

HIV-Related Travel Restrictions: A Focus On US And Canada

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Abstract

This essay presents a review of HIV-related travel regulations for documented immigration in US and Canada. It outlines the evolution of HIV-related immigration policies in these countries and assesses the public health impact from HIV positive immigrants as well as the healthcare services available to such individuals. Furthermore, the essay discusses how the policies in the two countries relate to the global debate on HIV status and immigration.

INTRODUCTION

‘If we want to be a global leader in combating HIV/AIDS,

We need to act like it. Now we talk about reducing the stigma of this disease,

Yet we’ve treated a visitor living with it as a threat’¹

In a world with so many disparities, international migration which is the process of movement of people across national borders has become inevitable². Although, statistics on such routes remains in-exact due to the diversity in counting and classification³, nearly 3.2% of the world’s population representing about 215.8 million individuals reside temporary or permanently outside their countries of birth⁴. For many individuals a number of reasons motivate them to abandon their homes and move to a new destination. Some have fled extremes conditions such as war and hunger; others have been forcefully taken away whilst others have moved in anticipation of a better life⁵⁻⁶. However, contrary to the widely held perception that most migration occurs between south (developing) and north (High Income OECD countries), in fact south-south migration represents a greater proportion (43.1% vs. 42.8%) than the latter⁴. Regardless, for many years, individuals intending to transcend national borders have encountered several barriers⁷⁻¹⁰. Although, the exact barriers change with time, one barrier has been the imposition of restrictions on persons with certain health-related conditions¹¹⁻¹³. Such has been the case of HIV/AIDS since its inception in the early eighties.

BACKGROUND: HIV-TRAVEL RELATED RESTRICTIONS

In June 1981, the world was astonished by a CDC report that began the global battle with HIV/AIDS¹⁴. Although scientific, public and political interests were heightened; little was known about the disease. It was not until 1985 that scientific knowledge of HIV/AIDS became clearer and reliable testing became available¹⁵. Since then, the disease has claimed over 28 million lives globally¹⁶. According to UNAIDS, nearly 34million individuals today are living with the disease, about 95% of these are in impoverished countries in the global south¹⁷⁻¹⁸. In the heat of the worldwide panic to the HIV/AIDS epidemic in the 80’s, imposing travel restrictions on persons living with the disease (PLWHIV) assumed centre-stage in many international debates¹⁹. As such, many countries instituted various restrictions which came in the forms of limitations on entry and stay²⁰. Subsequently, HIV-testing became mandatory for individuals seeking entry into many countries who were required to declare themselves HIV-free²¹. However, these developments caused many agitations and the World Health Organisation (WHO) issued a statement in 1978 describing the practice as ‘ineffective, impractical and wasteful’^{22(P2)}. Over the years, sustained protests coupled with new evidence have resulted in many countries abolishing their restrictions. However, as at January-2013, 44 countries still have some form of HIV-related travel restrictions²³.

OVERVIEW OF IMMIGRATION IN US

For many years, migration has been part of the American history. In fact; the country's success has been linked in part to its massive inflow of people from all corners of the world²⁴. According to Lyndon Johnson -the 36th US president, 'The land flourished because it was fed from so many sources--because it was nourished by so many cultures and traditions and people'²⁵. However, in recent times, many Americans 'are deeply divided whether immigration helps or hurts the country'^{24(pxiii)}. Currently, US immigration rate stands around 1.8million per year²⁴. In US laws, 'any person not a citizen or national of the United States' is considered an 'alien'²⁶. Immigrants are considered subsets of aliens. However, 'immigrant' as defined has been used to describe individuals legally admitted for permanent residency in the country²⁷. Groups such as students, diplomats, tourists and intra-company business personnel are regarded as part of the non-immigrant category²⁷⁻²⁸. In 2009, nearly 37million individuals representing about 12.5% of the US population were foreign-born^{24,29}. Of these, nearly 31% are unauthorised migrants²⁴.

THE US IMMIGRATION SYSTEM

The American immigration system has been labelled as complex and confusing²⁴. Immigration is typically classified into 'family-based, employment-based and Refugees & Asylees'³⁰. About two-thirds of US immigration is due to family-unification³¹. Immigration is governed under the 'Immigration and Naturalization Act (INA)' created in 1952³². This Act sets a yearly cap of 675,000 for permanent-immigrants with some exceptions for close-relatives³⁰. Yearly refugee admittance is determined by the President together with Congress³⁰. There are about 20 kinds of temporary non-Immigrant visas³⁰. The type required is dependent on the intended purpose of travel³³. Most non-immigrants and short-term transits are not required to undergo any medical examination³⁴. Medical examination is required for all other applicants (immigrants, Refugees and status adjusters)³⁵. According to CDC; the medical-examination is aimed at identifying 'applicants with inadmissible health-related conditions'³⁴. The medical examinations are undertaken by panel Physicians who then categorise any medical-condition into Class A or B³⁴⁻³⁵. Individuals with CLASS-A condition (e.g. Leprosy) are refused admittance (Figure.3). Prior to 4th January 2010; HIV was listed as Class A³⁶. The 'Class B conditions are physical or mental abnormalities, diseases, or disabilities serious enough or permanent in nature, as to amount to a

substantial departure from normal well-being'³⁷. Waivers may be granted for such conditions although such persons are followed-up soon an arrival in the country³⁷.

Requirements to undertake some vaccination have been in place since 1996³⁷. Besides these medical requirements, persons must satisfy that they will not become a public charge and have no history of felony conviction²⁸.

Figure 3

'The four conditions making a person inadmissible on medical grounds'³⁴⁻³⁷

1. Persons with communicable diseases of public health importance including; Chancroid; gonorrhoea; granuloma inguinale; infectious leprosy etc.
2. Immigrant visa and adjustment applicants who have not received all required vaccinations
3. Persons with current or past history of 'physical or mental disorders with associated harmful behaviour'
4. Persons who are drug abusers or drug addicts

EVOLUTION OF US HIV-RELATED TRAVEL BAN

Health-related immigration restrictions have been in existence in the US since 1882³⁸. For instance, in 1891, individuals who suffered 'loathsome or contagious' diseases were tagged as inadmissible and medical examination became a requirement for all non-citizens entering the country³⁹. The HIV-travel ban began when congress passed a proposal by Senator Jesse Helms for the addition of HIV into the 'dangerous contagious disease' in 1987⁴⁰. Although, original intention of the legislation was the application to immigrants (permanent), it was used against temporal visitors⁴¹. One classical case was the Dutchman Hans Paul Verhoef who was detained in 1989 as he tried to enter US to speak at a gay conference⁴². This case generated a huge global outcry on the negative impacts of such policies⁴¹. As a protest, several countries and organisations refused to attend the 1990 AIDS conference in San-Francisco⁴¹. Under pressure to do something, Edward-Kennedy proposed a bill seeking amendment to the travel ban in 1990³⁸. This proposal was supported by many organisations including the WHO³⁹. However, congress rejected the idea and rather passed HIV-travel ban into law³⁹. Many records indicate that this decision was triggered by poor understanding of how the disease is transmitted as well as public resentment for persons who were gay and who were suspected to be the key persons suffering HIV³⁸. According to Vinikoor, the public wrote over 40,000 letters to congress asking for the ban to be passed⁴¹. Moreover, many Congress leaders opined that allowing HIV positive immigrants entry into US was a public-health threat as well as putting strain on public

resources³⁸. From that time, there were many campaigns and agitations against the policy⁴⁰. The world's AIDS day in 2006 marked a historic turn when George W Bush- then US president promised to lift the ban by using his executive order⁴¹. However, many legal and bureaucratic challenges made it impossible for him to achieve in his term⁴¹. It was not until January 4 2010, that President Obama succeeded in removing HIV as an inadmissible disease⁴³.

Timeline of US HIV travel ban⁴⁰

1987	Travel ban initiated after congress approved
1990-1991	Protest campaigns suffers many bureaucratic challenges
1992	Massive walk out from Aids conference hosted in US as a protest
1993	The U.S. restrictions are statutorily enacted in 1993 when the U.S. Congress adds HIV to U.S. immigration law.
2006	George Bush Makes public commitment to overturn ban
2007	International AIDS Society decides not to hold conference in US if ban is not lifted
Jan 2008	UNAIDS constitutes International Task Team on HIV-related Travel Restrictions; which included US government
Nov 2008	Global Fund and UNAIDS decides no meetings and conferences in countries with HIV-restrictions
July 2008	Senate vote overturns restrictions. President Bush endorses it into statutory books
July 2009	Public comment on ban lifting collected
Nov 2009	Ban-lifting legislation entered into Federal register with a two months window period
Jan 4 2010	HIV-travel restriction officially lifted.

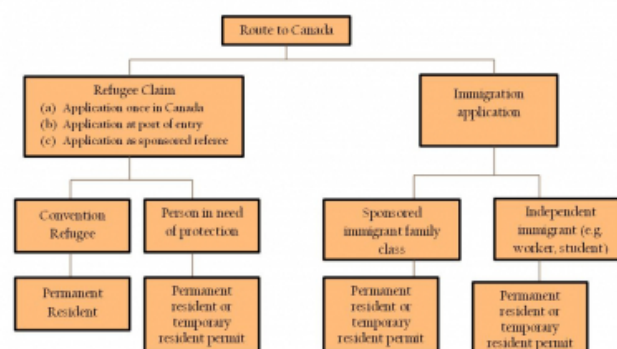
HEALTHCARE ACCESS & IMPACT OF IMMIGRANTS ON HIV-BURDEN IN THE US

Immigrants contribute significantly to HIV-burden in US, although studies suggest that most get the infection after immigration⁴⁴. Immigrant population constitutes about 21% of HIV cases in the US⁴⁵. In New York, immigrant population accounted for about 29% of HIV diagnosed in 2009⁴⁶. Foreign-born populace have higher chances of been diagnosed with HIV (32%) than native populace (24%)³⁸. However, accessibility to healthcare services is poor for such group as they are less likely (29%) to receive HIV-testing than native populace (32%)³⁸. According to Weiwei et al⁴⁶, 'HIV infection may remain undiagnosed longer' in foreign-born than native populace. Prior to lifting the ban, HIV positive (PLHIV) immigrants were detained by the Immigration and Customs Enforcement (ICE) unit⁴⁷. However, according to Venters et al, 'Because ICE is under no mandate to report basic statistics concerning detainee morbidity or mortality, little is known about the true impact of HIV among detainees or about the medical care afforded to those living with HIV/AIDS'⁴⁸. Nevertheless, the 2007-report 'chronic indifference' by the Human Rights Watch, highlighted significant atrocities in which many PLHIV-immigrants were denied medical care or refused access to HIV-medications⁴⁷. With the removal of the ban, the CDC has estimated around 4,275 PLHIV entering US annually⁴⁹. There are concerns that lifting the ban and

subsequent abolition of compulsory testing though a huge success, must be complemented with developing 'stronger alliance with immigrant communities' to avert any surge in HIV⁴⁵. Weiwei et al has indicated that attention must therefore be focused on developing 'culturally sensitive, language-specific HIV prevention outreach and other services'⁴⁶.

Figure 4

Entry routes to Canada⁵⁵



OVERVIEW OF IMMIGRATION IN CANADA

Canada with its large geographic size has for many years 'viewed immigration as a key instrument of population and economic growth'⁵⁰. The country is one of the most-diverse among developed nations and the 2006 census identified over 200 ethnic-groups⁵¹. About 19.8% of Canada's population are foreign-born (immigrants) with 2nd and 3rd generation immigrants constituting about 39% of total population^{52,53}.

CANADA'S IMMIGRATION SYSTEM

Canada's immigration system just like the US has been labelled as complex and confusing⁵⁴. Since 2002, immigration is governed by the 'Immigration and Refugee protection Act (IRPA)'⁵⁵. The Act sets out three (3) objectives for admitting people into Canada which are; 'reuniting families, contributing to economic development and protecting refugees'⁵⁵. In 2006, about 59.6% of persons admitted were for economic reasons, 24.2% for family-unification, 13.6% refugees and 2.6% other reasons⁵⁶. The entry-route into the country i.e. immigrant/refugee (Figure.4) demands different requirements and conditions.

As part of the immigration process, everyone aged 15 years or more who seeks to gain permanent residency (e.g. Refugee, immigrant) or temporal residency (e.g. migrant workers, students from selected countries) must undergo mandatory medical screening⁵⁵⁻⁵⁷. Medical screening is

usually not required if stay is 6 months or less unless one intends to engage in activities in which public-health protection is deemed necessary⁵⁸. The medical screening is conducted in accredited Canadian and foreign medical office. If persons admitted into the country are deemed to have lied about their health conditions, they are deported⁵⁷. The IRPA, highlights in Section 38(1) that;

Persons intending to migrate to Canada will be refused on medical grounds if he/she

(A) 'Is likely to be a danger to public health ...

(B) Is likely to be a danger to public safety; or

(C) Might reasonably be expected to cause excessive demand on health or social services'⁵⁹.

HIV-TRAVEL RESTRICTION IN CANADA

As highlighted above, the Canadian Immigration Act does not quote HIV or related-illnesses directly⁵⁷. Nevertheless, the country's strategy of not admitting persons living with HIV/AIDS (PLHIV) as permanent residents is well-documented⁶⁰. Prior to the Act in 2002, many debates in Canada concerning the admittance of PLHIV immigrants centred on economic and public-health risks⁶⁰. For instance, according to a well-known Canadian Physician Dr Hall 'the threat of HIV infection to public health is at the core of the controversy [about testing immigrants], and it does not make much sense to me to deny that it exists'⁶¹(p172). Moreover, a travel-ban Proponent Parker as cited in Hoffmaster and Ted Schrecker opined that 'To remove any screening procedures between Canada and the pool of infection south of the border or elsewhere (e.g., central Africa) is folly of the highest order and in nobody's best interests'⁶²(p1). Therefore, as Professor Klein of McGill University indicated, the government drafted the IPRA to deliver the best strategy to offer public-health security for Canadians; 'the lowest health risk course of action [and] the preferred option'⁵⁷(p2). However, in recent times, economic reasons are the most frequently cited for inadmissibility of PLHIV to Canada as permanent residents⁶⁰. Refusal of admittance has been based on the premise that PLHIV will demand excessively from public resources⁶⁰. The IRPA deems 'excessive-demand as 1) anticipated costs over five years likely to exceed related per capita expenditures for the average Canadian, and 2) adding to waiting lists and increasing morbidity or mortality by delaying access to services to Canadians'⁵⁷(p120). Hence persons living with HIV/AIDS are evaluated on estimated annual healthcare cost

and must not exceed the average Canadian which was \$5,401 in 2009⁶³.

HEALTHCARE ACCESS & IMPACT OF IMMIGRANTS ON HIV-BURDEN IN CANADA

There are an estimated 70,000 PLHIV in Canada although about 33% remain unaware⁵⁷. Immigrants (foreign-born) contribute enormously to the burden of HIV in the country as for instance, in 2005, 16% of all new infections were attributable to persons from HIV-endemic zones⁶⁴. According to Boulos et al, HIV-infection rates are 12.6 times higher in foreign-born populace from endemic areas than in other Canadians⁶⁵. It is worth mentioning that although, Canada's Act denies many PLHIV admissions, majority are admitted. For instance, between 2006 and 2007, 1050 PLHIV applied for Permanent residency⁶⁰. Of these, 99.4% gained admittance as family-class members, refugees or refugee applicants⁵⁷. These 3 groups of applicants are eligible under Canadian Law for admission irrespective of their health-status⁵⁷. In Canada, access to medical care for immigrants living with HIV/AIDS is dependent on one's immigration status⁶⁶. For refugee-claimants, medical care is delivered free of charge through the Interim Federal Health program⁵⁴. The program also covers all expenses for anti-retroviral medications⁶⁶. All other categories of immigrants must purchase private health insurance or access care through out-of-pocket payments.

GLOBAL DEBATE ON HIV-RELATED TRAVEL RESTRICTIONS

As exemplified by the cases of US and Canada, the global debate on HIV-related travel restrictions centre around two main themes; 'public-health security' and 'economic-impact'¹⁹. In relation to public-health security, advocates of bans have argued that entry and stay by immigrants with HIV raises public health risks through spread of infection to local-population^{19,40}. However, counter-arguments have labelled such thinking as flawed and travel-restrictions have been described as ineffective in delivering public health protection²². For instance, the UN International Guidelines on HIV/AIDS and Human Rights notes that 'any restrictions...based on suspected or real HIV status alone, including HIV screening for international travellers ... cannot be justified by public health concerns'⁶⁷. Several reasons have been outlined to support this position.

Firstly, the risk of contracting HIV comes from not from nationality but from specific sexual behaviours⁶⁸ and there is unavailable evidence identifying immigrants to have

riskier-behaviours than general populace²⁹. In any case prevention is not the sole-responsibility of HIV positive individuals but also uninfected persons. Moreover, even in the US, a number of studies have indicated that many immigrants attract the virus after immigration⁴⁴. Also, studies by Melissa et al, among Mexicans who migrate to California but who return to their country indicated that HIV/AIDS was more prevalent in communities with highest migration rates suggesting that most of the migrants acquired infection in US⁶⁹. Moreover, HIV unlike infectious-diseases like SARS, is not transmissible via casual contact; meaning that infection-rates do not necessarily increase just by the mere presence of HIV positive immigrants¹⁹.

Travel restrictions also create 'a false sense of security among residents that counteracts sound prevention efforts, including raising awareness of their own vulnerability'^{40(p3)}. According to UNAIDS, indigents of countries with restrictions tend to perceive HIV as a 'foreign' problem that has been taken care of⁷⁰. Such perceptions are dangerous considering the fact that HIV is already present in every country in the world⁷¹. Moreover, no state requires its citizens returning from abroad trips to undergo HIV testing and hence there is no assurance that the virus has not already entered the country⁷². Furthermore, even if all persons entering the country are screened, many HIV-testing technologies have inherent disabilities such as failure to detect recently-infected persons¹⁹.

Another weakness inherent in travel restrictions is the tendency to nurture a culture of 'secrecy' as it may encourage HIV positive individuals to hide their status such as through lying or getting fake-certificates for travel^{21,73}. Such practices derail the collective societal-responsibility for HIV/AIDS⁷³. Moreover, the fear of been 'caught' can drive PLHIV to abandon their medication during trips and in seeking care in destination countries¹⁹. For instance, in a Brighton study by Mahto et al, as much as 11.3% of PLHIV who travelled to USA in 2006, a time when travel restrictions were in operation stopped using 'their medication in an unplanned manner'⁷⁴. Such breaks in treatment are detrimental to public health as they can potentially contribute to development of drug-resistant HIV strains and further increase chances of treatment-failures⁷³.

The economic argument for instituting restrictions has also been challenged on so many grounds with some labelling it as 'force and illusory'⁷². Counter arguments have centred on the fact that current advancements in science have made

it possible for persons with HIV/AIDS to live long and productive lives and as such it is wrong to equate them to financial-burden⁷². According to Canadian researchers, the 'estimated cost of screening [for HIV] would have been \$3.3 to \$3.4 million. The in-hospital costs of treating HIV-infected immigrants in whom AIDS developed...would have been \$5.0 to \$17.1 million. Accordingly, screening would have saved \$1.7 to \$13.7 million over the 10 years after immigration'^{75(P101)}. However, this economic argument is incoherent as equally 'expensive-to-treat' conditions such as Coronary Heart Disease (CHD) and cancers attract no restrictions., although, studies by Zowall et al concluded that 'The economic impact of HIV infection in immigrants to Canada is similar to that of CHD'^{76(p1163)}. Moreover, the economic argument is flawed in the sense that immigration screening measures are excessively costly²². For instance, in the periods of US-restrictions; the country spent almost \$10 million every year just to prevent about 500 HIV positive immigrants from entering the country³⁸. Such waste of resources could be put to better use, such as investing in health improvement (e.g. HIV awareness campaigns) in low-resourced countries²². For instance, according to Gay and Edmunds, 'the resources needed to prevent one carrier through universal vaccination in the United Kingdom could prevent 4000 carriers in Bangladesh, of whom four might be expected to emigrate to the United Kingdom. This suggests that it would be four times more cost effective for the United Kingdom to sponsor a vaccination programme against hepatitis B virus in Bangladesh than to introduce its own universal programme'^{77(p1457)}.

A third component of arguments against HIV-related travel restrictions centres on human-rights, stigma and discrimination¹⁹. Restrictions have been described as a breach of international instruments such as 'Universal Declaration of Human Rights'⁷⁸, and 'The International Covenant on Civil and Political Rights'⁷⁹ by setting separate rules for HIV-positive individuals. In Canada for instance, although all immigrants are assessed for the 'excessive-demand' on a 5-year duration, 10-years is the case for persons suffering HIV/AIDS. This is gross discrimination. Moreover, many US-records in the era of travel-bans indicated massive abuse of HIV positive immigrants in detention centres⁴⁷. There are also concerns that in many instances HIV-test is 'conducted without informing people of the test or its results, without providing counselling or confidentiality and without connecting people to HIV prevention and treatment services'^{80(p1)}. Hence, the UNHCR has kicked against travel-restrictions stating that

'While travel restrictions are a question of State sovereignty, it must be pointed out that States also have obligations under international law within which sovereign rights may be exercised'⁸¹.

CONCLUSION

The debate about HIV-related travel restrictions has come a long way. Improvement in knowledge or understanding of the disease coupled with available evidence suggests that such measures actually benefit no one. However, travel bans only go further to entrench what Peter Piot termed the 'exceptionalism of HIV/AIDS'⁸². The US has set a good precedence, but it must impress upon other countries like Canada to abolish what clearly infringes many international laws. It is time that HIV-positive fellows are seen as humans and 'not just a virus'⁸³. For Canada, perhaps it must take lessons from its own countrymen - Somerville and Wilson who opined that applying the 'excessive-demand' criterion for inadmissibility towards immigrants is 'an unacceptable attitude towards migrants as persons - in that it views them only in terms of the economic benefit they offer. In addition, it places only a monetary value on their worth'⁸⁴(p831).

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