POSITIVE DESTINATIONS OR PERSISTENT BARRIERS?
RETHINKING HIV-RELATED TRAVEL RESTRICTIONS

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Background

HIV-related travel restrictions emerged during the early years of the epidemic, driven by fear, stigma and scientific uncertainty. Although many countries have removed entry, stay and residence restrictions, approximately 50 jurisdictions continue to maintain some form of HIV-related migration barrier. We examined how restrictions were introduced, what contributed to their removal, and why progress has slowed.

Methods

We conducted a comparative policy analysis using data from *Positive Destinations*, historical UNAIDS datasets, government sources, civil society documentation, and lived experience reports collected over three decades.

Findings

PROGRESS HAS STALLED AND MAY BE REVERSING

Between 2008 and 2014, the number of jurisdictions imposing HIV-related entry, stay or residence restrictions declined substantially, reflecting coordinated advocacy, increased political commitment, and sustained multilateral pressure.

However, recent estimates suggest that progress has largely stalled, with some evidence that the number of jurisdictions maintaining restrictions may be increasing. While some countries have formally repealed entry bans, others continue to require HIV testing within immigration frameworks or maintain restrictions in practice.

This plateau, and possible reversal, coincides with rising anti-migrant sentiment, weakening multilateral engagement, and growing disregard for evidence-based public health recommendations.

CHANGE HAPPENED WHEN ADVOCACY LEVERAGED POLITICAL INCENTIVES

The most significant reductions in HIV-related travel restrictions occurred when community advocacy, international pressure, and institutional leverage converged to make discriminatory policies politically costly to maintain.

Communities documented harms, challenged misinformation, and highlighted the incompatibility of restrictions with contemporary HIV science and human rights standards. International organisations reinforced these efforts through normative guidance, global monitoring initiatives, peer review mechanisms, and high-level political advocacy.

International conferences proved particularly influential. The re-location of the 8th International AIDS Conference 1992 from Boston to Amsterdam because of the United States' entry ban on people living with HIV demonstrated that exclusionary policies could jeopardise international prestige and economic opportunities.

Similar pressure contributed to reforms elsewhere. China temporarily suspended its travel ban to host major international events before permanently lifting restrictions in 2010, while the United States repealed its HIV entry ban in 2010, paving the way for the 19th International AIDS Conference to be held in Washington, DC, in 2012.

POSITIVE DESTINATIONS

INFORMATION AND ADVOCACY ON TRAVELLING AND RELOCATING WITH HIV

Positive Destinations (www.positivedestinations.info) is the new home for the former *Global Database on HIV-Specific Travel and Residence Restrictions* (hivtravel.org), now hosted by the HIV Justice Network.

It provides up-to-date information on travel and migration policies, legal and policy developments, and supports informed mobility and life planning for people living with HIV.

Before 2010, HIV-related travel restrictions were primarily justified as public health measures.

Today, many remaining barriers are embedded within immigration, labour, and economic assessment frameworks, making them less visible, more administrative in nature, and often more difficult to challenge.

HIV-related travel restrictions still exist and they are evolving.

TRAVEL RESTRICTIONS ARE INCREASINGLY EMBEDDED IN MIGRATION GOVERNANCE

Travel restrictions no longer persist because governments believe HIV poses a public health threat; they persist because HIV has been absorbed into broader systems of migration governance.

While public health arguments *for* restrictions have largely been discredited, remaining barriers are increasingly justified through economic cost assessments, labour regulations, migration control measures, or opaque administrative practices affecting long-term residence.

This shift coincides with rising anti-migrant sentiment, weakening multilateral engagement, and growing disregard for evidence-based public health recommendations:

- **Anti-migrant politics –** Growing hostility towards migration has made restrictive border measures more politically acceptable.
- **Nationalist sovereignty narratives –** Governments increasingly frame international human rights standards and public health recommendations as infringements on national sovereignty.
- **Declining multilateralism –** Reduced commitment to multilateral institutions has weakened diplomatic pressure to align migration policies with evidence-based HIV responses.
- **Competing global health crises –** Ebola, Zika and COVID-19 diverted political attention, resources and advocacy capacity away from HIV-specific issues.
- **Disregard for public health evidence –** Recent infectious disease outbreaks have demonstrated a willingness by governments to adopt ineffective travel restrictions despite explicit guidance from public health authorities.

TIMELINE OF MIGRATION-RELATED LEGAL AND POLICY CHANGES

1987
WHO concludes HIV-related travel restrictions lack a public health justification.

1992
International AIDS Conference moves from Boston to Amsterdam because of the US HIV entry ban.

2008
UNAIDS establishes the Global Task Team on HIV-related Travel Restrictions.

2010
China and the United States repeal HIV-related entry bans.

2011 - 2015
Armenia, Fiji, Moldova, Mongolia, Tajikistan, Ukraine, and Uzbekistan remove or ease restrictions.

2016 - 2020
HIV-related restrictions increasingly become embedded within broader migration frameworks, including medical inadmissibility assessments, employment-related screening, and health insurance requirements.

2021 - 2024
New Zealand removes HIV-specific migration barriers. Canada and Australia ease some restrictions, but continue to assess applicants through medical inadmissibility frameworks that can disadvantage people living with HIV.

2025
The Russian Federation expands mandatory medical examinations and registration requirements for many foreign nationals, reinforcing HIV-related surveillance and deportation risks.

2026
HIV-related exclusion increasingly operates through migration systems – including visa rules, healthcare access, work authorisation, and administrative decision-making – rather than explicit entry bans. Current data identify 33 countries maintaining partial restrictions and 16 enforcing severe restrictions.

Conclusions

HIV-related travel restrictions persist not because of scientific uncertainty, but because stigma, migration politics, and weakened multilateral engagement continue to sustain discriminatory policies.

While public health justifications for such restrictions have largely been discredited, many barriers now persist through migration governance, including economic cost assessments, labour regulations, and opaque administrative practices affecting long-term residence.

Past successes demonstrate that coordinated community advocacy, strategic use of evidence, and institutional leverage can achieve reform. Future advocacy should therefore move beyond rebutting outdated public health arguments to engaging with migration governance, administrative decision-making, and broader debates about mobility, inclusion, and belonging.

Greater attention should also be paid to documenting the lived experiences of people navigating HIV-related migration barriers, including uncertainty, disrupted life planning, and exclusion from opportunities for work, study, and family reunification.

WHAT WORKS? KEY INGREDIENTS FOR SUCCESS

Community mobilisation: documenting harms, gathering evidence, and challenging discriminatory policies

Strategic use of scientific evidence: demonstrating the absence of a public health justification for HIV-related travel restrictions

Conference-related leverage: using the prestige and economic benefits of hosting international meetings to incentivise policy change

Reliable global monitoring: maintaining databases and tracking restrictions to support advocacy and accountability

International peer pressure: leveraging WHO recommendations, UN mechanisms, and diplomatic engagement to encourage reform

Political champions: securing support from influential government officials and international leaders willing to prioritise reform

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www.hivjustice.net

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