected food, sharing a comb), and attitudes toward people living with HIV were neither friendly nor tolerant. Concerning entry restrictions, 97% of the respondents felt that all people entering UAE should be tested.

HIV testing is mandatory for all foreign workers entering the UAE, although tourists and sex workers who enter on tourist visas are excluded from such testing[8]. The authors point out that students may mistakenly believe that universal testing for foreigners would stop transmission of the virus in their own society.

The article notes several potential risk factors for UAE young people: recent rapid development, with opening of the society to workers or tourists who bring new values; increasing ease of international transportation and communication; influence of media; large differences in incomes; decreased influence of family and religion, which is engendering rapid change in family, cultural, and religious values. In addition, conflict and related displacement is engendering trafficking of young females into UAE and elsewhere.

In addition, citizens of UAE may take risks during travel to high-risk destinations. Injecting drug use, which is not currently believed to be frequent in UAE, is expected to increase because it is highly prevalent in some neighbouring countries.

See also: K. M. A. Al Mulla, R. N. H. Pugh, M. M. Hossain, and R. H. Behrens. *Travel-Related AIDS Awareness among Young Gulf Arab Men*. J Travel.Med. 3 (4):224-226, 1996.

Discussions of costs and benefits

67. Arguments about the costs and benefits of barring access of non-nationals with HIV are extremely complex, for a number of reasons, starting with the fact that the cost of an HIV test is usually borne by the potential traveller or immigrant. In addition, estimating the potential cost of health care of immigrants, whether HIV-infected or not, is highly dependent on the funding of the health care system in the destination country. In addition, the picture is shifting rapidly as costs for ART decrease (differently in different countries).

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

Health-related costs and benefits of immigrants

69. **S. A. Mohanty, S. Woolhandler, D. U. Himmelstein, S. Pati, O. Carrasquillo, and D. H. Bor. *Health care expenditures of immigrants in the United States: a nationally representative analysis*.** *Am J Public Health* 95 (8):1431-1438, 2005.

Subjects covered
Medical expenditures, immigrants compared with US-born

Location
US, national

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

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

Key findings

The authors cite a previous study, a comprehensive analysis on the costs and benefits of immigrants to the US economy, in which the National Research Council concluded that immigrants add as much as $10 billion to the American economy each year, and that over their lifetimes, they will pay an average of $80,000 per capita more in taxes than they use in government services[9].

In this study, they find that health care expenditures for immigrants are substantially lower than for US-born persons. In the year 1998, the study showed that immigrants accounted for a total of $39.5 billion in healthcare expenditure, of which about $25 billion was reimbursed by private health insurers, $12 billion was reimbursed by government programmes, and the remaining - just under $3 billion - was paid out of the immigrants' pockets.

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

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

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

See also:

70. **Goldman, D. P., Smith, J. P., & Sood, N. 2006, *Immigrants and the cost of medical care*,** *Health Aff.(Millwood.)*, vol. 25, no. 6, pp. 1700-1711.

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

71. **A. Fowler, L. Collins, N. Larbalestier, R. Kulasegaram, Ruiter A. de, and V. Micunovic. *HIV, HAART and overseas visitors***. *Sex Transm.Infect.* 82 (6):516, 2006.

    This article reports on the case of a newly diagnosed HIV positive patient for whom antiretroviral treatment for HIV was delayed because she was not eligible for treatment

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

on the National Health Service and was unable to fund the cost of the treatment herself. The patient became severely ill, spent 11 days in intensive care then had a lengthy convalescence period. In the clinical opinion of her physicians, the patient would have avoided both of these had HAART been started earlier. They conclude that the consequences of delaying treatment may in fact place a greater cost burden on the NHS.

Other insights on costs and benefits (scientists, people with hepatitis, and altruists)

72. Several lines of thinking, not necessarily related to HIV, may provide some useful insights for thinking about the costs and benefits of restricting access of people with HIV to countries. Some examples are:

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

    This article predicted that tightening of visa regulations in the United States (unrelated to HIV) would have negative consequences for universities. The new regulations would keep many foreign students and academic staff out of the country, causing "classes to be cancelled, and educational and research opportunities to be lost". The author predicted that some students and staff would head for other countries such as Britain, France and Australia.

74. **M. Rice. *New visa "will attract scientists to Europe"***. *Eur.J Cancer* 40 (10):1461, 2004.

    On the other side of the Atlantic, the Chief Executive of the European Biomedical Research Association noted that the European Union announced that it was going in the opposite direction: the European Commission has moved to introduce a 'scientific visa' to aid the movement of third country researchers both to and within the EU.

75. **N. J. Gay and W. J. Edmunds. *Developed countries could pay for hepatitis B vaccination in* developing *countries***. *BMJ* 316 (7142):1457, 1998.

    Along totally different lines, the WHO document on migration, health and human rights[10], unearthed the following intriguing insight:

    It has been shown by mathematical modelling for hepatitis B that the resources needed to prevent one carrier in the United Kingdom could prevent 4,000 carriers in Bangladesh of whom, statistically, four might be expected to migrate to the UK.

    Thus, it would be four times more cost effective for the UK to sponsor a vaccination programme against hepatitis B in Bangladesh than to introduce its own universal vaccination programme.

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

    In a discussion about what makes people do generous things, Light notes that, rather than keep them for themselves and their pleasures, millions of people give away scarce time and valued resources that they worked to earn. He discusses "compassionate care", the fact that some health professionals give care *pro bono* to people who need it, including irregular migrants and other needy visitors.

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

    The authors of this text point out that controlling migration is costly, that the twenty-five richest countries spend 25 to 30 billion dollars per year on enforcing immigration laws.

[10] World Health Organization. International migration, health & human rights. Geneva: 2003, p 8.

The costs come from controlling borders, but also from issuing visas and residence permits, prosecuting, detaining and removing undocumented migrants, carrying out labour inspections and implementing sanctions on employers, treating asylum-seekers' claims, resettling refugees, and searching for undocumented migrants.

They note that tight migration policies generate undocumented migration, smuggling, and trafficking, which then prompt calls for more control.

As a solution, they suggest unpacking citizenship, and distributing its different components (political, civil, social, family and cultural rights, notably) in a differentiated way. Migrants would initially receive a first set of rights (civil rights and fundamental social rights), but only later receive full welfare entitlements or political rights in a step-by-step manner. By avoiding the binary logic of inclusion/exclusion, this approach would ensure that migrants are not "rightless" (as undocumented migrants tend to be) while at the same time enabling high mobility and addressing the reluctance of nationals and long-term residents to share their privileges with newcomers.

Possible models for monitoring and mitigating

78. Some quite different reports or handbooks are presented in this final section, as potential models for the way in which HIV travel restrictions might be monitored and/or mitigated. The first is a review carried out by the European AIDS & Mobility project, which monitored the way in which the press in 12 European countries discussed migration and HIV. The review was carried out in the aim of assessing potential stigma. The second is a presentation of national policy audits concerning HIV and migration, carried out in four South East Asian countries. A similar process might be used to raise awareness as to HIV-related travel restrictions issues among policy makers and other relevant stakeholders, and to monitor changes.

79. Finally, there is no doubt that giving information, and voluntary counselling and testing, are critical elements for both AIDS prevention and for access to timely care and support. In parallel with efforts to stop mandatory HIV testing and related travel restrictions, and in acknowledgement that policy change sometimes takes far longer to bring about than activists might wish, a third document is presented in a spirit of harm reduction. This element of the annotated bibliography returns to the notion of "migrant friendly testing" discussed in the first section, to discuss the way in which HIV testing and counselling might be carried out in a positive way for immigration health assessments.

Press coverage

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

Subjects covered

What information on HIV and migrants is being published and how it is portrayed by the major newspapers in Europe? Is information misused? Do press stories lead to promotion of xenophobia and racism?

Location
European countries

Methodology
48 daily newspapers selected from across 12 countries

All news stories about HIV/AIDS in migrants and/or ethnic minorities published in any section of the selected newspapers from 1st of January to 31st of December 2004 were identified. Pre-defined data collection forms in English were completed by a research

team from each country. Country teams usually consisted of one person from an NGO and another from the Governmental sector.

Key findings

150 news stories were considered eligible for the study. The UK had the highest number of articles (57) followed by Spain (27) and Portugal (22). Poland and Slovenia had no news. The number of articles meeting the eligibility criteria was lower than initially expected.

Neither of the two major AIDS events of the year (Bangkok AIDS conference, World AIDS Day) seemed to have a significant impact on the amount of HIV and migration news.

Articles of more than one page were very uncommon.

No author was credited in nearly one quarter of the articles. Discriminatory messages towards HIV-infected migrants were more common in anonymous articles. Press agency news stories were found to be the least discriminating.

Epidemiological/statistical data was present in six out of ten articles, with substantial differences between countries. Discriminatory messages towards HIV-infected people were not found to be more common in news items using epidemiological data.

In all, three out of ten articles were judged to contain discriminatory messages against HIV-infected migrants or ethnic minorities. Clear differences were identified by country, with Lithuania, UK and Greece showing the highest proportions of discriminatory messages.

The discriminatory messages were closely related with the content of the news, which blamed HIV-infected migrants for costing tax payers large sums of money and bringing HIV into the country. In the UK, migrants originating from Sub-Saharan Africa were most targeted. For other countries, especially those from the Baltic States, the fear concerned HIV infections originating in Russia.

News published by conservative newspapers was 2½ times more likely to contain discriminatory content, but discrimination was also detected in 2 out of 10 articles in newspapers whose political orientation favoured the rights of the disadvantaged.

In contrast, 1½ out of ten contained messages of solidarity towards HIV positive migrants and ethnic minorities, arguing that all people should have equal rights to HIV treatment and calling for changes in attitudes towards HIV positive people.

The commonest theme in the articles was that of European enlargement and the fear of HIV infections coming from the East. This was much more common in the Baltic States. The UK was a very distinct case: in comparison with other countries messages were more often inflammatory in tone, and politically sensitive themes such as "health tourism" and asylum were treated harshly.

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

Policy review

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

Subjects covered
Compliance with signed agreements concerning reduction of mobile populations' HIV vulnerability

Location
Cambodia, Lao PDR, Thailand, Vietnam

Methodology
Development of a regional Strategy on Mobility and HIV Vulnerability Reduction

National capacity-building workshops to present and discuss the international and regional policy instruments relevant to HIV and mobility

Development of an audit tool to measure national government perceptions of compliance with the relevant instruments[11]

Reports prepared in each country, supervised by a multisectoral working groups on HIV and mobility, which included representatives of international organizations, NGOs, groups of people living with HIV and AIDS, donors and other partners.

Key findings

In some cases the policy audits caused officials to become aware of their government's position on issues relating to HIV and mobility for the first time.

The first National Policy Self Audit:

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

Migrant friendly testing

82. **International Organization for Migration 2006, *IOM Guide for HIV Counsellors: HIV counselling in the context of immigration health assessments***, IOM, Geneva.

Subjects covered
HIV counselling and testing procedures for immigration health assessments

Location
World wide

Methodology
Manual

Key findings

The International Organization for Migration has been carrying out health assessments according to the admission requirements of resettlement countries for over five decades.

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

Some countries require HIV testing. While IOM promotes HIV voluntary testing as opposed to mandatory HIV testing for travel purposes, the organization nevertheless carries out HIV testing for migrants going to countries that require it. In doing so, IOM follows a harm reduction model, attempting to ensure that high quality counselling is offered: although not necessarily sought-after, the HIV test may also provide an opportunity to give applicants information on HIV and AIDS, to help them learn how to protect themselves and their partners, and to provide referral services and appropriate support.

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

See also:

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

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

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

    A study carried out in one IOM sites for health assessments, comparing passive and more active information-giving, demonstrated that interactive and culturally sensitive information-giving under these circumstances is easy to give and can lead to increased knowledge.

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

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

Importance of migrant health

86. A final reference is given as a starting point for going beyond the issue of HIV-related travel restrictions, to address the policy implications of migrant health in general. This is an article published in the Bulletin of the World Health Organization.

87. **Macpherson, D. W., Gushulak, B. D., & Macdonald, L. 2007, *Health and foreign policy: influences of migration and population mobility***, *Bull.World Health Organ*, vol. 85, no. 3, pp. 200-206.

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

    Although in recent years efforts have been made to bridge the policy gaps between migration and economic outcomes, labour-force movements and international humanitarian issues, policy-makers have as yet failed to address migration with respect to health, and to the boundaries of disparity through which migration occurs. The authors call upon policy makers to begin to address the complex challenges thus posed, and provide a 48 item bibliography to serve as a good start.