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**The global debate over HIV-related travel restrictions: framing and policy
change**

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The global debate over HIV-related travel restrictions: framing and policy change

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In 2010 the United States repealed Section 212(a) (1) of the Immigration and Nationality Act which stated that a non-citizen determined to have a ‘communicable disease of public health significance’ is not admissible into the country without a waiver. This included HIV+ non-citizens. In the same year, several other countries including China and South Korea removed similar restrictions. This paper examines the global debate over HIV-related travel restrictions which has been ongoing since the mid-1980s and attempts to account for these recent policy changes. Entry restrictions have almost always been justified as necessary in two ways: to protect public health from the supposed threat posed by the entry of people living with HIV, and to limit the costs HIV+ migrants impose on domestic health systems. Opponents of these restrictions have consistently sought to challenge the evidence underpinning these claims and also to re-frame the issue in rights terms. However, in this paper I argue that this re-framing was not in itself sufficient to bring about policy change. Some other factors also have to be taken into account, including the changing political context (both domestic and international), and the network building strategies employed by opponents of the restrictions from 2008 onwards.

Keywords: HIV; travel restrictions; United States; global health; public health; framing

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Introduction

The world should make war against AIDS, not against people with AIDS.

UN Secretary-General Javier Perez de Cuellar, 1 December 1998

We talk about reducing the stigma of this disease, yet we've treated a visitor living with it as a threat. If we want to be the global leader in combating HIV/AIDS, we need to act like it.

President Barack Obama, 30 October 2009

For over 20 years United States immigration regulations stated that people living with HIV (PLWHIV) were inadmissible for entry into the country without being granted a waiver. Having formally removed that restriction in 2010 – a year designated by UNAIDS as the ‘year of equal freedom of movement for all’ – the US has finally aligned itself with those countries which no longer (or in many cases never did) impose entry restrictions on PLWHIV. Other states – including Canada, South Korea and China – have also amended their immigration regulations to address this issue in the last few years. It may be too early to declare victory for those who have long opposed the imposition of such restrictions, but there is a palpable sense that the tide has at last begun to turn.

The debate around entry restrictions has been ongoing since the 1980s. States imposing them have generally justified them through the use of two frames. The first is public health security/public safety, with the argument being made that allowing PLWHIV to enter the country exposes the domestic population to a public health risk. The second common framing of restrictions is an economic one: that allowing PLWHIV to enter, particularly on a long-term or permanent basis, imposes significant economic costs on the domestic health system. Whilst these framings have provided the rhetorical justification for HIV-related travel restrictions in virtually all cases, there have often been suspicions that

other concerns, not least homophobia and other prejudices, have been an important (although usually unspoken) factor motivating proponents of restrictions.

The opposing side in the debate has sought both to counter these economic and health security arguments directly and also to link the travel restrictions issue to broader concerns about human rights and stigmatisation. In attempting to 're-frame' the issue of travel restrictions in rights terms, advocates have utilised a wide variety of techniques including the use of individual testimony to dramatise the issue and demonstrate the human costs of travel restrictions; moral shaming, linking the imposition of restrictions by governments with prejudice and discrimination; and legal argument, claiming that such restrictions are incompatible with international human rights law. A wide range of actors, especially drawn from civil society and the UN system, have consistently sought to forward such arguments over the last 25 years in an attempt to delegitimize HIV-related travel restrictions. Indeed in many ways the global debate has been a static one, with opponents of restrictions consistently forwarding these same arguments, but until recently to little effect. These advocates have done precisely the things which scholars who have examined the use of framing as an advocacy tool would suggest: they have credibly re-framed the issue in terms of human rights – a frame which is widely seen as legitimate within international society and which 'resonates' with a range of audiences - and have made use of exactly the kinds of advocacy techniques which have proven effective in other cases. Why, then, did the breakthrough take so long? And why now?

Framing has been widely discussed as a tool which enables advocates to apply pressure on governments for policy change. As is discussed elsewhere in this issue, frames are often described as linguistic, cognitive and symbolic devices used to identify, label, describe and interpret problems and to suggest particular ways of responding to them. In policy debates actors often deliberately (and in many cases strategically) use frames as a tool

of persuasion, deploying them to call attention to an issue, influence other actors' perceptions of their own interests, and convince them of the legitimacy/appropriateness of the advocate's preferred policy response. When they are successful in doing so, the chosen frame 'resonates with public understandings and are adopted as new ways of talking about and understanding issues' and actors will be likely to modify their behaviour accordingly (Finnemore and Sikkink 1998, p. 897). The social constructivist literature has examined a wide range of cases in which framing has been a successful advocacy strategy, often involving sophisticated and influential transnational advocacy networks (e.g. Keck and Sikkink 1998).

In recent years a number of scholars in global health have examined the ways in which different framings of health issues have impacted on policy debates at both the global level (e.g. Shiffman and Smith 2007, Rushton 2010) and the national level (e.g. Labonté and Gagnon 2010). Building on social constructivist work, what they have found is that the ways in which health issues are framed can have a significant impact upon prioritisations and policy outcomes. A wide variety of factors have been identified as determining the success or failure of a particular framing including who is doing the framing, the nature of the audience they are trying to persuade, the extent to which the frame resonates with other deeply-embedded ideas, the intrinsic credibility of the frame; and the prevailing political context (e.g. Shiffman and Smith 2007, p. 1370).

Both the literature on framing in global health, and the wider social constructivist literature within which it is rooted, has tended to examine successful examples of framing. Whilst it is certainly not my intention to argue here that framing does not matter, this paper uses the global campaign against travel restrictions to highlight some of its limitations. In particular the paper examines the effectiveness of reframing an issue as a strategy for policy entrepreneurs, and the extent to which the successful use of framing to advocate for policy change is dependent upon a receptive audience and a conducive political environment. It is

argued here that framing a global health issue in particular ways, alongside other advocacy strategies such as coalition-building and moral shaming, can be effective. However, as we see in the travel restrictions case, framing alone is not always enough to persuade states to change their policies, even where those frames seem to be convincing, appear to resonate with widely-recognised norms, and are supported over a significant period of time by a wide constellation of actors. Crucially, however, this does not mean that the years spent unsuccessfully forwarding human rights arguments against travel restrictions were wasted. As agents and structures are mutually constitutive, framing, even when it does not immediately precipitate policy change, can itself play a part in gradually changing the political environment and in creating a more receptive audience. In this case the enormous efforts which AIDS activists went to in establishing human rights as being fundamental to the global response to AIDS was an important foundation on which the campaign against travel restrictions was able to build.

The paper begins by examining the campaign against HIV-related travel restrictions, arguing that that campaign has been remarkably consistent in its arguments over time and that re-framing travel restrictions as a violation of human rights has been central to this effort. The paper then moves on to put forward some possible explanations for the high-profile recent examples of policy change, in the process seeking to shed light on a number of political and contextual factors which, alongside framing, seem to have played a crucial role in bringing about policy change. The paper concludes with a discussion of the light which this case can shed on the use of framing in global health debates, in particular on the relationship between framers, their audience, and the political context within which they operate.

The global debate on HIV-related travel restrictions

The imposition of HIV-related travel restrictions has usually been justified by governments

(and, much less frequently, by scholars (e.g. Nelson, 1987)) on two principle grounds. The first is protecting the public against the supposed threat posed by HIV+ visitors and/or immigrants. The second is an economic argument: that the long-term costs of providing the necessary treatment and care for PLWHIV is a burden upon the state's resources, and as such grounds on which to deny entry. Here I examine the arguments which have been put forward by those opposing travel restrictions and trace the remarkable consistency in the arguments and frames they have deployed, with the essential contours of the debate having remained more or less unaltered since the mid-1980s.

The WHO made a strong case against the imposition of HIV-related travel restrictions from a very early stage in the development of the epidemic. As early as 1985, the year in which a reliable HIV test first became available, a meeting of Directors of WHO Collaborating Centers discussed the issue after member states had sought the WHO's advice. The meeting concluded that testing and certification of international travellers was not warranted. As that meeting was reported in the *Weekly Epidemiological Record*, that advice appeared to be on the basis of two findings: that testing and certification were not warranted on public health grounds; and that they were not required under the International Health Regulations (WHO 1986).

From that point onwards, the fact that there is little evidence to support the claim that travel restrictions serve a useful public health purpose has been one of the main arguments used against them both by international organisations and civil society. A range of flaws in the claim that travel restrictions protect public health have been identified. These include the limitations of testing technology, which mean that recently-infected immigrants may not be identified as HIV+ (e.g. Cimini 1991-2, pp. 380-5, UNAIDS/IOM 2004, p. 8); the fact that HIV cannot be transmitted through casual contact (UNAIDS/IOM 2004, p. 2); that there is

little evidence to suggest that visitors or immigrants are any more likely than the general population to engage in risk behaviours (e.g. Public Health Service 1991); and that those countries which have not imposed entry restrictions have not found themselves subjected to a flood of HIV+ immigrants (e.g. Nieburg *et al.* 2007).

Indeed the argument has often gone beyond the claim that travel restrictions are ineffective to add that they may actually be counterproductive in public health terms, creating a false sense of security (e.g. Ganczak *et al.* 2007) and dissuading would-be immigrants from undergoing testing and seeking treatment (e.g. John Bradshaw, cited in Bristol 2009). Here a link has often been made between public health efficacy and respect for rights. This argument has been reflected in many of the UN System's engagements with the travel restrictions issue. Jonathan Mann, who as head of the WHO's Global Programme on AIDS was a prominent and passionate advocate of the human rights dimensions of the pandemic, laid out the case at an early stage, arguing in an address in June 1988 that travel restrictions lead to stigmatization and discrimination which in turn threaten public health as 'those who are concerned they might be infected will take steps to avoid detection and will avoid contact with health and social services' (Mann 1988, pp. 9-10). The evidence-base to support the claim that travel restrictions can have a negative health impact has gradually increased over time. One of the most commonly-cited examples is a 2006 survey of 1100 PLWHIV who travelled to the USA (which, at the time, did not allow HIV+ individuals to enter without applying for a waiver) (Mahto *et al.* 2006). The study found that a majority in practice travelled to the USA illegally (i.e. without a waiver and without declaring their HIV sero-status) and that, fearing that the discovery of ARV medication in their luggage would lead to them being denied entry, a significant minority stopped their treatment for the duration of their visit. Ironically, given the fact that protecting public health was used to justify

restrictions, Mahto *et al.* (2006, p. 204) note that such unplanned interruptions to treatment pose a public health risk through the potential development of drug resistance.

There has been similarly widespread scepticism about the argument that admitting PLWHIV puts a significant economic strain upon the national health system. This scepticism has only grown as the cost of antiretroviral therapies has plummeted over the last 15 years. Here, however, the counter-argument has tended to be more nuanced. Rather than arguing that PLWHIV do not impose healthcare costs the argument has tended to be that this is not always the case, and therefore that blanket bans are inappropriate and that individual assessments are required (e.g. UNAIDS/IOM 2004, p. 9). This has been supplemented by the arguments that in this respect HIV is no different to other causes of ill health, and therefore that regulations targeted specifically at HIV are not appropriate (e.g. Academia Mexicana de Derechos Humanos *et al.* 2008), and that economic considerations should be outweighed by humanitarian factors, for example in asylum cases (UNAIDS 2006, para 128). The WHO (e.g. WHO 1988) and others (e.g. UNAIDS/IOM 2004, p. 10) have long argued that the imposition of measures such as widespread HIV testing as part of immigration processes are disproportionately costly, particularly given the fact that PLWHIV are often (especially with the advent of more effective treatment regimens) able to make a significant economic contribution to a society for many years.

As well as addressing the public health and economic arguments on their own terms, the opponents of travel restrictions have also deliberately sought to re-frame the issue in human rights terms. Here I briefly outline four of the most common claims that have underpinned that framing. Often these arguments are supported by reference to international human rights laws and norms. Clearly all of these arguments are linked, and they are frequently deployed together. First, the principle of freedom of movement is widely cited, and UNAIDS called for 2010 to be the ‘year of freedom of movement for people living with

HIV' (UNAIDS 2010d). The *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS 2006) also address the 'right to liberty of movement', noting (in paragraph 127) the absence of a public health rationale for restricting movement on the basis of an individual's HIV status. Second, travel restrictions have been presented as a clear case in which the policies of many states have been discriminatory. This argument has been reflected in virtually all anti-restrictions rhetoric. Often, significantly, this has been backed-up by reference to international norms and to explicit commitments and obligations to avoid discrimination. Kyung-wha Kang, the UN's Deputy High Commissioner for Human Rights, for example, made a powerful intervention in the restrictions debate on exactly these grounds in 2008 (OHCHR 2008). The UN General Assembly's 2001 Declaration of Commitment on HIV/AIDS, as part of which all states committed to removing discriminatory legislation, has also been used as a touchstone in the travel restrictions debate (e.g. Academia Mexicana de Derechos Humanos *et al.* 2008). Third, the right to privacy has often been deployed (e.g. UNAIDS/IOM 2004), particularly in cases where travellers or immigrants are required to declare their sero-status. Even more serious issues are raised by requirements for mandatory testing which, in some cases, has been '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' (HIVtravel.org 2008). Again international law has been used to criticize some states' immigration regulations, for example through the invocation of the International Covenant on Civil and Political Rights which protects the right to privacy (e.g. Ecumenical Advocacy Alliance, 2008, 5). Fourth, particular attention has been paid to the rights of refugees and asylum seekers. These vulnerable groups have been subject to some of the most high-profile instances in which HIV-related travel restrictions have had serious consequences for individuals. The infamous case of the US's quarantining of Haitian refugees at Guantanamo in 1993 (Johnson 1994) caused a significant outcry. Yet

UNHCR had made it clear in its policy guidelines as early as 1988 that refugees and asylum seekers should not be targeted for special measures regarding HIV infection and that there is no justification for screening being used to exclude HIV-positive individuals. The *International Guidelines on HIV/AIDS and Human Rights* (UNAIDS 2006) make exactly the same points.

Various institutions and organisations have therefore consistently argued against the imposition of HIV-related travel restrictions over many years. The essential outlines of the arguments used to support that position were in place from the mid-late 1980s and have barely altered despite the massive changes which have taken place in the nature and scale of the pandemic in the intervening period. Such statements have been regularly endorsed by member states in bodies such as the WHA and the UN General Assembly. But despite the unambiguous nature of these international statements and guidelines, and despite almost universal expert consensus on the ineffectiveness of restrictions (Hendricks 1990, p. 196), those restrictions have been remarkably persistent.

The majority of states which have had such measures put them in place in the 1980s when far less was known about HIV and the global pandemic was less advanced. Nevertheless, it is striking that the real boom in the imposition of such restrictions came *after* the WHO's clear advice to the contrary. The academic literature of the late 1980s and early 1990s pointed to an increasing prevalence of restrictions (e.g. Duckett and Orkin, 1989, Cloßen and Wojcik 1990, Hendricks 1990), with Nelson (1987, p. 232) arguing that a new international norm concerning the imposition of restrictions on travellers was developing as more and more states imposed them. The form that those restrictions took varied widely, including, variously, self-declaration or proof of status followed by entry subject to restrictions, through to automatic exclusion and even deportation. A 1989 global survey found that 50 countries imposed some kind of restrictions and that 32 had actually refused

entry and/or deported individuals on the basis of their HIV status (Duckett and Orkin 1989). The survey found that a further 11 countries were at that stage considering introducing restrictions. The authors concluded (Duckett and Orkin, 1989, p. S251) that ‘while a significant number of countries have, or claim to have, rejected travel restrictions as a measure to control the spread of HIV, an increasing number of countries are imposing such restrictions.’ In 2008, UNAIDS, drawing on the Global Database on HIV-Specific Travel & Residence Restrictions¹, reported that 59 countries denied the entry, stay or residence of HIV-positive people because of their HIV status (UNAIDS 2008, p. 7).

Thus the number of countries imposing some kind of restrictions remained more or less stable between 1989 and 2008, at just over one in four. Nevertheless, recently there have been some high-profile examples of countries removing their restrictions, not least the cases of the US, the People’s Republic of China, and South Korea, all of which occurred in 2010 and are discussed in the next section of this paper. This provides a puzzle. Given the consistency of the arguments against travel restrictions over the years, and given that those arguments have been framed in ways which, *prima facie*, ought to be convincing, why is it only now that the tide has begun to turn? The remainder of this article addresses that puzzle, putting forward four possible explanations for the timing of recent policy changes, explanations which, it is argued, help shed some light more generally on the conditions under which framing can be a successful advocacy strategy.

A new wave of policy change

During 2010 China, the United States and South Korea, all introduced changes in travel restrictions (although in some cases they were the result of processes which started some years earlier). The US policy change, on which much of this section focuses, had a catalytic effect on other states, and may even represent a tipping point in the overall delegitimisation

of travel restrictions. The US has been by far the most high-profile case of policy change in this area, a result of both its status as a global leader (including in the global response to AIDS) and also the ferocity of the domestic policy debate.

The US restrictions were originally introduced in 1987 and from that time onwards huge lobbying efforts were made by domestic opponents of the travel ban and a series of attempts were made to change the policy. In 1990 CDC recommended that HIV should be removed from the ‘dangerous contagious disease’ list, and indeed it was due to be removed in 1991 until a last-minute U-turn by the Bush administration. A subsequent effort under Clinton in 1993 was defeated in Congress (Cimini 1991-2, Macko 1995, pp. 547-552). Eventually, in 2008, George W. Bush began the process of removing the ban, a process which was completed by the Obama administration in 2009 and which came into effect in January 2010. South Korea’s travel restrictions were eased, specifically for those on short-term visits, at the same time as the US’s, in January 2010. Whilst both actions were welcomed by campaigners some, such as Human Rights Watch’s Joe Amon (2010), had concerns about continuing discriminatory measures in the Korean case (in particular around foreign workers who are found to be HIV positive). The Chinese government originally announced its intention to remove its ban on PLWHIV entering the country at the 2008 International AIDS Conference (China Daily 2008), although the change was not finally confirmed until April 2010, shortly after the US change came into effect and in advance of the 2010 World Expo being held in Shanghai (BBC News, 2010).² Senior UN figures – including UN Secretary-General Ban Ki-moon and UNAIDS Executive Director Michel Sidibé publicly praised China’s actions, with Sidibé saying ‘This is yet another example of China’s leadership in the AIDS response’ (UNAIDS 2010b).

Here, then, we have three cases of the removal (or at least partial removal) of travel restrictions in a very short period of time, and in each case by relatively powerful states, all of

which are G20 members. In this section I put forward a number of factors which can help to explain some of these changes. Consistently framing travel restrictions as a human rights issue, and the refutation of the economic and public health grounds for them, undoubtedly played a part but were not in themselves sufficient to bring about national policy changes. Rather these cases seem to have come about as a result of a coming together of various factors, including gradual changes in ideas about legitimacy of discriminating against high-risk groups and the severity of the ‘threat’ posed by PLWHIV; the domestic political context within these states; the existence of opportunities to apply pressure on governments, particularly around major events; the creation of a determined transnational advocacy effort from 2008 onwards; and domestic US politics, amplified to international significance via its global leadership role.

Firstly, at least in the US case, there has clearly been a significant change in attitudes towards HIV (and indeed towards some of the high-risk groups). From the very early days of the pandemic, HIV and AIDS have been heavily politicised and responses to them have been in part at least driven by a variety of non-science based considerations including fear and prejudice. Terms such as ‘gay plague’ were a common feature of early public debates over AIDS (e.g. Daily Telegraph 1983). The US commentator Patrick Buchanan, previously a speechwriter for Richard Nixon, famously wrote in his newspaper column that, ‘The sexual revolution has begun to devour its children. And among the revolutionary vanguard, the Gay Rights activists, the mortality rate is highest and climbing’ (Buchanan 1983, p. 311). Even if less stridently expressed, such views were also common in government circles. Indeed it was not until 1987 that Ronald Reagan first used the word ‘AIDS’ in public, and when asked what people should do about AIDS he replied ‘Just say no’ (Gill 2006, p. 10).

Senator Jesse Helms, the key figure in the creation of the US’s regulations through the 1987 ‘Helms Amendment’, was often cited by advocates as evidence that the US travel

restrictions were in reality based on prejudice rather than any legitimate public health or economic concerns. Helms' statements on the issue were frequently vitriolic, for example accusing President Clinton of 'kowtowing to the arrogant and repugnant AIDS lobby and to the homosexual rights movement which feeds it' (quoted in Macko 1995, p. 552). The International AIDS Society is one example of advocates' linking of the US travel ban with Helm's own views on homosexuality, repeating his infamous statement that 'We've got to have some common sense about a disease transmitted by people deliberately engaging in unnatural acts' (Kallings and McClure 2008, p. 17).

Whilst such attitudes have not entirely disappeared, they do tend to be far less commonly found, and more quickly condemned, in contemporary political discourse in the West as compared to two decades ago. Even Helms eventually reversed his position in 2002 as the religious right in the US took up the cause of AIDS in Africa. As well as these softening attitudes to some high risk groups, especially gay men, there has also been a gradual change in social attitudes in many countries towards PLWHIV, changes which have been a product partly of public health education efforts and a better understanding of the modes and risks of transmission, but which are also in part attributable to the passage of time since the emergence of HIV and AIDS as new health threats. To a great extent AIDS has become normalized in the West. Certainly some saw this as an important factor in the US policy change with Victoria Neilson, legal director of Immigration Equality, being quoted as saying 'I think it's a sign of changing attitudes across the board ... It just seemed like more of a non-issue at this point' (Agence France-Presse 2010). Whilst such attitudinal changes have been gradual, complex and non-linear (see Herek *et al.* 2003), generally, it seems that three decades on from the emergence of HIV/AIDS the climate in the West, and most importantly for the current argument within the US, has changed dramatically amongst both politicians

and their electorates. Thus timing – or ‘ripeness’ – certainly had a part to play in some of the recent examples of policy change.

Secondly, the development of a transnational advocacy network around the travel restrictions issue was crucial. Advocacy groups, in many cases with their origins in the gay community, have been vocal opponents of HIV-related travel restrictions from the outset. Whilst many of these groups, particularly those within the US and Canada, originally focussed their efforts on lobbying their own governments, a number of high-profile advocacy organisations have engaged in a broader global campaigning effort in an attempt to delegitimize travel restrictions on PLWHIV. Human Rights Watch has been one of the most prominent, arguing against such restrictions on human rights grounds whilst at the same time holding governments to account for their policies (e.g. Human Rights Watch 2007a) and documenting the effects which such restrictions have on individuals (e.g. Human Rights Watch 2007b). A host of others including the International AIDS Society (discussed below), the Ford Foundation and the Canadian HIV/AIDS Legal Network have also made high-profile interventions on this issue. Beyond this, as discussed above, there was from an early stage, clear and explicit policy guidance from major global health institutions, including the WHO and more recently UNAIDS.

Whilst these efforts had been ongoing for many years, from 2007 onwards a greater sense of high-level international leadership on the issue began to be apparent. Ban Ki-moon, who began his term as UN Secretary-General in January 2007, made it known that he saw combating HIV-related stigma and discrimination as a personal mission (Agence France-Press 2009). Ban has frequently been outspoken on the travel restrictions issue, making a number of high-profile speeches criticising countries for their discriminatory legislation (e.g. UNAIDS 2009b; UNAIDS 2010d). Ban’s campaign against travel restrictions included attempts to persuade his home country, South Korea, to remove their travel ban, which they

did for the majority of travellers in 2010. It was subsequently reported that Ban had continued to press the South Korean government on their remaining restrictions (China Daily 2010).

Helen Frary, UNAIDS' Chief of Board and UN Relations, described the extent to which this was something to which Ban is personally committed:

It was a good example with South Korea because Ban ki Moon never knew that they had travel restrictions, and when he found out he personally lobbied the government in Seoul and got them to change it because he said “this is outrageous.” But until he was Secretary General he had never knowingly met someone who was HIV positive and he was put in a room – we have an organisation called UNPlus for UN HIV positive staff - and there was a meeting between him and them, and he still talks about it. And he was extremely emotional because he'd never met somebody. And as a result he lobbied Seoul and that's one more to cross off the list. (Frary 2010)

Michel Sidibé, Executive Director of UNAIDS, has been similarly forthright on the issue and was responsible for the creation of the International Task Team on HIV-related Travel restrictions, which was set up by UNAIDS (with support from the Global Fund and the WHO) in 2008 in order to spearhead a major global effort for the elimination of such restrictions. The Task Team brought together a range of individuals from national governments, the UN System, civil society and the private sector (UNAIDS 2008, pp. 37-9). Many of the civil society organisations which have played a high-profile role in the global debate were represented on the Task Team, including Human Rights Watch, the Canadian HIV/AIDS Legal Network, the International AIDS Society, the Ford Foundation, the International HIV/AIDS Alliance, the Terrence Higgins Trust, the Ecumenical Advocacy Alliance and others. The Task Team carried out a number of activities including an audit of current restrictions (drawing on the HIV Travel database); a review of the evidence; and the drawing up of recommendations which were then passed on to governments and other bodies

including UNAIDS' PCB and the Global Fund Board. From the outset, however, the Task Team was designed to perform an advocacy role, 'to galvanize attention to HIV-related travel restrictions on national, regional and international agendas, calling for and supporting efforts toward their elimination' (UNAIDS 2008, p. 35).

A key part of the Task Team's approach was what amounted to a 'naming and shaming' exercise, publishing listings of those countries which imposed restrictions. China, South Korea and the US all appeared amongst the 59 countries on the Task Team's June 2009 list (UNAIDS 2009a). The US, indeed, was found to be one of only seven countries which required 'declaration of HIV status for entry or for any length of stay and either bar HIV-positive people from entering or apply discretion concerning their entry.' The other countries in this category were Brunei Darussalam, China, Oman, Sudan, United Arab Emirates and Yemen (UNAIDS 2009a, p. 6).³ Speaking about the effect of this shaming tactic on the US, Joe Amon of Human Rights Watch, one of the foremost commentators on the travel restrictions issue over a number of years, said of this shaming effort: 'I think it was important. ... The US doesn't like to be grouped with those other states in this worst category.' (Amon 2010b) As noted above, by the time the December 2010 list was published the number of countries had reduced to 49, and China and the US had been removed. Whilst it would clearly be over simplistic to attribute the removal of restrictions in those cases to a single cause, the Task Team's approach represents a clear attempt to use governments' reputational concerns to apply pressure for policy change.

Thirdly, in the cases analysed here, as well as such general attempts at shaming, specific events have been strategically used by advocates as opportunities to apply pressure on governments. In at least two cases in recent years the influence of the International AIDS Society (IAS) has been widely credited with having a significant policy impact. Given that HIV-related travel restrictions directly affect the ability of PLWHIV to attend the IAS's

International AIDS Conferences, the IAS has sought to use those conferences as a shaming tool and a lever for policy change (IAS 2009, p. 6). The Conferences were originally intended to alternate between France and the US, but the refusal of the US government to revoke the ban led to the cancellation of the 1992 conference, scheduled to be held in Boston, and a policy decision by the IAS to hold no further conferences in the US (or, indeed, any other country imposing such restrictions) until the restrictions had been removed. Following President Bush's pledge to rescind the ban, the IAS announced in June 2009 that it would consider Washington, DC as a venue for the 2012 conference if the ban were lifted (Bristol 2009). The conference venue was confirmed following the 2010 change in US legislation.⁴

The Global Fund, in no small part due to the efforts of the communities delegation on the Fund Board (Kowalski 2010), has also sought to use its influence to pressure governments into making policy changes, making a statement in 2007 that it would not hold its Board meetings in countries which imposed HIV-restrictions on short term visits and specifically referring to its ongoing dialogue with China (the venue for the 16th Global Fund Board meeting). The statement noted that the Chinese government was working with the Global Fund to change its national law (Global Fund 2007, p. 1).⁵

It seems clear from these cases that major events such as the International AIDS Conference and Global Fund Board meetings offer such organisations the opportunity to engage in a meaningful way with governments, and to exert leverage over them. Again it would be over simplistic to attribute recent policy changes solely to these events, but it is clear that advocates have been able to place national governments in a position in which they feel that their reputations are at stake. Coupled with the power of the human rights framing, this puts advocates of policy change in a potentially strong position.

Finally, the travel restrictions case shows what an important role the US can play as a global policy leader. Indeed in this case the US has played both positive and negative roles as

its own position has changed over time. Although public health security and economic rationalizations were by far the most common justifications of travel restrictions, in Quereshi's 1995 study of a number of countries with restrictions a further common argument was detected: that 'Many of the countries with restrictive policies barring HIV-positive aliens have rationalized their policies by reference to those of the United States' (Quereshi 1995, 91). Quereshi details in particular statements from Vietnam, the Philippines and Indonesia, all of whom pointed to the US restrictions then in force as precedent and justification for their own regulations (1995, 94-6). This only heightened the extent to which achieving US policy change would be likely to ripple-out across the international community. As Craig McClure, Executive Director of the IAS, said on the announcement of the US's intention to remove its restrictions: 'The U.S. always sets the tone. This is huge not only for the people who have not been able to enter the U.S., but finally these laws might be overturned throughout the world' (USA Today 2008).

As the US increasingly came to see itself as a global leader in the fight against AIDS – particularly under the administration of George W. Bush who put in place the President's Emergency Plan for AIDS Relief – the anachronistic nature of the US's entry restrictions became a source of potential embarrassment which was seized upon by the opponents of restrictions both within and outside the country. Democratic Senator John Kerry, a long-term opponent of the US's policy, argued that their continuation 'squanders our moral authority' (Bristol 2009). In a similar vein a CSIS report argued that the US regulations were 'viewed increasingly as antiquated and incompatible with the goals and practices of the President's Emergency Plan for AIDS Relief (PEPFAR) and as a liability in ensuring effective U.S. global leadership on HIV/AIDS' (Nieburg *et al.* 2007, p. 2).

Conclusion: framing is not enough

It is too early to know how quickly and how far and how quickly the US's change of policy will ripple out to other countries. The early signs, however, seem promising given the almost simultaneous changes in China and South Korea. Namibia also removed its restrictions in 2010, whilst India and Ecuador 'issued clarifications to underline that they too no longer employ such restrictions' (UNAIDS 2010c). Advocates, including Ban Ki-moon, have been explicitly using the US's policy change as an example for other states to follow (UNAIDS 2009b). The emergence of new international norms is often dependent upon a 'tipping point', following which a norm cascade is set in train, diffusing the new standard of appropriate behaviour through international society (Finnemore and Sikkink 1998). It is possible, although not yet certain, that the change in US policy could be just such a tipping point.

It is argued here, however, that the travel restrictions case provides some interesting and more general lessons about the use of framing as a global health advocacy strategy. Whilst much of the existing literature has highlighted the potential of framing to play a significant part in precipitating policy change, the travel restrictions case suggests that there are very real limitations on what framing can achieve in the absence of an enabling political environment.

On the one hand there are elements of the case examined here which support the kinds of strategies which the existing literature has viewed as being important: the need to build a broad-based advocacy network, for example (Keck and Sikkink 1998), and the ability of (supposedly) apolitical heads of international organisations to utilise framing in order to promote normative change (Rushton 2008). Yet this is a case in which a virtually universal expert consensus against the public health security and economic framings was in place, and in which continuous attempts were made over decades to reframe the issue in human rights terms. Despite this, little progress was made until the political conditions (and in particular

the domestic political conditions within the US) were right. Yet once those conditions were in place, in other words once the audience was susceptible to persuasion, the advocacy strategies used by opponents of restrictions began to bear fruit. Framing does not take place in a vacuum, and its chances of success are highly context-dependent.

Yet if, as constructivists argue, agents and structure are mutually constitutive (Wendt 1987), is it impossible to entirely separate agents from the political context within which they operate. International politics is not a Habermasian 'ideal speech' situation, and the better argument does not always win out. But framing, even when it does not immediately bring about policy change, might nevertheless play a part in gradually changing the political environment. The continuing efforts of AIDS activists from the very earliest days of the epidemic – efforts which were much wider than but which included the travel restrictions issue – helped establish the case that respect for human rights must be a fundamental part of the response to AIDS. The establishment of this common sense was a vital foundation on which the campaign against travel restrictions was able to build.

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Notes

- (1) See <http://www.hivtravel.org>
- (2) There was a temporary lifting of the ban for the 2008 Beijing Olympics.
- (3) Similarly the same report named the US as one of only 26 countries which deport people once their HIV-positive status becomes known (UNAIDS 2009a, p. 8).
- (4) The IAS had earlier succeeded in persuading the Canadian government to change their immigration regulations by threatening to cancel the 2006 International AIDS Conference in Toronto unless changes were made (Mellors 2008).
- (5) The change came into effect in 2010.

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