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HUMAN RIGHTS CONSEQUENCES OF MANDATORY HIV SCREENING POLICY OF NEWCOMERS TO CANADA

Laura M. Bisailon

We were uncomfortable with the fact that the Canadian HIV policy did not apply for work visa applications for nationals of all countries. We started to say jokes like, "HIV from Germany is very welcome in Canada. HIV from UK, well, very nice! But, HIV from Brazil? No, we don't want Brazilian HIV." It is meaningless! (Informant)

Ethics always has trouble competing with economics.¹

The promise and implications of a policy are not transparent and easily evident in its text . . . the "architecture of meaning" of a policy is revealed by the systematic investigation of policy categories and labels, metaphors and narratives, programs and institutional places.²

ABSTRACT

This paper focuses on the key human rights consequences of the HIV screening policy that applies to all permanent and some temporary resident applicants to Canada. This mandatory policy was introduced in early 2002 by Citizenship and Immigration Canada after consultation with Health Canada. The policy has yet to be evaluated and, until recently, the actualities of the medical encounters where testing occurs in domestic and international settings have not been researched. There is no systematic documentation of the policy's implications on either the lives of persons who submit to mandatory testing or on health systems. This article argues that there are sound options for responding to the human rights challenges posed by the screening policy. Data were obtained from secondary literature and findings from empirical fieldwork and research among immigrants living with HIV/AIDS in Canada. This paper adds to theoretical and applied health services and interventions work by focusing attention on avenues for addressing key human rights concerns posed by the policy. These are identified and critically explored through the framework that Lawrence Gostin and the late Jonathan Mann developed in 1999, which was later extended by Barry Hoffmaster and Ted Schrecker in 2000. The article concludes with four recommendations for addressing the central human rights consequences of the policy.

INTRODUCTION

Since 2002, Canada has required HIV testing of all persons aged 15 years and above who request Canadian permanent residency (such as immigrant and refugee persons) and temporary residence (such as migrant workers, students, and long-term visitors from designated countries).³ HIV screening, which takes place during the immigration medical examination carried out in sanctioned Canadian and foreign medical offices, is a mandatory component of Canada's immigration process. Until recently, little has been documented about the empirical functioning and consequences of the mandatory policy on persons tested and on health systems because the policy has not been systematically followed or reviewed since its introduction more than eight years ago.⁴

This serologic screening program is said to be "unique" because its public health goals are said to include health promotion rather than exclusion

of persons living with HIV/AIDS (hereafter referred to as PHA).⁵ However, while the policy is arguably effective in containing costs to the public health care system in Canada by limiting the number of HIV-positive immigrants and making inadmissible certain categories of HIV-applicants, it remains a challenge to critique chiefly because it has multiple objectives that remain implicit and not articulated in official documents.⁶ The policy is also normatively and uneasily situated at the junction of discussions about economics, public health ethics, human rights, and immigration; any evaluation must therefore take into account the uncomfortable tensions it raises between constitutional divisions of powers, law making and political interests in Canada, as well as the politics and rhetoric associated with global health and population mobility.⁷

This paper focuses on the key human rights consequences of the mandatory HIV screening policy. It does so by using a theoretical framework that Lawrence Gostin and the late Jonathan Mann proposed in 1999, which was later extended by Barry Hoffmaster and Ted Schrecker in their investigation of ethical issues raised by what were then proposals for mandatory HIV screening and exclusion of seropositive newcomers.⁸ Hoffmaster and Schrecker's investigation was situated within a family of advocacy scholarship that was part of a national civil society lobby effort aimed at informing and influencing federal government decision making, specifically that of Health Canada and Citizenship and Immigration Canada (CIC) as the partners in deciding whether or not to implement blanket immigration HIV screening and automatically exclude all applicants who were diagnosed HIV-positive.

This article makes the case that Canada's mandatory immigration HIV testing policy poses challenges to human rights and is not without ethical concerns. There are options for responding to these challenges, and this paper suggests that efforts can and should be made to develop policy responses that fully respect human rights. Four recommendations emerge from both analysis of the secondary literature and from research and fieldwork among immigrant persons in Canada living with HIV/AIDS.⁹

POLICY HISTORY

There is no reference to HIV/AIDS in the Canadian Immigration and Refugee Protection Act (hereafter the Act) or the Canadian Immigration and Refugee Protection Regulations (hereafter the Regulations).¹⁰

Changes to the Act and the Regulations in late 2001 meant that as of January 15, 2002, all applicants for Canadian permanent residency and some applicants for temporary residency were obliged to undergo serologic HIV testing; tuberculosis and syphilis are the two other conditions for which applicants are mandatorily screened.¹¹ There was no blanket testing for HIV/AIDS before early 2002, and the addition represented the first change to the immigration medical examination in approximately fifty years.

The practice of restricting the mobility of PHA based on health status has been repeatedly rejected in international guidelines.¹² Nonetheless, beginning in the late 1990s, Commonwealth countries such as the United Kingdom, New Zealand, Australia, and Canada reviewed domestic immigration policies.¹³ Within a short time of each other, governments of these countries (and others worldwide) enacted various HIV-specific legislation and policies that included restrictions on the entry and immigration of PHA.¹⁴ The late 1990s coincided with the appearance of effective antiretroviral (ARV) treatment in Organisation for Economic Co-operation and Development (OECD) countries that delayed the onset of AIDS-defining illnesses. The expected lifespan of individuals living with HIV/AIDS was considerably extended in settings of medicine availability.

Pursuant to Section 38(1) of the Act, an applicant for permanent and temporary residency can be deemed medically inadmissible and denied a Canadian visa based on a medical condition, if 1) she/he is likely to be a danger to public health or public safety, or 2) she/he might reasonably be expected to cause excessive demand on public health and social services. The Regulations define 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.¹⁵ Since 1991 in Canada, PHA are not considered dangers to public health or safety by virtue of their HIV status.¹⁶ This is echoed in the HIV policy, which states,

HIV infection is not considered a reason for non-admittance [to Canada] on grounds of public health . . . HIV infection could only be considered a risk to public safety under the unusual circumstance in which an HIV-infected person were a sexual offender.¹⁷

However, for purposes of determining excessive demand, applicants living with HIV/AIDS are evaluated for a ten-year period and not the five-year period against which other applicants are assessed.¹⁸

In 2000, Health Canada recommended that CIC automatically exclude HIV-positive applicants based on health status, including refugees and refugee applicants who are otherwise protected under international law. In her comprehensive review of immigration and HIV in Canada, McGill University law professor, Alana Klein, reported that this was framed as the optimal strategy to protect the health and safety of Canadians; the “lowest health risk course of action [and] the preferred option.”¹⁹ Decision making was based on results of internal government consultations and technical working groups convened to discuss new medical screening tests and risk assessment procedures associated with HIV/AIDS.²⁰ The Montebello Process, named after the conference center where consultations took place, reviewed hypothetical public health risks associated with various diseases by estimating their spread through the Canadian population. The supposition was that HIV-positive migrants would spread HIV to at least one resident Canadian.²¹ There is no evidence suggesting that the government review made use of instruments linking the law, public health ethics, and human rights designed to assist states in creating rights-based responses to HIV/AIDS, despite these being available at the time of the Montebello Process (for example, in the Siracusa Principles and International Guidelines on HIV/AIDS and Human Rights).²²

The Canadian HIV/AIDS Legal Network, the country’s leading organization related to HIV, law, and human rights, opposed mandatory testing and blanket exclusion of prospective immigrants.²³ As part of an “informed and rigorous discussion” on immigration and HIV that spanned approximately eight months, the Canadian HIV/AIDS Legal Network commissioned research that challenged official decision making and evidence about HIV/AIDS and the need for mandatory immigration screening.²⁴ Many concerns that were first elaborated in these projects that date from the late 1990s remain current concerns. A number of these are outlined in Table 1, and the six concerns listed there are integrated throughout this article’s analysis.²⁵ The table presents quotations from recently established immigrant persons living with HIV/AIDS in Canada who underwent HIV testing for immigration purposes as these relate to each of the six concerns.

DATA ON IMMIGRATION AND HIV

The overall number of HIV-positive applicants admitted to Canada is small relative to the population increase through immigration and the resident HIV-positive population. Between 2001 and 2006, more than one million new immigrants settled in Canada, a country with a current population of approximately 31.2 million; it is approximated that one in five persons resident in Canada is foreign-born.²⁶ Figure 1 shows the multiple immigration pathways that applicants take in applying to Canada as referenced in this section. There are up to an estimated 70,000 persons are known to be living with HIV/AIDS in Canada, with one third of these people unaware that they are HIV-positive.²⁷ Many applicants apply from countries in which HIV/AIDS is endemic, and most since 2002 have been women and men between 26 and 45 years old from Africa and the Middle East.²⁸ In 2006 and 2007, there were 1,050 HIV-positive applicants for Canadian permanent residency.²⁹ Of this total, 994 were categorized either as refugees, refugee applicants or family class members: these three categories of applicants are eligible by law to remain in Canada independent of their health status.

In her research reporting on the history of medical screening technologies in Canada, Sarah Weibe found that annually in Canada, “2,000 visa applicants are rejected on health grounds”; recent data show that only a small number of these denials relate to HIV-positive status.³⁰ Since mandatory HIV screening was introduced in 2002, 4,374 persons have tested HIV-positive during immigration procedures (Table 2).³¹ Of this number, 453 persons were found inadmissible to Canada based on the CIC assessment process, in which calculations are ostensibly made on a case-by-case basis about an applicant’s anticipated costs to public health and social systems. Peter Coyte and Kednapa Thavorn briefly outlined Canadian and international experience with medical admissibility of prospective immigrants where PHA were the sample population.³² The authors produced a statistical definition of the admissibility criteria that are outlined in Canadian legislation that currently guide CIC officials in reviews of applications made by PHA. Coyte and Thavorn suggested a review of current thresholds in evaluating medical admissibility, one that would take into account recent clinical, epidemiological, and economic evidence.

However, as noted above, several categories of applicants to Canada cannot be denied admission based on anticipated costs to public health and social sys-

Table 1. Concerns and personal experiences related to mandatory HIV immigration testing*

| Concern | Elaboration | Informant Quotation |
|--|---|---|
| More harm than good associated with mandatory HIV screening | HIV and AIDS are stigmatized conditions. Settings worldwide in which persons are tested are highly variable and mediated by health determinants. ^a | “Where testing is carried out in overseas offices, counselling is consistent with the standards of that country. If it is not offered, then it is not offered.” |
| Whether and how pre- and post-HIV test counseling occurs in practice | Counseling is internationally recognized as integral to responsible health practice in relation to HIV screening. ^b | “Interesting that the WHO facility [where I was tested] did not obey its own recommendations about counselling [in the context of my test]. It has a staff that seems unaware of WHO guidelines on counselling [because I prompted them to talk to me about HIV].” |
| Health-based denial of immigration application | Methodologies and international policies exist to evaluate the human rights consequences of public health interventions. ^c Mandatory testing is framed as inconsistent with these, as is testing for the sole purpose of immigration. ^d | “I explained to the doctor [outside of Canada] that I was applying to immigrate to Canada [and that I had HIV]. He said, ‘why are they making you do blood work and waste your money? I do not know anybody who was HIV+ who immigrated to Canada.’” |
| Legality of mandatory testing for the sole purpose of possible immigration | Involuntary HIV testing is permissible in rare circumstances in Canada. Mandatory testing remains an exception under Canadian law. ^e | “I signed a waiver indicating informed consent. I had no choice but to do an HIV test. If not, I would not have been granted a visa. From a legal point of view, everything is correct because I agreed and signed a document. But, in reality, I did not have a choice but to submit to a test because I wanted to come to Canada. No HIV test, no visa. So I had to do it.” |
| Exclusively negative assessment of an applicant to Canada neglects to project positive contributions | Government agencies are experienced in considering qualitative evidence, but potential contributions of an applicant are not currently calculated into the cost-benefit analysis that is made of application. ^f | In the absence of a review of adjudication guidelines and policies used by CIC [in reviewing visa applications], “current policy results in immigration denial on medical inadmissibility grounds and the consequent loss to Canadian society of some gifted individuals.” ^g |
| Exceptional status of HIV | Applied to HIV and AIDS since the 1990’s, where public health responses to and funding for AIDS programming are criticized by public health authorities as being differentially treated at the expense of other conditions. ^h Applied colloquially where PHA are treated differently as related to health status. ⁱ | “I think of all the immigrants who go through the immigration process to the end, just like me; who are intelligent; with good experience, but who would get blocked because of their numbers [CD4 count and viral load]. I did not know that these could determine my fate. If I had had a low CD4 count and high viral load, I would not be sitting here [in Canada].” |

*See note 25 for Table 1 sources.

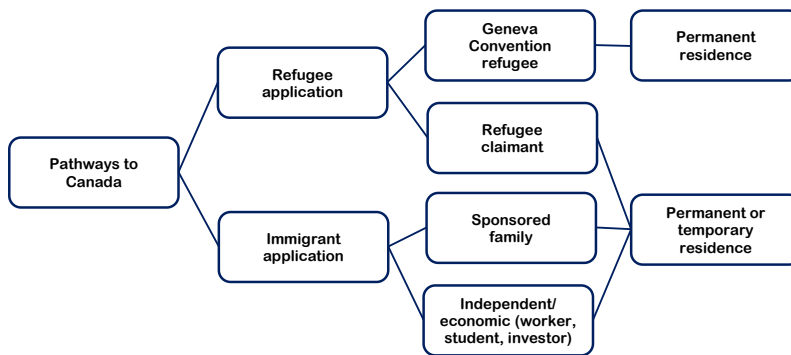


Figure 1. Immigration to Canada

tems; these include refugees, refugee applicants, and family class applicants. It is revealing that, from 2002 to 2010, the percentage of admissible economic class applicants with HIV/AIDS was approximately 2% as compared with 92% for refugee, refugee applicants and family class persons combined.³³ Also significant is that the policy specifies that a person who is already on ARV treatment is inadmissible for reasons of cost.³⁴

HUMAN RIGHTS AS SUBSETS OF PUBLIC HEALTH

Human rights and public health have been linked from the earliest days of the HIV/AIDS pandemic.³⁵

The late Jonathan Mann and colleagues wrote that HIV testing models, policies, and protocols rooted in human rights principles are in the best interest of individual and collective public health goals; as health inequities are subsets of inequalities, so too are human rights integral subsets of public health.³⁶

The adoption of HIV/AIDS-relevant public health practices that exist within a sound human rights framework has achieved measurable gains.³⁷ Notably, Brazil placed human rights at the center of its national response to HIV/AIDS and as a result now legislates universal access to ARV treatment for populations

Table 2: HIV-positive tests by category and admissibility status, January 2002 to March 2010

| Application category | Admissible n (%) | Inadmissible | Totals | |
|----------------------|---------------------|-------------------|--------------------|------------------------|
| | | | Category totals | % of all applicants |
| Convention refugee | 1,176 (30%) | 8 | 1,184 | 27.1% |
| Refugee claimant | 1,635 (41.7%) | 8 | 1,643 | 37.6% |
| Family | 799 (20.4%) | 67 | 866 | 19.8% |
| Economic | 70 (1.8%) | 198 | 268 | 6.1% |
| Temporary resident | 205 (5.2%) | 101 | 306 | 7.0% |
| Other* | 31 (0.8%) | 70 | 101 | 2.3% |
| Unknown | 5 (0.1%) | n/a** | 6 | 0.1% |
| TOTALS: | 3,921 (100%) | n/a (100%) | 4,374 | 100% |

Source: Citizenship and Immigration Canada (CIC), Health Management Branch Database, as of May 15, 2010.

* "Other" included humanitarian and compassionate and temporary resident permit applicants.

** CIC masked this data to preserve confidentiality in the material it provided to the author.

in need.³⁸ HIV/AIDS-related legal and human rights networks around the world have provided strong evidence that promoting human rights is a productive way to meet and ensure public health requirements.³⁹

In 1999, Lawrence Gostin and the late Jonathan Mann produced a seven-point methodology to evaluate the human rights consequences of public health interventions.⁴⁰ The following year, Barry Hoffmaster and Ted Schrecker extended this framework with the purpose of considering the ethical implications of mandatory HIV testing and the proposed health-based exclusion of HIV-positive applicants to Canada.⁴¹ The discussion below reviews each of the seven-points in this framework (summarized in Table 3), which serves as an analytic tool with which to consider Canada's HIV testing policy. By working through the steps of this framework, and integrating recent research findings based on comments from immigrants living with HIV/AIDS and a constellation of others who work in association with such persons in Montreal and Toronto, the discussion below offers a useful method for articulating and exploring features of the mandatory policy that have presented themselves as problematic and challenging from ethical and human rights perspectives.⁴²

Step 1: Clarity of the public health purpose

The objectives and goal of the Canadian testing program are inferred rather than explicitly stated in legislation and the HIV policy. Gostin and Mann stressed, in their first point in the framework, that public health goals need to be specific to be effective and understood by the public. Thus, there can be no presumption that the objectives and goals of the HIV screening program are either effective or generally understood. One report on the program rationale noted that immigration HIV testing serves the purposes of notification, reporting, and program management.⁴³ Canadian government medical personnel Brian Gushulak and Linda Williams wrote that it would be useful to have the immigration medical examination contribute to national health planning purposes "rather than only identifying conditions that could bar admission."⁴⁴

The basis on which an HIV-positive applicant would be denied entry to Canada is fundamentally economic. Concerns about the public purse are relevant, given that governments in Canada have been under pressure to improve health services and reduce wait

times while containing health care costs. However, a strong ethical case can be made for reviewing applications for permanent and temporary residency using a broader yardstick than health economics alone, since health economics is an imprecise measure in light of the unpredictability of the disease course of HIV/AIDS, among other considerations.⁴⁵ As Hoffmaster and Schrecker noted,

If safeguards for individual human rights are to be meaningful, they should be at least as strong when the collective objective against which they are counterposed [sic] is the protection of the public treasury as when it is the protection of public health.⁴⁶

Step 2: Effectiveness of the program

The second step in the framework is to "[a]ssess the probable effectiveness of the proposed measures, alone and in comparison with other available options, with reference to such questions as the accuracy of screening programs." The conditions under which HIV testing occurs vary widely because immigration medical examinations take place both within and outside of Canada. Prospective immigrants are examined by designated medical practitioners (DMP) who are appointed by CIC for renewable, three-year terms. Until recently, there was little empirical data about the actualities of immigration medical encounters where prospective immigrants are examined by DMPs. In one interview, a DMP described himself as a man in the trenches, an "information gatherer" performing "functional inquiries" about applicants to Canada. There is paperwork to file and certain procedures that physicians are instructed to follow when a person discloses his or her HIV status or is diagnosed positive through immigration serotesting. These physicians are not likely to be the long-term treating physician of an HIV-positive applicant, and the DMP refers paperwork to CIC rather than make health assessments and decisions about an applicant's immigration file. DMPs who were interviewed for this study characterized as irregular the communications and reporting between CIC and themselves. DMPs who conduct immigration medical examinations in Canada also stated that international contexts are more challenging to monitor than their domestic equivalents.

| Table 3. Seven-step methodology for evaluating human rights consequences of public health interventions | |
|---|---|
| Step | Action |
| 1 | Clarify the public health purpose, with an emphasis on avoiding vague, general goals like the prevention of HIV infection. |
| 2 | Assess the probable effectiveness of the proposed measures, alone and in comparison with other available options, with references to such questions as the accuracy of screening programs. |
| 3 | Determine whether the measure is appropriately targeted. In other words, it should be neither over- nor under-inclusive. |
| 4 | Examine each of the feasible policy measures for human rights burdens. “The human rights assessment involves a meticulous balancing of the potential benefits to the health of the community with the human rights repercussions of the policy,” with reference to such statements as the Universal Declaration of Human Rights and with the recognition that “human rights burdens may outweigh even a well-designed policy.” The assessment may take into account: “1) the nature of the human right; 2) the invasiveness of the intervention; 3) the frequency and scope of the infringement [of human rights]; and, 4) its duration.” |
| 5 | Determine whether the policy is the least restrictive alternative — in terms of human rights — that will achieve the public health objective, or whether there are “alternative public health policies that burden human rights to a lesser extent, while still protecting the health of the community.” |
| 6 | If the least restrictive alternative still carries a significant human rights burden, ensure that its application is based on “an individual determination that the person poses a significant risk to the public. . . . Significant risk must be determined on a case-by-case basis by means of fact-specific, individual inquiries. Blanket rules or generalizations about a class of persons do not suffice.” |
| 7 | In the process of making such determinations, fair procedures must be guaranteed for the persons affected. |
| <p>Source: B. Hoffmaster and T. Schrecker, <i>An ethical analysis of the mandatory exclusion of refugees and immigrants who test HIV-positive</i> (Ottawa: Health Canada, 2000), p. 15. Available at http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=583. Adapted from L. O. Gostin and J. Mann, “Toward the development of a human rights impact assessment for the formulation and evaluation of public health policies,” in J. M. Mann, S. Gruskin, M. A. Grodin, and G. Annas (eds), <i>Health and Human Rights: A Reader</i> (London: Routledge, 1999), pp. 54–71. Used with permission.</p> | |

The literature indicates that where testing is voluntary and accompanied by counseling, and where there is respect for confidentiality, impacts on individual health outcomes are positive and human rights commitments are most effectively respected.⁴⁷ When the HIV testing policy was introduced in 2002, CIC agreed to have DMPs administer pre- and post-HIV test counseling, in accordance with established Canadian and international guidelines.⁴⁸ Field research from Montreal and Toronto revealed that pre- and post-test counseling does not routinely occur. DMPs

mobilize their general practitioner knowledge when delivering key messages about HIV/AIDS to HIV-positive applicants, rather than referring to the practitioner manual. One informant living with HIV/AIDS said, “Maybe there was intended counseling that I very quickly aborted. Probably he was going to give me that talk. I read through his paper; I agreed with everything it said. I signed it.” Upon being called back to receive a positive diagnosis by the DMP, the majority of study informants in Montreal reported that the post-diagnosis encounter consisted of the

DMP providing them with a referral slip on which there was contact information and directions to a hospital with expertise in HIV/AIDS treatment.

There is a dramatic difference between DMPs and applicants with respect to the meaning, quality, and content of pre- and post-test counseling for HIV/AIDS. Many informants tested for HIV/AIDS in Canada and overseas (including Brazil, Russia, Sudan, and Kenya) reported that counseling did not happen at all during the immigration medical examination. For their part, DMPs interviewed in this work reported providing information on condoms, blood donations, and protecting others as per population health concerns. Most informants living with HIV/AIDS were surprised and dismayed at the absence of post-test counseling. One person said,

I prompted them [medical personnel] several times, giving them the chance to do pre-test counseling. That was my goal: to receive details about this. That did not happen. At least they are supposed to explain something about the HIV test.

After receiving an HIV-positive diagnosis, there is a gap at worst and inconsistency at best between what is expected of DMPs with respect to counseling and what reportedly happens at many immigration medical encounters from the standpoint of the person tested. Currently, DMPs are remunerated for delivering post-HIV testing if they bill, and they are asked to have applicants sign an acknowledgement form upon receiving post-HIV test counseling. However, only one informant in the study signed this form. Two others recalled having put their signature to what they called an “informed consent” form to be tested for HIV/AIDS, noting, however, that there was actually no choice other than to be tested. Another informant reported,

The DMP gave me a piece of paper that I had to sign that stated that I tested HIV-positive, that I am aware that I am HIV-positive, and that I have been educated about the means of transmission. I had not been educated through him.

A government advisor said that this form was part of the DMP manual, “to at least have a control record that positives are actually receiving post-test counseling.”⁴⁹

Step 3: Appropriateness of targeting

Another human rights challenge that was identified before the mandatory screening policy was introduced in 2002 is that imposed HIV/AIDS testing on would-be immigrants and refugees is in fact unconstitutional to impose on Canadians, and is rarely constitutional in Canada under any circumstances (as per Table 1). While the Canadian Constitution of 1867 and the Charter of Human Rights and Freedoms of 1982 only exceptionally apply to non-Canadians or foreign nationals in Canada, the Canadian HIV/AIDS Legal Network argued that it was unfair and inconsistent with the 1948 Universal Declaration of Human Rights to test citizens of foreign countries for a stigmatized health condition where the only purpose was *possible* immigration.⁵⁰

Canada’s approach to mitigating the effects of HIV/AIDS has generally been to endorse public health interventions that focus on promoting safe behavior and reducing harm and risk.⁵¹ Domestic health promotion approaches rely less on exclusion and screening and more on cooperation with various populations.⁵² In spite of this, a different strategy was applied to migrants; implementing mandatory testing as a method of ostensibly protecting and securing the health of Canadians.

Step 4: Controlling for human rights burden

The fourth step is the most complex step of Gostin and Mann’s methodology because it is where collective/individual and domestic/international human rights intersect. Several key domestic questions relate to the federal immigration HIV screening program: In whose interests are prospective applicants tested? And for what explicit public health aim is HIV testing mandated as an integral feature of medical examination? Mandated testing is not done primarily in the interest of the applicant. Since HIV/AIDS was de-listed in 1991 as a condition posing threat to Canadian public health and safety, as discussed above, there has not been a clear public health purpose for controlling for HIV/AIDS.

In the international arena, whereas health has been established as a human right under a variety of international legal instruments, the “most elusive right” is “the right to choose one’s place of habitation on earth.”⁵³ Human rights, public health, and forced migration literature point to tensions with undocumented migration and permeable borders;

the absence of enforceable laws governing human mobility; and the disparate availability of ARV treatment in countries with shared borders, such as South Africa and Zimbabwe.⁵⁴ It is politically attractive, though ethically dubious, to frame immigrants — and in particular those with identified illness — as potential contributors to financial and other pressures on health care systems.⁵⁵

Step 5: Least restrictive policy response

Hoffmaster and Schrecker note that there is no evidence to indicate that mandatory testing is the least restrictive way to pursue public health goals, despite such evidence being a fundamental human rights requirement. McGill University ethicist Margaret Somerville notes that health concerns are rarely, if ever, exclusively about health.⁵⁶ She wrestles with how to meaningfully define public health, human rights, and ethics in the era of HIV/AIDS, concluding that these are embedded in political, public interest, and economic decision making. It is thus useful to consider implicit and explicit drivers of health policies because the sum of these has human rights implications.

Evaluating policy responses that fully consider and respect human rights is possible when objectives and public health goals are explicit and clearly communicated. This is not the case with Canada's HIV testing policy. In light of the fact that the policy has multiple suspected purposes, discussed above, some of which are defensible from a human rights standpoint and some of which are not, it may be difficult to suggest less restrictive policy responses.

Step 6: Individual assessment of immigration applications

Prior to 2002, DMPs tested an applicant for HIV/AIDS if they assessed the person to be at risk for the virus. Importantly, under the current policy of screening all applicants, selective testing of citizens from certain global regions is no longer in practice. There is thus less discretionary decision making in this regard on the part of the DMP, who is already an influential actor in the processing of immigrants to Canada.⁵⁷ Individual analysis of an applicant is a key feature of ethical due process in immigration contexts.⁵⁸

However, while there is currently no blanket exclusion of HIV-positive applicants to Canada, one group

of applicants — independent class applicants — are in a category that is not exempted from examination for anticipated cost to public health and social systems. Applicants in this class represent a significant proportion of those who are rejected, as illustrated in Table 2.

Step 7: Fairness for all

Anthropologist Ida Susser wrote that testing strategies that enhance the autonomy of individual decision making achieve public health goals and respect human rights obligations.⁵⁹ Testing for HIV/AIDS in a consensual situation where there are treatment options available is consistent with ethical practice. The same cannot necessarily be said of testing carried out in a context of power imbalances, where individuals denied entry to Canada following a positive HIV test may have few options for treatment; where individuals may have been unprepared for the test; or where they may face considerable hardship and health-based stigmatization.

Since the majority of applicants for permanent residency make application from outside of Canada, immigration HIV screening is most commonly done in the country of application. Thus, there are reasonable grounds for investigating and being concerned about the contexts in which mandated HIV screening occurs. From 2002 to 2010, the majority of HIV-positive tests by applicants who were deemed inadmissible because of anticipated excessive costs to Canadian public health and social services were performed outside of Canada.⁶⁰ Several informants in this study reported that while they expected to be tested for HIV/AIDS in their immigration application, they were not informed they were being tested for HIV/AIDS. One person remarked,

I was not told what the tests were going to be. I had a TB [tuberculosis] test. The urine test was perhaps for pregnancy. This is a requirement for all immigrants. Maybe they did not inform me because they assume that everybody knows that if you are going for a test, then that [HIV] is what it is for.

Two informants, refugees who tested HIV-positive through Canadian immigration processes in Africa, waited over one year between diagnosis for immigra-

tion purposes and their arrival in Canada, where their ARV treatment began. One informant noted,

In Sudan, there is no referral to legal or other organizations that can assist you. It is hidden. That is why the doctor does not refer you. Secondly, if the Sudanese government knows [that as a foreign national] you are HIV-positive, they will deport you.

While the Canadian government has the constitutional authority to regulate its borders and implement immigration policy, a critical feature of which is medical screening, the ethical authority with which Canada carries out HIV screening of possible prospective immigrants can be questioned.⁶¹

CONCLUSION AND RECOMMENDATIONS

This paper has made use of human rights frameworks, findings from advocacy scholarship, and results from an empirical study among persons who tested HIV-positive during Canadian immigration procedures as well as persons working with them, to identify and explore key human rights and ethical implications of Canada's HIV screening policy.⁶² The context of the policy's creation and implementation was presented, and the point was raised that in the absence of clearly stated objectives and goal, policy alternatives remain hard to identify.

The characteristics of sound population health programs and policy interventions include focus on reducing inequities, prioritizing upstream actions, and integrating socio-ecological frameworks.⁶³ Untapped potential exists for exploring the intersections of human rights and public health ethics.⁶⁴ Human rights norms, for example, provide a productive basis for advocating for responsibility and accountability in health in relation to the health of mobile populations.⁶⁵ HIV/AIDS researchers Stephanie Nixon and Lisa Forman have suggested combining the analytic tools offered by public health ethics and human rights to explore resolving tensions between public health and human rights, particularly in identifying and addressing health inequities experienced by migrant populations.⁶⁶

Despite the fact that life for HIV-positive individuals can be prolonged as a result of the advent of ARVs (where medicine is available), HIV/AIDS has yet to be treated in the same way as other chronic and man-

ageable diseases. This article has drawn attention to one example of regulated exceptionalism in the form of mandatory immigration HIV testing policy as it is applied to all those who have sought Canadian permanent residency and some who have sought temporary residency since early 2002. HIV screening is the only procedure that has been added to the Canadian immigration medical examination in approximately fifty years. Stigmatization based on HIV status is unfortunately persistent, as documented in immigration adjudication and health care settings in Canada.⁶⁷ The examples provided and discussed in this paper would seem to reinforce the observation that HIV/AIDS has achieved what Susan Sontag described as an exaggerated meaning of illness; an unfortunate motor for health-based discrimination.⁶⁸ In response to human rights and ethical implications based on the analysis in this article, four actions are proposed, outlined below.

Recommendation 1: Clarify objectives and goals of the HIV testing policy

It is recommended that testing program objectives and goals be made explicit so that they can be well understood and fully examined by the public. Research results indicate that neither informants nor those working in association with them are clear as to policy objectives and goals. More apparent and immediate to applicants for permanent and temporary residency is the wide range of activities in which they must engage in the wake of a positive diagnosis through immigration screening. Clarifying objectives and goals of the program would enable the undertaking of practical analyses of the human rights, ethical implications, and fundamental animating principles of the legislation and policy. Frameworks such as those mobilized in this article could serve as a point of departure.

Recommendation 2: Evaluate the functioning of the mandatory screening policy

The second recommendation is that the federal government develop an evidence base from which to regularly monitor how the testing policy is actually playing out in practice in Canadian and foreign settings. Regular monitoring would lead to consideration of the strengths and weaknesses of the policy. An evidence base would be useful in making corrections if findings reveal weaknesses or suspected infringements on human rights. Specifically, involvement from persons who test HIV-positive during immigration screening as well as their legal advocates would

be useful to cast light on concealed or subtle dimensions of how the policy plays itself out in practice.

As this article goes to press, it would appear that CIC is reviewing immigration medical screening procedures. Details including the scope and anticipated outcomes of such review are unknown. However, it would also appear that the participants are internal to government agencies, with limited or no involvement from civil society. Critically, persons who underwent mandatory HIV screening for Canadian immigration purposes would seem not to have been invited to the process.

Recommendation 3: Monitor the policy using public health, ethics, and human rights approaches

The third recommendation calls for regular review, monitoring, and evaluation of the HIV testing policy by a nongovernmental source through the lens of the emergent field of public health ethics. There are precedents for critical and comprehensive evaluations done by agencies outside of government using health and human rights-based frameworks and integrating best evidence and recent knowledge. For example, Country Reports were produced by coalitions of women's organizations globally in accordance with the recommendations emerging from the Committee on the Elimination of Discrimination against Women.⁶⁹ These country status reports, produced by nongovernmental authors, comment critically on the actualities of how domestic policy and practices are carried out on the Millennium Development Goals in general, and women's legal, human, and health rights, in particular. These reports provide critical counterpoints to official government reports on the status and functioning of domestic policy and practice.

Recommendation 4: Provide stable funding for domestic social science research on HIV/AIDS and immigration

The final recommendation calls for permanent funding that explicitly links health and immigration policy research and development. Specifically, the Canadian Institutes for Health Research (CIHR), Canada's health research-granting agency, should support a line of funding for research in immigration and HIV/AIDS. This would provide the impetus for scholarship and knowledge-generation relevant to both fields. Importantly, such funding would have the potential to stimulate critical investigation into the everyday character, quality, functioning, and con-

sequences of health policy and programs at the intersection of immigration and HIV/AIDS.

With support from CIHR, an intersectoral working group called the Immigration Testing Consultative Committee might be established. This committee would be mandated to monitor and evaluate the HIV screening policy. It could be housed at the 15-member Ministerial Council on HIV/AIDS (Council) that has reported to Health Canada since 1998 on population health matters and HIV/AIDS.⁷⁰ The Council prioritizes topical issues relating to HIV/AIDS and communicates these to the federal government. Additionally, the Council also monitors and evaluates the effectiveness of the work accomplished under the federal government's national plan for addressing HIV/AIDS.⁷¹

There is precedent for the Council's interest in immigration and HIV/AIDS in Canada. In 2001, the Council made immigration HIV screening a priority by working with Health Canada and CIC to guide implementation of the HIV testing policy. The Committee could work in coordination with the Canadian HIV/AIDS Legal Network, an established Council partner and established expert in the field of immigration and HIV/AIDS. The Committee could report to Health Canada and CIC, given that immigration HIV screening is situated within the purview of both public health and immigration in Canada.

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REFERENCES

1. B. Hoffmaster and T. Schrecker, *An ethical analysis of the mandatory exclusion of refugees and immigrants who test HIV-positive* (Ottawa: Health Canada, 2000), p. 23. Available at <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=583>.

2. D. Yanow, *Conducting interpretive policy analysis* (Thousand Oaks, CA: Sage, 2000), p. v.
3. For the current list of designated countries and territories, see <http://www.cic.gc.ca/english/information/medical/dcl.asp>.
4. L. M. Bisailon, "Implications of mandatory HIV screening as pre-condition for immigration to Canada" (presentation at the Ontario HIV Treatment Network Annual Research Conference, Toronto, Canada, November 16, 2009). Available at http://uottawa.academia.edu/documents/0063/6468/Microsoft_PowerPoint_-_Implications_OHTN_16Nov_Bisailon.pdf; R. Elliott, Personal communication (March 27, 2008).
5. M. Zencovich, K. Kennedy, D. W. MacPherson, and B. D. Gushulak, "Immigration medical screening and HIV infection in Canada," *International Journal of STD and AIDS* 17 (2006), pp. 813–816.
6. Citizenship and Immigration Canada (CIC), *Operational processing instruction 2002–2004. Medical assessment of HIV positive applicants* (Ottawa: CIC, 2002).
7. On the junction of discussions, see D. Stauffer, P. Kamat, and P. Walker, "Screening of international immigrants, refugees, and adoptees," *Primary Care* 29 (2002), pp. 879–905; see also H. Worth, "Unconditional hospitality: HIV, ethics and the refugee problem," *Bioethics* 20 (2006), pp. 223–232. On the tensions, politics, and rhetoric, see D. W. MacPherson, B. D. Gushulak, and L. Macdonald, "Health and foreign policy: Influences of migration and population mobility," *Bulletin of the World Health Organization* 85 (2006), pp. 200–206. Available at <http://www.who.int/bulletin/volumes/85/3/06-036962.pdf>; see also J. S. Woodsworth, *Strangers within our gates* (Toronto: University of Toronto Press, 1972).
8. On the original framework, see L. O. Gostin and J. Mann, "Toward the development of a human rights impact assessment for the formulation and evaluation of public health policies," in J. M. Mann, S. Gruskin, M. A. Grodin, and G. Annas (eds), *Health and Human Rights: A Reader* (London: Routledge, 1999), pp. 54–71; on the subsequent extension, see Hoffmaster and Schrecker (see note 1).
9. L. M. Bisailon, "Examining bodies: Putting the HIV testing policy to the test," *HIV/AIDS Policy & Law Review* 15/1 (2010), pp. 84–90. Available at <http://aidslaw.ca/publications/interfaces/downloadFile.php?ref=1775.pdf>; see also, L. M. Bisailon, "Working from within endemic HIV stigma: Developing Canadian social workers' understanding of the challenges faced by newcomers managing HIV," *Canadian Social Work* 12/1 (2010), pp. 20–44.
10. Department of Justice Canada, Immigration and Refugee Protection Act, c 27 (2001). Available at <http://laws.justice.gc.ca/eng/I-2.5/page-1.html>; and Department of Justice Canada, Immigration and Refugee Protection Regulations (SOR/2002-227) (2010). Available at <http://laws.justice.gc.ca/eng/SOR-2002-227/index.html>.
11. Citizenship and Immigration Canada (see note 6).
12. Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International guidelines on HIV/AIDS and human rights* (Geneva: UNAIDS, 2006). Available at http://data.unaids.org/Publications/IRC-pub07/jc1252-intern-guidelines_en.pdf; see also, Joint United Nations Programme on HIV/AIDS and International Organization for Migration, *UNAIDS/IOM statement on HIV/AIDS-related travel restrictions* (Geneva: UNAIDS and IOM, 2004). Available at http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/PeopleHIV/mobility_technical_policies.asp; and International AIDS Society, *Denying entry, stay and residence due to HIV status: Ten things you should know* (Geneva: International AIDS Society, 2008). Available at http://www.iasociety.org/Web/WebContent/File/travel_restrictions_English_WEB.pdf.
13. All-Party Parliamentary Group on AIDS (APPG), *Migration and HIV: Saving lives in Britain: An inquiry into the impact of the UK nationality and immigration system on people living with HIV/AIDS* (London: APPG, 2003); see also, R. Coker, *Migration, public health and compulsory screening for TB and HIV* (London: Institute for Public Policy Research, 2006). Available at <http://www.ippr.org/publicationsandreports/publications.asp?title=&author=coker&pubdate=&theme=&search=search>; see also, UK Joint Committee on Human Rights of the House of Lords and House of Commons, *The treatment of asylum seekers: Tenth report of session 2006–07* (London: The Stationery Office, 2007). Available at <http://>

- www.publications.parliament.uk/pa/jt200607/jtselect/jtright/81/81.pdf.
14. J. J. Amon and K. Wiltenburg Todrys, "Fear of foreigners": HIV-related restrictions on entry, stay, and residence," *Journal of the International AIDS Society* 11 (2008), doi:10.1186/1758-2652-11-8. Available at <http://www.jiasociety.org/content/pdf/1758-2652-11-8.pdf>; see also, M. A. Somerville and S. Wilson, "Crossing boundaries: Travel, immigration, human rights and AIDS," *McGill Law Journal* 43 (1998), pp. 781–834; see also, D. Wiessner and K. Lemmen, *Quick reference guide 2010/2011: Entry and residence regulations for people living with HIV*, 9th edition (Berlin: Deutsche AIDS-Hilfe e.V, 2010). Available at <http://hivtravel.org/Web/WebContent/EATG/File/Quick%20Ref/2010-2011%20%20Quick%20Reference%20English.pdf>; see also, H. Worth, C. Patton, and D. Goldstein, "Introduction to reckless vectors: The infecting other in HIV/AIDS law," *Sexuality Research & Social Policy* 2 (2005), pp. 3–14.
 15. Canadian HIV/AIDS Legal Network, *Canada's immigration policy as it affects people living with HIV/AIDS* (Toronto: Canadian HIV/AIDS Legal Network, 2009). Available at <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1477>.
 16. T. M. Bailey, T. Caulfield, and N. M. Ries, *Public health law and policy in Canada* (Markham: LexisNexis Canada, 2005).
 17. Citizenship and Immigration Canada (see note 6), n.p.
 18. *Ibid.*
 19. D. Dodge [Deputy Minister, Health Canada], "Letter to Janice Cochrane, Deputy Minister, Citizenship and Immigration Canada, 10 August 2000," cited in A. Klein, *HIV/AIDS and immigration: Final report* (Toronto: Canadian HIV/AIDS Legal Network, 2001), p. 2. Available at <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=853>.
 20. See Angus Reid Group, *Migrant screening. Final report* (Ottawa: Health Canada, 1999); see also D. C. Kirkpatrick and D. Frankel-Howard, "Screening migrations for infectious diseases" (presentation to the Ministerial Council on HIV/AIDS, Ottawa, Canada, n.d.).
 21. Klein (see note 19).
 22. On these principles and guidelines, see UN Commission on Human Rights, *The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, 28 September 1984, E/CN.4/1985/4. Available at: <http://www.unhcr.org/refworld/docid/4672bc122.html>; and Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International guidelines on HIV/AIDS and human rights: 2006 consolidated version* (Geneva: Joint United Nations Programme on HIV/AIDS [UNAIDS]), 2006. Available at http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf.
 23. T. De Bruyn, Personal communication (April 11, 2008); R. Jürgens, Personal communication (March 27, 2008); see also Klein (see note 19).
 24. Klein (see note 19), p. iii.
 25. Sources for the noted elaborations and quote in Table 1 are as follows: a) Hoffmaster and Schrecker (see note 1); b) Public Health Agency of Canada, *HIV testing and counselling: Policies in transition?* (Ottawa: Minister of Public Works and Government Services Canada, 2006); Minister of Public Works and Government Services Canada (see note 48); and S. Gruskin, "It's time to deliver right! HIV testing in the era of treatment scale up: Concerns and considerations," *AIDS Legal Quarterly* (2006), pp. 11–12; c) J. Csete and R. Elliott, "Scaling up HIV testing: Human rights and hidden costs," *HIV/AIDS Policy and Law Review* 11 (2006), pp. 1–9; and J. Csete and R. Elliott, *Prevention and protection: Enhancing both HIV testing and human rights in Canada*. (Toronto: Canadian HIV/AIDS Legal Network, 2007). Available at <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=711>; d) Gostin and Mann (see note 8); and Hoffmaster and Schrecker (see note 1); e) Canadian HIV/AIDS Legal Network, *Forced HIV testing* (Toronto: Canadian HIV/AIDS Legal Network, 2007). Available at <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1258>; and Klein (see note 19); f) CIC (see note 6); and Klein (see note 19); g) P. Coyte and K. Thavorn, "When does an immigrant with HIV represent an excessive demand on Canadian health or social services?" *Aporia* 2 (2010), pp. 16. Available at <http://www.oa.uottawa.ca/journals/>

aporia/articles/2010_06/Coyte_Thavorn.pdf; h) K. H. Mayer and S. K. Chaguturu, "The evolution of comprehensive AIDS clinical care," in K. H. Mayer and H. F. Pizer (eds), *The AIDS pandemic: Impact on science and society* (St. Louis: Academic Press, 2005), pp. 261–285; K. M. De Cock, D. Mbori-Ngacha and D. Marum, "Shadow on the continent: Public health and HIV/AIDS in Africa in the 21st century," *Lancet* 360 (2002), pp. 67–72; and T. R. Frieden, M. Das-Douglas, S. E. Kellerman and K. J. Henning, "Applying public health principles to the HIV epidemic," *New England Journal of Medicine* 353 (2005), pp. 2397–2402; i) C. Hanssens, "Legal and ethical implications of opt-out HIV testing," *Clinical Infectious Diseases Society of America* 45 (2007), pp. 232–239. With the exception of note g), all informant experiences listed in Table 1 are drawn from fieldwork.

26. Statistics Canada, *2006 Census: Immigration in Canada: A portrait of the foreign-born population, 2006 census: Highlights* (Ottawa: Statistics Canada). Available at <http://www12.statcan.ca/census-recensement/2006/as-sa/97-557/p1-eng.cfm>.

27. Canadian Public Health Association, *Leading together: Canada takes action on HIV/AIDS, 2005–2010* (Ottawa: CPHA, 2005). Available at http://www.leadingtogether.ca/pdf/Leading_Together.pdf.

28. Citizenship and Immigration Canada, Access to Information and Privacy Division (July 5, 2010); see also, D. A. Falconer, *Springboarding a national HIV/AIDS strategy for Black Canadian, African and Caribbean communities project: Environmental scan report* (Ottawa: Interagency Coalition on AIDS and Development, 2005). Available at <http://www.icad-cisd.com/content/pdf/Springboarding%20a%20National%20Strategy%20for%20Black%20Canadian,%20African%20and%20Caribbean%20communities%20project%20Environmental%20scan%20report.pdf>; see also, Réseau des chercheuses africaines, *Santé et droits des femmes francophones de minorités raciales et ethnoculturelles issues des pays où le VIH/sida est endémique* (Toronto: Public Health Agency of Canada, n.d.).

29. Citizenship and Immigration Canada. Access to Information and Privacy Division (May 12, 2008).

30. S. Weibe, "Producing bodies and borders: A review of immigrant medical examinations in Canada," *Surveillance and Society* 6 (2009), p. 135. Available at <http://www.surveillance-and-society.org/ojs/index.php/journal/article/view/bodies/>

bodies.

31. Citizenship and Immigration Canada (see note 28).

32. Coyte and Thavorn (see note 25).

33. Citizenship and Immigration Canada (see note 28).

34. Citizenship and Immigration Canada (see note 6).

35. J. F. Childress, R. R. Faden, R. D. Gaare, et al., "Public health ethics: Mapping the terrain," *Journal of Law, Medicine and Ethics* 30 (2002), pp. 170–178. Available at <http://www2.cdc.gov/phlp/docs/CDC.Childress.web.pdf>; see also, S. Epstein, *Impure science: AIDS, activism, and the politics of knowledge* (San Diego: University of California Press, 1996); see also, L. O. Gostin, *The AIDS pandemic. Complacency, injustice, and unfulfilled expectations* (Chapel Hill: University of North Carolina Press, 2004).

36. Mann et al. (see note 8).

37. S. Anand, F. Peter, and A. Sen, *Public health, ethics, equity* (Oxford: Oxford University Press, 2004); see also, K. Hogan, *Women take care: Gender, race, and the culture of AIDS* (Ithaca: Cornell University Press, 2001); see also, R. Jürgens and J. Cohen, *Human rights and HIV/AIDS: Now more than ever* (New York: Open Society Institute, 2007). Available at http://www.soros.org/initiatives/health/focus/law/articles_publications/publications/human_20071017/nmte_20090923.pdf; see also, I. Susser, "Women and AIDS in the second millennium," *Women's Studies Quarterly* 35 (2007), pp. 336–344; and I. Susser, "Health rights for women in the age of AIDS," *International Journal of Epidemiology* 31 (2002), pp. 45–48.

38. J. Galvão, "Brazil and access to HIV/AIDS drugs: A question of human rights and public health," *American Journal of Public Health* 95 (2005), pp. 1110–1116.

39. M. DeBruyn, "Women, reproductive rights, and HIV/AIDS: Issues on which research and interventions are still needed," *Journal of Health, Population and Nutrition* 24 (2006), pp. 413–425; see also, L. O. Gostin, "Public health, ethics, and human rights: A tribute to the late Jonathan Mann," *Journal of Law, Medicine and Ethics* 29 (2001), pp. 121–130; and Hanssens (see note 25).

40. Gostin and Mann (see note 8).
41. Hoffmaster and Schrecker (see note 1).
42. Findings are based on data from interview, focus group and participant observation research with 33 PHA in Toronto and Montreal between fall 2009 and winter 2010. Twenty-nine informants were living with HIV and four were not. Among the former, one informant was born with HIV. Interviews were primarily conducted in English and French, with additional languages including Amharic, Cantonese, Mandarin, and Mongolian. Informants were citizens of 19 countries, and they all arrived in Canada since the HIV testing policy was introduced in 2002. Informants entered Canada under various categories: skilled workers, family members (including spouse and common law partners), Geneva Convention refugees, and refugee applicants. The majority of informants were from the refugee category. Some informants were humanitarian and compassionate ground applicants, and others were in the pre-removal risk assessment stage. In both cities, informants were recruited through AIDS service organizations, HIV clinics and word-of-mouth. Despite best efforts to locate PHA outside of Canada whose immigration applications had been denied, this population was unfortunately not part of the study. Second-level data were gathered through the review of official and informant documents, forms, and other publicly available texts, and 26 bilingual interviews in Toronto and Montreal with persons working with PHA informants: lawyers, immigration and HIV physicians, social workers, nurses, AIDS service organization case workers, shelter personnel, Canadian Border Services Agency employees, and government advisors and officials.
43. Zencovich et al. (see note 5).
44. B. D. Gushulak and L. S. Williams, "National immigration health policy," *Canadian Journal of Public Health* 95 (2004), pp. 1–29.
45. For discussion see Coyte and Thavorn (see note 25).
46. Hoffmaster and Schrecker (see note 1), p. 16.
47. Childress et al. (see note 35); see also, L. O. Gostin and Z. Lazzarini, *Human rights and public health in the AIDS pandemic* (New York: Oxford University Press, 1997); see also, Canadian HIV/AIDS Legal Network (see note 25).
48. For the official practices and procedures associated with the Canadian immigration medical examination, including HIV testing and counseling, see Minister of Public Works and Government Services Canada, *Handbook for designated medical practitioners* (Ottawa: Minister of Public Works and Government Services Canada, 2009). Available at <http://www.cic.gc.ca/English/pdf/pub/dmp-handbook2009.pdf>.
49. Ibid. Post-test counseling guidelines appear on pp. v–1–2, and the acknowledgment form appears on p. vi–1.
50. See extensive commentary in Klein (see note 19).
51. Public Health Agency of Canada, *Strengthened leadership: Taking action: Canada's report on HIV/AIDS 2005* (Ottawa: Minister of Public Works and Government Services Canada, 2005). Available at <http://www.phac-aspc.gc.ca/aids-sida/publication/reports/report05/pdf/wad2005-e-wo-mm.pdf>.
52. Ibid.
53. On international legal instruments, see Bailey et al. (see note 16); Coker (see note 13); and Gostin (see note 39). On the right to choose one's place of habitation on earth, see J. Martinez-Alier, "Ecological perception, environmental policy and distributional conflicts," in R. Costanza (ed), *Ecological economics: The science and management of sustainability* (New York: Columbia University Press, 1991), p. 133, also cited in Hoffmaster and Schrecker (see note 1), p. 16.
54. On border-related tensions, see J. Kehler, "HIV testing editorial," *AIDS Legal Quarterly* (September 2006), pp. 2–6.
55. B. Kaufmann, "HIV no barrier to immigration," *The Calgary Sun* (March 20, 2008).
56. M. A. Somerville (ed), *Do we care? Renewing Canada's commitment to health* (Montréal: McGill-Queen's University Press, 1999).
57. Klein (see note 19).
58. Hoffmaster and Schrecker (see note 1).
59. Susser (see note 37).
60. Citizenship and Immigration Canada (see note 28).
61. D. W. MacPherson and B. D. Gushulak, "Human

- mobility and population health: New approaches in a globalizing world,” *Perspectives in Biology and Medicine* 44 (2001), pp. 390–401; Weibe (see note 30); see also, S. Wiebe, *Designing bodies and borders: A review of biological screening in Canada*, Masters thesis (2008).
62. Gostin and Mann (see note 8); Hoffmaster and Schrecker (see note 1); and Bisaillon (see note 9).
63. N. Krieger, “Genders, sexes, and health: What are the connections — and why does it matter?” *International Journal of Epidemiology* 32 (2003), pp. 652–657; see also, D. Stokols, “Establishing and maintaining healthy environments: Toward a social ecology of health promotion,” *American Psychologist* 47 (1991), pp. 6–22.
64. S. A. Nixon and L. Forman, “Exploring synergies between human rights and public health ethics: A whole greater than the sum of its parts,” *BMC International Health and Human Rights* 8 (2008), pp. 2–18.
65. A. E. Yamin, “Beyond compassion: The central role of accountability in applying a human rights framework to health,” *Health and Human Rights: An International Journal* 10 (2009), pp. 1–20.
66. Nixon and Forman (see note 64).
67. Committee for Accessible AIDS Treatment, *Transformation through collective action: Best practices in Migration, HIV and mental health. Summary Report* (Toronto: CAAT, 2008). Available at <http://library.catie.ca/PDF/ATI-20000s/26023.pdf>; see also, N. Gilmore and M. A. Somerville, “Stigmatization, scapegoating and discrimination in sexually transmitted diseases: Overcoming ‘them’ and ‘us,’” *Social Science and Medicine* 39 (1994), pp. 1339–1358; see also, J. Mill, W. Austin, J. Chaw-Kant, et al., *The influence of stigma on access to health services by persons with HIV illness: A community-based research project: Final research report* (Ottawa: Canadian Institutes for Health Research, 2007). Available at <http://www.caan.ca/pdf/The%20Influence%20of%20Stigma%20on%20Access%20to%20Health%20Services%20by%20Persons%20with%20HIV%20Illness.pdf>.
68. S. Sontag, *Illness as metaphor and AIDS and its metaphors* (New York: Anchor Books Doubleday, 1989).
69. See country reports until August 2006. Available at <http://www.un.org/womenwatch/daw/cedaw/reports.htm>.
70. For current and historic activities on the Council, see <http://www.phac-aspc.gc.ca/aids-sida/fi-if/minister-eng.php>.
71. Public Health Agency of Canada (see note 51).