



**HIV, HEALTH AND MIGRATION:
An Intersectional Analysis of Human Rights
Vulnerabilities for People Living with HIV/AIDS
During the Canadian Immigration Process**

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The work I have submitted is of my own effort. I certify that all the material in the dissertation which is not my own work has been identified and acknowledged. No material is included for which a degree has been previously conferred upon me.

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ABSTRACT

The intersection of health and migration has become a topic of particular interest in the field of human rights. This thesis will examine how people living with HIV experience particular vulnerabilities to human rights violations during the process of immigration and settlement in Canada.

The relationship between international law and the responsibility of states to provide for the highest attainable standard of physical and mental health is challenged by national immigration procedures and global health disparities. For people living with HIV, the context of migration is exacerbated by the intersections of their health status with multiple physical, social and economic identities. Migrant PHAs experience immigration through various lenses of race, gender, economic and social class, as well as through their individual and cultural histories. Migrants to Canada are likely to see their overall health decrease the longer they live in Canada as legacies of violence, racism, and wealth disparities negatively compound limited access to social and health-related resources. An elongated view of the immigration process highlights that vulnerabilities for human rights violations occur in pre- and post-migration situations and that migration health therefore cannot be isolated in time or location.

Stigma and discrimination continue to influence Canadian HIV-policy both in public health and criminal law. As Canada continues to only meet the basic needs of migrant PHAs, they fail to uphold international human rights standards for the promotion and protection of privacy, holistic health, and freedom from discrimination. Gaps in policies based on the Canadian Immigration and Refugee Act, the Immigration Medical Exam, and HIV non-disclosure rulings by the Supreme Court are identified for their lack of explicit human rights language and offered alternatives for incorporating an intersectional perspective that recognises the lived experiences and multiple identities of PHAs; providing a continuum of care through both policy and practice.

KEYWORDS

HIV, health, human rights, immigration, policy, public health, intersectionality, vulnerability

1. INTRODUCTION

In the fields of human rights and medical ethics there are resource and policy-based tensions between individual health and public health because the responsibility to regulate individual wellbeing is undertaken both by individuals and the state. For the individual this includes lifestyle choices that contribute to their strength and longevity, and on the part of the state it includes access to resources, medicines and medical infrastructure to ensure public wellbeing: including the prevention and treatment of disease. Public health and individual health in the context of HIV are not mutually exclusive nor inherently at odds, however social stigma and misinformation regarding the transmission of HIV has resulted in people living with HIV/AIDS (PHAs) having their individual health choices made the focus of discriminatory public health policies. Despite improvements in science and technology that have contributed to an increased awareness of the ways in which the body responds and adapts to HIV, stigma and discrimination continue to cause some of the most detrimental health impacts of living with the virus. This thesis highlights the multiple systemic and procedural circumstances that make immigrants living with HIV increasingly vulnerable to human rights violations and their effects on physical, mental and social wellbeing.

Health and wealth inequalities are complementary issues at both the national and international level. In Canada, the distribution of goods and services is positively correlated to financial stability, and wealth has direct effects on the social determinants of health. Individual wealth itself is not a deterrent of disease and therefore individuals with more money are not immune from adverse health; however individual wealth does support greater access to better nutrition, healthcare and social supports that encourage better overall health (Evans and Stoddart, 2000). In addition, state wealth aids in the prevention and protection of individual health through access to and the development of social and medical services. The ability of the state, under international law, to provide the highest attainable standard of physical and mental health is largely impacted by the global distributions of wealth, medicines, and access to technologies that support national health. State capacity is also driven by public health laws, opinions about the communicability of diseases, and the stereotypes that surround the people living with them. Canada is a global leader in medical technologies and a producer of several life-saving drugs related to HIV. This benefit is shared by Canadian citizens and landed refugees through the provision of universal healthcare, including access to

antiretroviral drugs (ARVs), and can be used to highlight one of the many reasons that migrants living with HIV might chose Canada as a landing destination.

There are two main routes for people seeking to migrate to Canada: via an immigration application (as a sponsored migrant of the family class, or as an independent immigrant moving to study, work, or conduct business) or by a refugee claim (as either a convention refugee or a person in need of protection). Canada's ratification of the UN Declaration on the Status of Refugees is important for the later group, whereas ratification of the Universal Declaration and International Convention on Economic, Social and Cultural Rights is more significant for protecting health of the former applicant group. Canada's failure to ratify the Convention on the Protection of All Migrant Workers and Members of their Families poses challenges for the promotion and protection of PHAs who migrate for economic or educational purposes and are unable to access socially funded health services in Canada. Immigration requirements and state obligations vary under national and international law for each category and subcategory of immigrant, and result in access to a unique and limited sets of rights compared to those of Canadian citizens. This thesis will analyse the impacts of immigration in three stages, and conduct a linear analysis that identifies periods or points of time at which vulnerabilities to human rights violations are particularly high as a result of an individual's immigration and serostatus.

Particular focus is given to people immigrating to Canada who come from HIV-endemic countries as they represent more than two thirds of HIV positive diagnoses from Immigration Medical Exams (IMEs) completed both in Canada and abroad (Challcombe, 2015). The Public Health Agency of Canada's list of HIV-endemic countries¹ is made up of primarily low income countries where access to healthcare, political turmoil, and civil conflict exacerbate the health impacts that cause a virus such as HIV, which in Canada is chronically manageable, to be a serious and life threatening virus. People from endemic countries face regular racism and discrimination during immigration, which can have detrimental economic, social and health effects upon arrival and during settlement in Canada, meanwhile undermining their ability to fully exercise their human rights. Intersectionality theory and social structuralism offer pathways to assess why people from endemic countries are found in different social and economic spaces with varied and detrimental health outcomes.

¹ See Appendix 1.

² Note: The International Convention on the Protection of the Rights of All Migrant Workers and their Families (2003) offers insight into the particular vulnerabilities faces by economic migrants, however Canada has not yet

In order to address the complementary effects of migration on the health of PHAs, intersectionality theory will be used to pinpoint timelines for and locations of trans-sectoral vulnerabilities. It is important to not isolate the characteristics of physical and mental health from their host, including the ethnic, sexual, social and economic identities that construct their social lives. These intersections are the tipping points on which policy can turn stigma and discrimination into oppressive social determinants of health; as individuals and families are forced to choose between community and social supports, HIV-related healthcare access, and maximal opportunities for professional and economic growth (Gushulak, 2006:E952).

Public health policy relies both on scientific and medical research, as well as the support and influence of public opinion. Public health law is a prime example of how social structures that by and large do not directly affect most people can influence their perceptions and stereotypes of health, particularly regarding who is affected by certain diseases, their transmission, and their *right* to receive state protection from such situations (Ekos Research Associates, 2012). Issues of race, ethnicity, social and economic class, geography, and language all bring insight into the challenges of being an immigrant living in Canada with HIV. Human rights provide a platform for addressing how these issues are leveraged in Canadian society to justify differences between immigrant PHAs and other Canadians.

The current application of Canadian immigration policy and public health law systematically creates an incompatible hierarchy for addressing PHAs rights based on single-identity needs that do not fit neatly into programmes offered to migrants. This thesis will analyse and critically review the formation of existing policy and its inclusion of human rights, as well as for how changes in global migration, medical technologies, and social attitudes and structures affect these policies. A brief review of existing literature on HIV and immigration in Canada, and health and human rights will be followed by an explanation of the theoretical and methodological approaches to uncovering vulnerabilities for PHAs. State responsibilities under international law provide the context for assessing human rights in Canada. Intersectionality theory is then used to explore the compounding vulnerabilities introduced through the Canadian immigration process and public health policies. The thesis will end with a conclusion and recommendations for future action in both policy and practice.

1.1 Research Questions

- 1) How does the Canadian immigration process affect vulnerabilities to human rights violations for people living with HIV?

- 2) Does Canadian immigration policy include human rights-specific language? If so, how does this affect the protection of immigrants living with HIV from heightened stigma and discrimination?

- 3) How does the application of an intersectionality-based framework help address the longitudinal effects of vulnerabilities to human rights violations for migrants living with HIV in Canada?

2. LITERATURE REVIEW

Health is a human right, but good health is not. Good health is socially constructed through a system of privileges and limitations afforded to people based on their social, economic, political or physical wellbeing. The connections that physical and mental health share with wealth, employment, nutrition, social care, and political participation are important to highlight for their reciprocity; notably how a dramatic shift or interruption in one sphere can have negative effects across the board. These disturbances introduce opportunities for stigma and discrimination that are often exacerbated through several mediums in Canada: healthcare, migration, and public health policy. This chapter will familiarize readers with the role of the right to health, literature on migration, and the Canadian policy context as they pertain to people living with HIV. The following introduction of academic literature and combined policy review provide the background to inform how intersectionality will be used in Chapter 4 to highlight the experiences of PHAs in the immigration process to Canada.

2.1 The Right and Responsibility to Health

The paradox between state obligations and individual responsibilities in healthcare policy was introduced in the previous chapter. The following section aims to highlight the role that international law plays in administering health and healthcare at the state level and

positioning individual responsibility and the context of disease burden within social structures and stigmas resulting from intersecting identities. Hankivsky et al. (2012) use the National Collaborating Centre for Healthy Public Policy's concept of *healthy public policy*, in contrast to the more common *public health policy* because it constitutes "public policies, outside the formal health sector, that have an impact on health, such as education, transportation and fiscal policies" (2007: paragraph 2). This importantly notes the contribution of fiscal matters in deciding health-related policies and brings into question the cost burden of prevention and treatment for HIV. In order to maintain power, politicians must enact legislation that fits within the budget and policy priorities through which they were elected to public office. The protection of public health interests relies on the ability of a state to provide for the healthcare needs of its residents, and as a result migrants are assigned immigration statuses based on their potential healthcare cost burdens. Discrimination begins here as people living with HIV have their anticipatory health care cost burden calculated over a ten year period, versus a five year period for those people without significant predictable healthcare burdens.

2.1.1 State Obligations Under International Law

Existing literature on the topic of migration health is complemented by international legal frameworks which posit the duty of states to protect persons who seek refuge or political asylum, and on the responsibilities of states to provide for those persons that migrate on the basis of economic, social or cultural reasons (ILO, 2009). This thesis seeks to contextualize some of the factors that overlap these two areas of study, including how migrants with access to social and economic assets in their home countries already hold an advantage towards approved migration statuses over people living in abject poverty and without social mobility. The economic and social class in which a migrant originates is inextricably related to perceptions of personal security and the prioritization and exercise of their human rights. This complex interplay between health, economics, and social support will further be discussed in Chapter 4 as it outlines the continuation of inequalities experienced by migrants are a result of multiple, differentiating identities including race, gender, class and education.

The extent to which a receiving state must ensure the health of immigrants and refugees depends largely on the perceived vulnerability of the migrant, and whether there are internationally binding legal standards for their protection. The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host

population. There is no similar convention that offers the same assurance to economic or political migrants², including those living with HIV, nor is there an equivalent Interim Federal Health Program for this population in Canada. How do states justify this division of rights and the resulting disparity in access to healthcare? It is through these international obligations that states are able to begin to systematically discriminate against migrants based on their country of origin, health status, and perceived impacts of long-term stay on local healthcare and financial resources.

The reality is that national policy on healthcare provision for migrants is based on a concept that is divided at its most fundamental level. The rights of the individual are pitted against public health and the collective economic costs of access to healthcare services for migrants. The universality of the right to health is brought in to question as Immigration, Refugees and Citizenship Canada discriminates against applicants healthcare costs based on pre-existing conditions and the likelihood of accessing treatment. In the context of HIV this can be a lose-lose battle where the decision to not take ARVs makes an individual a greater public health concern, while taking ARVs increases the cost burden calculated by Citizenship and Immigration Canada and may result in medical inadmissibility to Canada. The apparent incompatibility between ethics and economics in migrant healthcare provision is only the first step in introducing the inequalities that underlie discrimination and devalue the dignity of PHAs in the Canadian immigration process (Weissner and Lemmen, 2012).

2.1.2 The Role of the Individual

The apparent paradox between the provision of care by a state and the responsibility of an individual to maintain and improve their own health should rather be understood as complementary. It is in the best interest of both the individual and the state to have healthy citizens. By using the WHO definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”³ the concepts of environmental health and health externalities are introduced. This expands to recognise the

² Note: The International Convention on the Protection of the Rights of All Migrant Workers and their Families (2003) offers insight into the particular vulnerabilities faces by economic migrants, however Canada has not yet ratified this document.

³ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

role of the individual in protecting themselves from sickness and not being wholly reliant on their state for disease prevention and treatment (Wikler, 2002). What the concept of individual responsibility for health fails to recognize are the systemic inequities in healthcare that are socially determined and restrict the ability of an individual both to make certain lifestyle choices and to seek treatments that are considered widely available to everyone (Wikler, 2002). These may include access to affordable, healthy food; the ability to provide for a large or traditional family structure; and proximity and transportation to healthcare facilities: each of which are significantly impacted by an individual's cultural, social and economic identities (Viruell-Fuentes *et al*, 2012). The cycles of poverty and discrimination that affect migrant communities are socially constructed and perpetuated the likelihood of meaningful employment, access to further education, and protection from social isolation that have detrimental psychosocial health effects in the long term. It is impacted by an individual's education, gender, and access to culturally appropriate social supports (Viruell-Fuentes *et al*, 2012).

The role of the individual, and why the state seeks to distance itself from the provision of care for marginalised populations, has to do with public perceptions, the concepts of fault and consequence, and individual risk (Finucane *et al*, 2000). For PHAs, the debate between personal and public health, and the measures that a state must take to protect both become increasingly divided when stigma suggests that they have in some way made a choice, or participated in an activity that resulted in them contracting HIV (Yoder, 2002). Public attitudes regarding HIV and its transmission are dominated by stereotypes of promiscuous homosexual relations, drug use, prostitution, and racialised immigration (Ekos Research Associates, 2012). These attitudes become self-fulfilling social structures that result in discrimination in employment, sexual partner selection, and targeted health promotion education where individuals learn about the social spaces that they are expected to occupy.

External and environmental factors can prevent access to physical healthcare and related social services. For a PHA, their serostatus is often morally implicated with blame from society; suggesting their participation in a taboo activity. For immigrants from endemic countries, it may also include internalized shame and fear of public perceptions that their home countries are riddled with disease, have poor healthcare systems, or that they are culturally misinformed and uneducated about contraception (Lawson *et al.*, 2006). These public misconceptions can have implications on mental health, lead to social isolation, and

negatively impact the role of the individual in determining their own health status (Kalichman, 1998; Treisman and Angelino, 2004). This multidimensional understanding of how an individual contributes to, or is limited by their health brings an added layer of depth to the conversation on immigrant PHAs in Canada and how state obligations to health must include healthy environments, both natural and socially constructed.

2.1.3 Global health disparities

The geopolitical nature of health disparities is important to address both internationally as well as locally. The urban-rural divide that prevents access to clean drinking water in many developing countries can have the same effect on accessing ARVs in developed countries, including Canada. Dean and Fenton (2010) argue that access disparities are magnified in the global arena as many nations face civil war, a lack of infrastructure, and the black market sale of pharmaceuticals which are serious threats to ensuring that PHAs can access medicines on a regular basis and at an affordable price. These concepts may seem distant, if not entirely unrelated, however many PHAs immigrating to Canada may actually move from one set of systemic inefficiencies straight into the other. The social determinants of health are, in this regard, a contributing factor that must include social supports in structuring access to biomedical technologies (Dean and Fenton, 2010). The compounding effects of unreliable access to ARVs in both locations can have deleterious effects on individual health, and should be protected under international law and cooperation to provide a continuum of care.

Mladovsky (2007) provides evidence of the limiting effects of geography on health disparities as they follow people through the migration process. The *healthy migrant effect* is a phenomenon referring to the situation in which migrants report initially better health than that of the population into which they are migrating. This is most generally explained as migrants have been predisposed to meet two conditions: 1) that they are in good enough health to migrate and therefore had access to adequate wealth and medical care before doing; and 2) that they passed a medical screening during immigration which would have rejected anyone in extremely poor health as medically inadmissible. What Mladovsky misses is the unique situation of people living with HIV and how their health is determined by access to a continuum of care that begins in their home state and ends in their host nation. The lack of culturally appropriate health services during the immigration process, particularly for refugees and asylum seekers, is worsened by the use of mandatory HIV screening, and creates

divisions of healthcare access that contribute to the systemic reallocation of people in ill health back to countries which already lack adequate access to HIV-related care.

Global health disparities are not only geographical or political but also temporal (Bauer, 2014). The slow pace at which international frameworks recognize and adopt scientific research into evidence-based policy has caused a discrepancy between scientific advancements and public awareness of HIV. As a result, people's opinions of HIV, to the extent that they are informed by public health policy, include reference to treatment and prevention technologies that may be causes decades behind current research (EKOS Research Associates, 2012). Perhaps the most pertinent example of this in Canada is the slow uptake of knowledge surrounding Treatment as Prevention (TasP) and the use of ARV's for pre-exposure prophylaxis (PrEP) as a prevention technology, despite resounding evidence of its scientific validity (Cohen *et al.*, 2012; Montaner *et al.*, 2014; The HIV Modelling Consortium Treatment as Prevention Editorial Writing Group, 2012; Walensky *et al.*, 2013).

Restricting the development and dispersal of pharmaceuticals under the control of a few international corporations and patent holders ensures public health is at the will of private enterprise, and determined by current political relationships between states and trade agreements (Cohen, 2013). Unfortunately the same political situations that give cause to embargos and trade reductions can have dramatic effect on PHAs who are dependent on the foreign production or provision of their antiretrovirals. WHO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) helps to overcome trade barriers and provide access to affordable HIV-related medications (Wise, 2006). Such an attempt to lessen the gap between global disparities in medical access assists immigrants in having improved health prior to arrival in Canada, but may actually make them medically inadmissible due to the increased cost of ensuring continued access to treatment on arrival. Farmer (2003) discusses in depth how it is not then only vulnerability to illness and human rights abuses that are absorbed by the poor, but also the responsibility to carry the global burden of disease.

2.2 Migration in Context

The International Organization for Migration estimated that in 2015 there were more than 224 million migrants in the world (UNDESA, 2015) and with a total population of nearly 37 million people living with HIV (WHO, 2015) it is safe to assume that those numbers

represent some of the same people. In Canada, the incidence rate of HIV is 6.3 times higher among people from HIV-endemic countries, representing a disproportionate number of PHAs compared to their composition of the Canadian population (Challacombe, 2015). Whether it is people coming to Canada who are already living with HIV, or those infected after they arrive, it is clear that the international movement of people equates to the same movement of disease. The following subsections highlight the extraordinary circumstances faced by PHAs at all stages of international migration.

2.2.1 Reasons for Migration

The reasons that migrants leave their countries of origin are also important in considering their likelihood of having acquired HIV (Spiegel, 2004). Racism and other structural barriers play an important role in understanding factors determining health outcomes for migrants and other vulnerable groups including women, children, people of colour, and migrants from conflict-affected states (Farmer, 2003). Local conflict and its impact on the prevalence of sexual violence contribute to refugees being at a higher risk of infection prior to leaving their countries. When discussing refugee health, it is important not to draw too exact of a distinction between pre- and post-migration risk accumulation. Halfon and Hochstein (2002) outline the Life Course Development Framework as a method for implementing health policy with specific regard for social histories and health determinants of migrant populations. Such a multidimensional strategy ensures that the right to health, as outlined in the ICESCR is not based on resource access or limitation but on the non-delineating right of the individual to their highest attainable standard of health.

Kenny *et al.* (2010) regard the context of forced migration as a time of extreme vulnerability for people living with HIV during which they are often overlooked. During such precarious situations, health is often not at the forefront of emergency response, and securing access to medicines and social supports are not financial priorities. Using general health exams during such times leaves room for sexual violence and trauma to go undiagnosed; factors that are associated with greater future risk of HIV infection. Most prevalent amongst these are life course traumas from adverse childhoods or unwanted sexual aggressions and violations (Halfon and Hochstein, 2002). These missed opportunities to address holistic aspects of HIV-related health and build trust can negatively affect patient-professional relations during immigration screening, as well as after arrival to Canada. The failure to provide adequate and

sensitive care in the early phases of immigration and HIV diagnosis create the conditions for continued distance from healthcare along the care continuum in Canada and negatively impacts the likelihood of treatment access and adherence (Sayles *et al.*, 2009)

2.2.2 Migration, Health, and Refoulement⁴

Current trends in global migration witness an overwhelming number of people moving into and across Europe as a result of war and political turmoil in North Africa and the Middle East. Although the full impacts of these movements cannot yet be known, the context of mass migration equates to tensions in economic and political stability, as well as the call for international cooperation. The global response to this call for cooperation has included the decision by Canada to embrace some 25,000 refugees from Syria. The demands put on the Canadian immigration system will test both its efficiency and effectiveness in informing public opinion on the relationship between immigration and the economic costs of the Interim Federal Health Program. The Syrian Arab Republic is considered to have a low-prevalence HIV epidemic with less than 100 reported infections in 2012 (UNAIDS, 2012) however the socioeconomic and cultural background of Syrian nationals may make them more vulnerable to HIV infection upon arrival and settlement in Canada.

Whether arriving as a refugee from a low-incidence country such as Syria, or an endemic country in central Africa, the provision of rights that protect and prevent the spread of HIV must be based on a continuum of care. The right to health should be enshrined in post-conflict reconciliation and protected during resettlement and reintegration in post-conflict settings. Human Rights Watch believes in the principles of *non-refoulement* for PHAs who are both conventional and non-conventional refugees, which prohibits their return to a home territory if, as a result, their life or liberty should be put at risk (Todrys, 2009). The European Convention on Human Rights has suggested that *refoulement* is a concept open to broad interpretation and has used resource accessibility as justification for the limitability of human rights for PHAs in two notable cases (ECHR, 1997; ECHR, 2008). With increasingly high levels of migrants arriving to Europe, and many being then sent onward, a continuity of care and the protection of health vulnerabilities is fundamentally important when guarding the principle of non-refoulement.

⁴ Refoulement refers to “the expulsion of persons who have the right to be recognised as refugees” (UNESCO.org, 2016).

2.2.3 The Migration of PHAs

Medical advancements in the fields of HIV and AIDS, partnered with improved global access to - and increased knowledge on - prevention and treatment now shape the livelihoods and longevity of PHAs around the world. Increasing international recognition of health-based rights and the further protection from health-based discrimination has resulted in numerous positive policy changes in Canada and abroad; however the threat of deportation or refusal-of-entry based on health status is real for many people living with HIV and looking to migrate. As of 2012, 61 countries had restrictions on entry, stay or residence based on HIV status (Wiessner and Lemmen, 2012:6). Fourteen of those countries refused *any* admittance of PHAs for any period of time, and 29 countries have laws that allow for the legal deportation of non-nationals based on their HIV status (Wiessner and Lemmen, 2012:6-7).

Countries conducting mandatory screening and/or refusing entry to people living with HIV/AIDS do so despite the International Guidelines on HIV/AIDS and Human Rights para 105 which stipulates that "[t]here is no public health rationale for restricting liberty of movement or choice of residence on the ground of HIV status" (UNAIDS, 2007). Somerville (1989) provides an old, but still very valid analysis of the unlikely contributions of immigrant PHAs to the spread of HIV in Canada. Her refusal to uphold the public health exception of PHAs during immigration screening is rounded out by a recognition that the transmission of disease must occur between two people and therefore the burden of disease should not rest on the individual immigrant alone.

Amon and Todrys recognise the impact of public health laws as “the experience of discrimination, dislocation and disruption in social networks around migration [for being] closely linked to HIV risk” (Amon and Todrys, 2008:4). They correctly identify the value of pressure by transnational and civil society organizations for states to incorporate advancements in HIV-related medicine into migration and public health legislation. Such pressure is important because it comes from the organisations that also provide majority of non-medical educational programming and services for migrant PHAs. Gee and Ford (2011) further suggest that exclusionary immigration policies are a legitimated form of structural racism, recognizing the tie of race to HIV-endemic countries.

Screening immigrants from HIV-endemic countries alone will not solve increasing HIV incidence among Canadians born abroad as many immigrants are infected after their arrival to Canada (Challacombe, 2015). Coker *et al.* (2004) suggest that the use of HIV screening policies may force the illegal migration of PHAs who are seeking healthcare, and will cause additional burdens on immigration, healthcare, and judicial systems. Undocumented or irregular migrants who are living with HIV face even greater barriers in accessing healthcare, education and employment as social structures and policy do not recognise such migrants under national and international human rights law. An economic analysis of migration will come head-to-head with human rights and public health in the debate around the cost of providing health services to non-nationals and the professional ethics enshrined in the reputation and universal accessibility of the Canadian healthcare system.

2.3 Situated in Intersectionality

The vast amount of literature available to address each theme of HIV, health, and migration separately begins to explore the complexity of relating the social, political and financial aspects of each thematic area. In order to situation this research amongst them, this thesis relies heavily on the role of immigrant being understood as part of a global structure of push and pull factors affected by war, politics, access to medicine and medical technologies, as well as the presence of diasporas and migration histories amongst particular communities. By recognizing that “immigrant” constitutes only a single part of an individual, a second identity is favoured, that being “person living with HIV/AIDS” (PHA). Each label has a certain set of social assumptions and political rights attached to it that may denote power, privilege or oppression, and times a mixture of the three. This thesis identifies opportunities for these identities to become points of oppression through institutional structures and social organisations but does not use them for the purpose of “othering”, rather to recognise their validity as constructive attributes that define an individual’s and a group’s identity, social influence and access to rights.

This thesis is situated in the crossover of structural and political intersectionality, where social categories become policy directives and the preservation of political power can be used as a project that perpetuates systemic privilege (Walby et al., 2012). Discriminatory immigration policies on the basis of country of origin or health status serve to perpetuate institutional racism and socially manifested systems of power. The consequences of mandatory testing and

criminalization laws reduce migrants to their HIV status and build on existing fear and stigma associated with the virus. It is the responsibility of both the individual and the state to be educated on current developments in HIV, including prevention and treatment options as education will decrease the economic costs of transmission and improve the ability of PHAs to freely contribute to economic, social and political development without fear of discrimination.

3. THEORETICAL FRAMEWORK AND METHODOLOGY

This chapter outlines the theoretical foundations for analyzing the policy-based and procedural experiences of migrants to Canada who are living with HIV. It first introduces the theoretical approach before introducing the methods used to apply the theories engaged in this research. The chapter ends with a note on the limitations of the research contained in this thesis as well as recommendations for further research that addresses methodological challenges within using an intersectional framework to identify vulnerabilities to human rights violations.

3.1 Theoretical Framework

This thesis uses two theoretical approaches to address the context of systemic barriers and inconsistencies that invite human rights violations for people living with HIV in the Canadian immigration process. Intersectionality theory and the theory of the social structuralism are interlinked approaches in social science that address the multiplicity of factors and identities which form the experiences of an individual in an any given context in relation to their exposure to power and privilege. The focus of this thesis is on the impacts of health in the particular context of migration, and the longitudinal effects and complementarity of stigma and discrimination in underlying the experiences of PHAs migrating to and settling in Canada.

The social, political and economic factors that contribute to an individual's decision to migrate are complex to a level that goes beyond the scope of this thesis. As such, it engages a secondary analysis of existing literature and investigates the laws and frameworks upon which the current Canadian immigration system has built itself. The objective is to highlight

the particular vulnerabilities faced by PHAs during the immigration process, including in their home country and during settlement in Canada.

3.1.1 Intersectionality Theory

Intersectionality is a relatively new theoretical paradigm born out of Black Feminism and Critical Race Theory which focuses on identity politics and is expanding both in academia and within its contributions to social policy, education and service provision (Smooth, 2013). Intersectionality is defined in this thesis as a theoretical framework that recognises and incorporates the existence and fluidity of multiple, compounding identities that impact and are impacted by social structures of power and the policies that direct them (Crenshaw, 1991; Hankivsky et al., 2012).

As the thesis examines the experiences of people that apply for immigration into Canada, it focuses on how a migrant-accepting country is required to protect certain rights for refugees, asylum seekers and independent or sponsored migrants, in conjunction with a respect for their experiences as racialised, gendered, and socially and economically classed people. Many of the social factors and power dynamics that feminists and race theorists brought into question for their contribution to intersectionality are core to understanding how communities, cultures, education, poverty and institutional stigma determine the health of individuals and social groups (Bauer, 2014; Grace and Hankivsky, 2011; Vireull-Fuentes *et al*, 2012). The interplay of race, gender and sexuality are of particular interest when studying HIV as there are both social and biological factors that contribute to the likelihood of exposure to and transmission of HIV being greater for women from endemic countries, transgender people, and men who have sex with men (Boerma and Weir, 2005).

Intersectionality should not only be used to dissect the many facets that cause additional vulnerabilities for people living with HIV in the immigration process, but also as a platform for expanding social services and providing the necessary supports for PHAs. Intersectionality theory allows for a multiple-identity approach to health and social services through which a disabled, gay, male, person of colour might find a community that consists of other disabled people, other gay people, other males, other people of colour, or in many instances a combination of several of these attributes (Smooth, 2013). Scholars such as Nash are quick to highlight intersectionality theory's lack of a singular definition and the

“murkiness” of its “theoretical, political and methodological” as a challenge in advancing the application of intersectionality to policy and social movements (Nash, 2008). This identified ambiguity creates challenges for making claims against failed protection of human rights, but is crucial in providing access to human identities that make rights worth fighting for.

3.1.2 Social Structuralism

From the outset it is important to recognize that there is no singular discourse in human rights and that the theoretical perspectives on universalism and relativism are heavily at play when it comes to administering human rights and upholding international human rights law (Freedman, 1995). Universalism is the idea that human rights are inherent, belong to all people, and are both indivisible and immutable; relativism is rather the idea that rights are socially constructed and vary depending on geopolitical, cultural and linguistic access to them. Migration health tends to suggest the latter is true; rights are afforded based on citizenship and refugee status rather than by guaranteeing equal access to health service for all immigrants regardless of application type.

Structuralism is a theory used to understand how social groups, organisations and other institutions are formed and operated (O’Byrne, 2012). The relationship between these spaces and the people who participate in them rely on a common set of expectations and norms that are both influenced by the structure and determined by the participants. These spaces are crucial for understanding how people, and the discourses that they use gain and perpetuate meaning based on the society in which they occur (O’Byrne, 2012). If it is possible to understand how socially constructed institutions can affect language and determine contextual meanings, it is then possible to evaluate the role of those structures in simultaneously perpetuating identities and any such consequences of having that identity. Intersectionality theory posits that individuals do not hold a single identity but rather multiple, interacting and compounding identities that can either enhance their position in society or become a source of oppression (Smooth, 2013). These include race, gender, sexuality, economic class, social capital, (dis)ability and health status.

Social structures are what constitute a person having power within a given context: a judge in a courtroom, a doctor in a hospital, or an immigration office at the border. Each of these locations also represents a place where PHAs have something substantial to lose, be that their

freedom, privacy, or legal status respectively. These structural hierarchies constitute part of the need to dissect misinformed policy by incorporating the lived experiences of PHAs and the necessity to simultaneously analyse medical advancements, legal grounds, personal education, consent, and human rights, including that to privacy (Taylor, 2001). Structuralism considers the potential role that a PHA and the virus they host may play in wider society without full consideration for the individual (Viruel-Fuentes, 2012). The policy analysis will highlight how particular discourses can be built into formal institutions as a method for social organisation and control. There is a delicate balance between policy formation and public opinion, and the need to please the masses in a parliamentary democracy. It is important here to consider that the voice of the majority does not necessarily protect the rights of the marginalized.

3.2 Methodologies

In order to bring together the theory of intersectionality with a useful approach to understanding the power relations and structural challenges faced by immigrant PHAs in Canada, this thesis engages social discourse analysis and an intersectionality-based policy analysis (IBPA) to review the relationships between migration and health policy..

3.2.1 Intersectionality-Based Policy Analysis

An Intersectionality-Based Policy Analysis is a framework developed by Hankivsky et al. (2012) as a method for analysing the impacts of policies on resource allocation, structures of power and public health outcomes in the context of HIV (Grace, 2013). The IBPA has a set of guiding principles and overarching questions that can highlight the locations and structures in which vulnerabilities and marginalisation are perpetuated. This thesis highlights the Canadian Immigration and Refugee Protection Act, the Citizenship and Immigration Canada Policy on Mandatory HIV Testing, and the Canadian criminal and public health laws on HIV non-disclosure. Each policy provides a context under which intersectionality can introduce new policy goals and direct the strengthening of mechanisms to protect human rights through an incorporation of individual histories and PHA experiences.

The same forces that produce vulnerabilities will be analysed for their contributions to protecting human rights through activism and the recognition of specific protection for HIV-

related rights. Gaps in policy, and the disconnect between public health policy and practice, offer the perfect opportunity to use intersectionality and address how HIV-related policy is not just about viral loads and CD4 counts⁷, but also about the social exposure to stigma and the resulting risk calculations.

If we consider health as a social good, Gee's (2011) theory of discourse analysis as a political tool explains how policy makers justify legislation that uses migration and race to invoke a fear of HIV as a threat to public health as a social good. In doing so, PHAs lose their right health by creating an environment in which they are not protected from stigma and discrimination. States often use rationalism when applying public health law (Landman, 2006) which results in an economically biased decision based on the perceived future allocation of resources in response to a possible, non-imminent threat of resource use: such is the justification for the medical inadmissibility of PHAs to Canada on the grounds of *excessive demand*.

Policy strategists engage this type of politics-building tool by introducing competing discourses around both the real and perceived threat that HIV has to public health. The criminalization of HIV exposure in the Canadian legal system serves to a greater extent to stigmatise PHAs than it does to protect the public from the possibility of transmission. This is increasingly important as scientific developments mean that new medications and knowledge on HIV provide the public with an increased awareness of risk reduction methods, though that is not necessarily measured in their attitudes towards PHAs (Grace, 2013).

3.2.2 Discourse Analysis

Two forms of discourse analysis are engaged in the research. The first looks at the specific relationships between text and context, primarily the relevance of Canadian criminal and public health laws as they relate to the scientific and qualitative reality of people living with HIV in Canada; and secondly the relationship between discourse and power: notably how interpersonal communication and the disclosure of HIV status create dynamics of power

⁷ Viral load and CD4 count refer to the two most common measures of HIV-related health. Each is measured per cubic millimeter of blood with the former counting copies of the HIV virus and the latter describes the number of the particular immune cells attacked by HIV. For more information on how these values are used see: http://www.aidsmap.com/v634665446220730000/file/1050016/CD4_and_viral_load_pdf.pdf

between PHAs and healthcare, immigration and employment professionals. Examples of language choice, context and interpreted meaning will be evaluated as they are extracted from the Immigration and Refugee Protection Act, Mandatory HIV Testing Policy, and the Supreme Court ruling *R. v. Ceurrier 1998* on HIV non-disclosure.

Discourse analysis is an analysis of language as it is contextualized by both lexicon and social environment (Gee, 2005). The strategic ways in which words, phrases and meanings are situated gives them specific authority to inform and influence beliefs and understanding. In the same way that the use of a particular discourse suggests an important relevance in a given situation; the absence of an alternative discourses says equally as much. Discourse analysis is engaged throughout this thesis as a method of analyzing the lack of human rights explicit language in Canadian immigration and public health policies. The value of a human rights discourse in such policy is a protective factor against stigma and discrimination, as well as providing a legal correlation to international human rights legislation signed by Canada.

A second type of discourse analysis that Gee (2005) expands on is regarding situated meaning: the ways in which the same word or concept can have different applications across several Discourses. It is important to understand the significance of situated meanings when it comes to HIV and human rights in that the medical nature of HIV is largely controllable, whereas the social and risk Discourses around HIV continue to have prominently negative and stigmatizing effects. The result is an engagement with the results of CANFAR's national survey on attitudinal adjustments and perceptions on HIV and AIDS in Canada (2012). This thesis includes results from attitudinal and public perception surveys carried out in Canada in order to highlight the potential HIV-related risks and continued vulnerabilities to human rights abuses faced by immigrants to Canada according to respondent attitudes and education on the subject⁸. Particular research focus has been given to the Black, African and Caribbean communities in Canada both in this paper as well as in previous research as this community contains the largest proportion of HIV-positive immigrants from endemic countries, and additionally encounters heightened vulnerability to racism, stigma, discrimination and human rights violations (Baidooobonso *et al*, 2013; Loutfy *et al*, 2012; Rao *et al*, 2008).

⁸ See Calzavara *et al*, 2012 and Lawson *et al*, 2006

The *distribution of risk* is a much-used tool in the field of HIV-related research to interpret how individual actions and personal characteristics increase individual susceptibility to HIV exposure through social structures (Lawson *et al*, 2006). Using epidemiological data as a discourse for analysing attitudinal surveys highlights the disconnect between public perceptions on HIV and the numerical and behavioral risks that immigrants from endemic countries actually pose. These personal characteristics are at the root of intersectionality theory and are relevant not only to heightening risk for HIV but to systemic racism, gender inequality, education-based discrimination and the other socioeconomic factors including incarceration, substance use, and homelessness. The social structures in which we discuss immigrants, people of colour, women and minorities greatly impact the discourses that drive new migrants to find community and set their own expectations of their participation in Canadian culture.

Linguistic determinism and the Sapir-Whorf hypothesis suggest that it is through the language that we use that we are able to construct our realities (Machin and Mayr, 2012:16). Within this logic we are therefore able to construct alternate realities by changing the language we use and the ways in which we use it. For ‘people living with HIV’ - a collective label that reflects an awareness that fewer people are dying of AIDS-related illnesses and more are living long and full lives with HIV - language remains one of the most powerful representational strategies⁹ for building positive awareness and changing people’s attitudes and perceptions about HIV and PHAs. Nash (2008) suggests that an ultimate goal of intersectionality is to provide the vocabulary necessary to respond to critics of identity politics through empowering social movements while Hankivsky et al. (2012) quote Bacchi and Eveline to locate intersectionality in policy by affirming that “policies do not simply ‘impact’ on people; they ‘create’ people” (2010:52) through particular discourses that structure power relations, access to health, and community. Discourse analysis can therefore explain the ways in which social structuralism dictates behavior and can perpetuate racism, sexism and cycles of poverty through institutional and linguistic mechanism.

3.3 Limitations, Contributions, and Recommendations for Further Research

⁹ See Machin and Mayr (2012): Chapter 4: “Representing People: Language and Identity” in How to do Critical Discourse Analysis. SAGE: London.

A typology of Canadians was established in the 2012 HIV/AIDS Attitudinal Tracking Survey prepared for the Public Health Agency of Canada that distinguishes levels of knowledge and comfort around HIV across respondents (Ekos Research Associates, 2012). This information is important in understanding the stigma and discrimination that PHAs might face when interacting with people who are not living with HIV. Although this paper does not have the scope to address the matter, it would be further beneficial to document the socio-economic backgrounds of respondents in order to see if the income and education of Canadian citizens contributes to their attitudes towards HIV in the same way that a lack of income and education make migrants more susceptible to HIV exposures.

For many of the reasons that intersectionality is pertinent to studying the ways that country-of-origin and immigration status impact HIV-related health and stigma, it also plays a role in directing the formation and collection of research. Structural racism, imbalances of power, and gender and identity dynamics restricted the capacity to conduct formal interviews with HIV-positive migrants from endemic countries for use in this thesis. Utilizing a life course perspective to address the longitudinal effects of stigma and discrimination during immigration and healthcare access offers opportunities to build cross-cultural relationships and engage endemic communities in the development and delivery of research about their lives (Acevedo-Garcia *et al*, 2012). Such relationships must be built on trust and mutual understanding; addressing the legacy of racism and colonialism that continues to impact race and gender-based dynamics during both pre- and post-migration phases.

It is important to recognise the effects of multiple identities based on sexuality, ethnicity, economic and social class, gender, education and migration status as cumulative rather than additive. This limits our ability to quantify the role that each identity has individually in determining HIV-related risk, cost, and burden: the factors that policy makers have used to misinform public opinion for years. Epidemiologically, and in terms of identifying areas to address intersecting vulnerabilities to human rights violations, an ‘immigrant PHA’ and a ‘low-income, gay, person of colour from an endemic country who is living with HIV’ personify two possibly very different people (Viruell-Fuentes *et al*, 2012). It is the application of intersectionality theory to the dissected identities of PHAs that will result in programs and services designed to specifically address their lived realities because, as Grace suggests, “[IBPA] requires that the discourse of policy *problems* be critically analyzed; that groups

who are adversely affected by dominant policy frameworks be identified; and that policy interventions that come from affected stakeholders be integrated meaningfully.” (2013:163)

4. HIV, HEALTH AND MIGRATION: Identifying Intersections of Power

The Immigration and Refugee Protection Act includes a provision “... to ensure that any person who seeks admission to Canada on either a permanent or temporary basis is subject to standards of admission that do not discriminate in a manner inconsistent with the Canadian Charter of Rights and Freedoms;4” (CIC, 2002); this chapter provides a chronological timeline during which immigrants may experience heightened vulnerabilities to human rights violations despite the protection offered under the act. It begins by defining the context of pre-immigration rights as a platform for explaining future health and the role of culture and socioeconomic background in determining how individuals understand and access their rights. The next section highlights vulnerabilities introduced through the regulatory processes of immigrating to Canada and is followed by a dissection of the environments in which PHAs might encounter specific rights violations during their initial arrival to and settlement in Canada. It concludes by exploring the intersectional aspects of accessing human rights while in Canada and the challenges introduced to accessing health as a newcomer.

4.1 Accounting for Pre-immigration Human Rights

Human rights are an amalgamated outcome of the physical, social, political and economic environment in which a person is located (Farmer, 2003). They provide a framework through which the impacts of globalization and immigration can offer a unifying access to common ground and the pursuit of individual freedoms (Morgan, 2011). These rights are something that in many cases are only upheld through their relationship to a state and its ability to provide for its citizens, and are often claimed on the basis of a particular identity (LGBT; woman; child; indigenous; refugee etc.). (In)Equity in accessing certain rights is often based on the presence of these identities and their validity within institutions of power; this is very evident with the right to health. The global disparities in access to health and healthcare mentioned before are contingent on international politics and the progressive realization of universal access to health and human rights for all people. Citizenship, migration, housing, food, and an adequate standard of living are internationally recognized human rights and

which may be prioritized in different ways at any given time whilst also contributing to an individuals overall health.

Health as a human right does not stand alone; it differs from other human rights in that it is determined by resource access, political climate, physical, social and spiritual environments, and by aspects of ethnicity, gender, sexual orientation, education and wealth. Health is also not static and therefore continual access to improved health and technologies is fundamental for people living with chronic and communicable illnesses. The diversity of social and political backgrounds from which a PHA entering Canada may have emigrated requires that the Canadian immigration system be able to act in a manner that is twofold: it should 1) address the application for immigration without discrimination based on health status to ensure future health is not impeded and 2) consider an applicant's health not as a static factor to be calculated at the time of immigration, but rather as an accumulation of lived experiences determined in part by access to identities and resources (Taylor, 2001).

The UDHR, 1951 Refugee Convention and Protocols, and Migrant Worker Convention establish that the conditions of migration require special protection. Just as there is international protection for women (CEDAW), children (CRC), indigenous people (UNDRIP), and disabled people (CRPD), so should protection be afforded to PHAs on account of the severe stigma and discrimination that perpetuates their marginalisation. The aspects of their health and relationship to rights must be understood in the context of their lived realities prior to immigration, during the immigration process, and during the settle and integration phase in their receiving country (Acevedo-Garcia *et al.*, 2012; Taylor, 2001).

4.2 Procedural Implications of Immigrating to Canada

4.2.1 Immigration Pathways

There are several immigration pathways through which a person wishing to migrate to Canada is able to do so. Refugees and asylum seekers are offered protection through Canada's ratification of the 1951 UN Convention Relating to the Status of Refugee whereas economic, educational and short-term migrants do not receive the same rights, as Canada has not ratified the International Convention on the Protection of All Migrant Workers and Members of their Families. The result is that standards of international cooperation to ensure the health of

refugees and asylum seekers put pressure on states to provide for these categories of migrants at their own cost. Financially this shifts the migration burden to “choice migrants” whose entry depends on political and economic climates that include the ability to restrict the ability of people living with certain diseases to enter into or reside lawfully within a country (Todrys, 2009).

By imposing differentiating policies in the immigration process for people living with HIV, there is an inherent bias that suggests that there is a particular burden to permitting PHA immigration (Bisaillon and Ells, 2014). Albeit that this may be true in a narrow fiscal view relating solely to the treatment costs of HIV, it does not take into consideration the advantage of preventative medicine in the public health sphere. The immigration application process therefore begins to introduce several distinct categorical separations, each associated with unique stigmas. Canadian citizens are guaranteed an access to health that is greater than that of refugees or asylum seekers, as is discussed later under the Interim Federal Health Program; which is still yet better than the protection of health offered to economic, educational and professional migrants who are unable to access the Canadian medical system without payment (Magalhaes *et al*, 2009).

4.2.2 The Immigration Medical Exam (IME)

The Immigration Medical Exam (IME) is an understandable part of the immigration process to Canada, but is not without its hazards. The main objective of the IME is to screen all immigrants and refugees for their general health and any pre-existing physical conditions that are associated with public health and safety (CIC, 2013b). Public health and safety in the context of immigration means not only generally attributable diseases that pose threat en masse such as tuberculosis, but also conditions that might disproportionately affect demand on the healthcare system: since 2002 HIV has been included in the IME (CATIE, 2016).

Citizenship and Immigration Canada (2013) states that HIV is not in and of itself considered to be a danger to public health and safety: unlike TB which is communicable and therefore can spread more rapidly. Why is screening for HIV among newcomers important to the state then? Although healthcare in Canada is provincially regulated and quite separate from the national immigration procedures, there are correlations in funding (Bisaillon, 2010; Coyte and Thavorn, 2010). People living with HIV are able to enter Canada and seek permanent

residence if they are of good enough health, and expect not to become an excessive burden on the healthcare system: that is to say not use more than or take away healthcare resources from the average Canadian, suggesting that even amongst PHAs there is discrimination based on viral progression (CIC, 2013).

Applicants who are arriving to Canada in either the Family Class or Dependent Refugee Class and are found to be HIV positive during the application procedure are guaranteed to not have their applications denied based on an excessive demand to the health care services (CIC, 2012); this includes protected persons, spouses, dependent children and conjugal partners. These exemptions serve to highlight the economic argument for HIV-related stay restrictions as they assume the medical financial costs will be shared by others.

4.2.3 Standards of Care

All persons subject to the IME must attend a designated testing site staffed by a licensed immigration health professional that has been commissioned by the government of Canada. These sites can be found all over the world. A secondary study conducted by Bisailon (2010) explored these sites and found that there is no universal standard of care across them. The result is that an individual is not guaranteed that they will receive the same generation and therefore accuracy of HIV test, the same pre- and post-test counseling, or that they have medical professionals who are adequately informing them of the consequences of a denied immigration application due to a resulting disease diagnosis (Bisailon, 2010).

Due to cultural norms it is also possible that an immigration medical officer does not complete a full evaluation of risk activities, or that a client may choose to answer some or all of the questions related to sexual activity and risk behaviours in a false manner. The social stigma surrounding disease transmission as it pertains to sex work and homosexuality continue to contribute to disease burden and underaccessed medical services for immigrants following their arrival to Canada (CIC, 2012). UNAIDS and WHO have guidelines for the treatment and diagnosis of people living with HIV in care, and the Canadian immigration procedure appears to have significant gaps in the structural processes that should protect the rights of migrants in it. The result of a non-standardized environment for conducting the IME is the introduction of stigma and the opportunity for missed diagnoses of additional health and

social circumstances that contribute to the vulnerability of migrants to institutional and interpersonal discrimination.

4.2.4 The Interim Federal Health Program

It is not often that refugees and asylum seekers are considered to have a level of benefit that is greater than migrants who are moving freely and without the threat of war or political deterioration in their homelands. However, in the unique case of the Canadian healthcare system, it could be argued that for PHAs, being a convention-protected migrant offers additional access to healthcare and social services that are not afforded to economic migrants or those people seeking residence for work or study. Interim healthcare is available for refugees and people who are seeking asylum in Canada, and covers access to antiretroviral medications, testing, and treatment (Li, 2016).

It is perhaps more accurate to acknowledge that people in these circumstances have the opportunity to access healthcare, not necessarily the means to access it, as the interim medical healthcare benefits are available only upon approval of an asylum status, not as soon as the application for asylum has been made. Due to the bureaucratic nature that is dealing with international migration and the protection of displaced persons, the process for approving an asylum application in Canada can often take between six months and one year (CIC, 2016).

The care offered through the IFHP does not cover all medications, hospital visits or procedures but rather only what are deemed essential services (Gagnon, 2002). The IFHP misses an opportunity to address the cumulative effect of refugee health through the provision of more than basic service provision as a means of enhancing both immediate and future quality of life, regardless of the success of a refugee application. For PHAs under refugee status, complications in healthcare arise when IFHP status ends or the individual is required to return to their home country and the availability of healthcare and social supports does not meet the standards set in Canada. The legal case of health in refoulement is a challenge in theory however there have yet to be any documented cases of PHAs returned to their country of origin under such circumstances.

4.3 Introduced Vulnerabilities: Intersections of HIV and Human Rights

There are many human rights issues linked to the experience of immigration; this thesis addresses how people living with HIV are made disproportionately vulnerable to human rights abuses during the Canadian immigration process. The following section explores the rights to privacy, health, a healthy working environment and freedom from discrimination, as well as the underlying factors that make accessing these rights a challenge for PHAs.

4.3.1 Disclosure, Confidentiality and Dignity: Finding a Right To Privacy

The right to privacy underpins the right to human dignity, particularly where dignity is challenged by stigma and discrimination (Todrys, 2009). For PHAs in medical situations, the vast number of opportunities to encounter a negative reaction to disclosing their serostatus makes it increasingly important to limit the number of situations under which they are legally obligated to do so (Aidslaw.ca, 2016). The regular use of ARVs, combined with good overall health can result in an undetectable viral load; an instance where there are too few copies of the virus in the blood to be detected on a standard HIV test. The PARTNER Study revealed that an undetectable viral load contributed to a zero-percent HIV transmission rate across serodiscordant sexual partners.¹³ In his address at the 20th Annual International AIDS Conference, Executive Director of UNAIDS Michel Sibidé noted that ‘an undetectable viral load is the closest we have to a cure’ (2014; 7); the strength of this association has led to undetectable being a buzzword used in awareness campaigns to combat fear and stigma. This linguistic shift recognizes both the scientific contributions to advancing medicine, as well as offers a standard by which criminal law can benchmark cases of culpability against a “realistic possibility of transmission”.

Article 12 of the UN Declaration on Human Rights confirms that “no one shall be subject to arbitrary interference with his privacy”. For people immigrating to Canada, and perhaps even more importantly for those who discover their HIV infection during the immigration process, protecting the right to privacy means navigating a new set of social and cultural norms, which may include the pressure to disclose. Such a right is particularly violated during the IME, as the threat of not being permitted entry or residence to stay in Canada due to a positive HIV status is weighed against a fear of disclosure (Rao *et al*, 2008). Medical professionals in this context can create systems of stigma and shame that impact future patient-practitioner

¹³ For more information see www.partnerstudy.eu

interactions beyond during migration (Bisaillon and Ells, 2014). It is important then that the institutions working with immigrants utilize a framework of intersectionality in developing relationships between PHAs and service-providers as an immigrants knowledge of their rights and how to access them in Canada may be intrinsically different from the understanding they had prior to departing their country of origin.

A further undermining of the right to privacy that increases vulnerabilities in immigrant communities is the process of partner notification undertaken by Citizenship and Immigration Canada when an applicant is discovered to be living with HIV (CIC, 2015). Partner notification is a commonly used practice among health professionals and involves informing the sexual partners of PHAs that they may have been exposed to the virus. There are no international standards of care for partner notification however the Canadian government has suggested that it is the “most effective” public health measure to ensure that individuals can seek any testing or treatment that may be necessary following possible exposure (CIC, 2015). Once again the discourse used suggests that there are other alternatives to partner notification, but that CIC has chosen the public health approach over the protection of an individual right to privacy.

The inherent implications of partner notification are that an individual’s health status is no longer confidential and the bonds within these relationships can be challenged by assumptions of infidelity, promiscuity, or drug use (UNAIDS, 2000). An applicant is given 60 days to disclose their HIV status to their spouse or partner, or withdraw their application for immigration, before immigration authorities will send a letter of notification on behalf of the PHA (CIC, 2015). The reality for many PHAs immigrating to Canada is that the IME may be the very first time that they are being tested for HIV. Pre- and post-test counseling are crucial for the immigrant themselves but are not often offered to family members and partners who may also not be aware of the exposure risks and relative transmissibility of the virus (CIC, 2013). The failure to provide adequate counseling violates upholding the right to health as a consideration of mental health. Partner notification disproportionately affects women and threatens their livelihoods as the implications of an unknown HIV status in many endemic countries is of promiscuity, for which the repercussions are often physical violence and emotional trauma (Rothenburg and Paskey, 1995).

In 2012 the Canadian criminal code used scientific data and quantitative medical analysis of CD4 count to pass new laws regarding the responsibility of PHAs to disclose their serostatus depending on the type of sexual activity they engage in (Aidslaw.ca, 2014). Such a law attempts to quantify “realistic possibility of transmission” through low viral load values, but fails to provide clarity around what exactly constitutes a realistic possibility. Additionally, the use of language such as “fraud”, “aggravated sexual assault”, and “sex offender” predisposes a discourse of criminality that dehumanizes PHAs and violates their dignity in situations of consensual activity. Courtrooms in Canada have been socially constructed to facilitate the prosecution of aboriginals and men of colour, the result is that the discourse around HIV non-disclosure charges weigh heavily on men in general, but particularly black men. Intersectionality is key to addressing why non-disclosure laws are most commonly used in heterosexual cases and how the discourse on HIV and race contributes to the media’s portrayal of men of colour as sexual threats despite the highest proportion (33%) of charges being brought forward against white men (Hastings et al., 2017).

Criminal culpability based on exposure not infection or seroconversion increases stigma due to the perception that sex with a PHA is inherently dangerous, regardless of the employment of risk reduction techniques such as condoms, or PEP being used. Punishing sexual exposures with PHAs serves to limit individual choice and the control of personal health, including the right to decide on who to engage in sex with, and what protection to use (Aidslaw.ca, 2012). The Supreme Court of Canada’s decision in *R. v. Mabior* carries on from the *Cuerrier* decision that identifies the need for HIV status disclosure based on the “significant risk” of HIV transmission, not on transmission of the virus itself.¹⁴ Grace (2012) explores how the increasing criminalization of HIV non-disclosure in Canada is disproportionately affecting racialised men and women from sub-Saharan Africa. These intersections highlight how race and gender are abstracts of power in judicial proceedings and how cultural norms and taboos reinforce social structures that limit women’s rights to monitor their own health and sexual activities out of fear (Rothenburg and Paskey, 1995).

Attention to the prevention of STI transmission through improved education, access to information, and the elimination of stigma would ultimately be more effective in reducing infection rates than the pursuit of criminal negligence. Not only does the criminalization of

¹⁴ See *R. v. Cuerrier 1998* and *R. v. Mabior 2012* for full decisions

HIV-non-disclosure infringe upon an individual's right to freedom from attacks on honour and reputation (UDHR Article 12), but it can actually deter public health initiatives that encourage testing (UNAIDS, 2006), as only people who are aware of their positive HIV status can be held legally responsible for an exposure to the virus when their status has not been disclosed (Grace, 2013).

4.3.2 Urbanity, Ethnicity and Community: Impacts on Health and Human Rights

For PHAs immigrating to Canada, balancing their ethnic identities, economic status, and desire to live with people from their home communities can often outweigh prioritizing access to healthcare. The prioritization of rights creates hierarchical structures that introduce vulnerabilities for overall wellbeing and divide physical, mental and social aspects of health that should be addressed together.

The right to the highest attainable standard of physical and mental health, as it is laid out in the Universal Declaration of Human Rights, the ICESCR, ICCPR and Canadian Human Rights Act all propose equal opportunity to access healthcare services, not necessarily equal health (Todrys, 2009). This differentiation is important in the field of human rights as it insists that individuals, not just states, have the responsibility to protect their own health. The diversification of health care needs for immigrants and refugees widens as health begins to intersect with employability, social support structures, the development of community, and familiarity with Canadian systems.

Urbanity and the Concentration of HIV-related Resources

The ways in which the social determinants of health impact a person's HIV status are dependent as much on the individual as they are on geographic location and access to services. Canada has the capacity to provide adequate HIV-related services to all of its current citizens, as well as those who are applying for refugee status, or asylum (Coyte and Thavorn, 2010). However, there are inherent geographical challenges in providing care due to the size of the country and the population density, particularly as HIV incidence is relatively low in rural areas (Krentz and Gill, 2009; Mitra and Globerman, 2014). Refugees and asylum seekers are not the only category of migrants living with HIV who immigrate to Canada and face particular vulnerabilities based on their health status. The movement of highly skilled

immigrants to rural areas in Canada is an institutionalized practice which promotes an express entry path during immigration. However, for highly skilled PHAs, the education and skills that would gain them points on their immigration application may result in poorer health upon arrival as they are pushed to rural areas with less access to HIV-related resources and social supports.

According to national health legislation, is it the provincial health authorities that are responsible for providing equal access to healthcare for all citizens, regardless of their proximity to an urban center. For PHAs, proximity to an urban center also equates to proximity to the HIV-specific treatment facilities and laboratories that help monitor and regulate their health. When a medical condition requires treatment and monitoring as often as four times per year when in good health (and significantly more often when HIV-related complications are present or new treatment regimes are introduced), the costs to living with HIV become significantly higher the further away from a city you are (Coyte and Thavorn, 2010). This specifically affects labour migrants in that their need to access HIV-related healthcare access reduces their ability to settle based on the location of prospective employment. For immigrant PHAs moving to Canada who are starting with fewer resources, the impact of such an uneven distribution of services can result in them forfeiting opportunities for employment in rural areas, as a result of their need to prioritise their health status (Mitra and Globerman, 2014).

Ethnicity, Community, and Social Supports

The overrepresentation of ethnic minorities, along with aboriginals and sexual minorities in Canadian HIV epidemiology would suggest that the design of programs and services intended for PHAs should address the multitude of overlapping issues that are compounded by being a newcomer to Canada¹⁶. However for many people the complexity of their ethnic and religious identities often precludes their ability to openly access services because of the fear of stigma and discrimination that comes from being a PHA within a black or African community (Lawson *et al.*, 2006). The invisible guiding authorities that are structures of social support and community reflect unspoken norms on the behaviours and participation of PHAs in ethnic and religious communities at the expense of their openness and disclosure of their HIV status.

¹⁶ See Appendix 3

Protection from discrimination based on race and religion under international law is generally considered from external forces, however for people of colour in religious communities, living with HIV can bring about discrimination within a religion that creates taboos around infection and fosters social isolation.

There is a growing body of research that highlights the important relationship between HIV and mental health, however the mental health impacts of being a migrant PHA are often overlooked (Farmer, 2003; Fouché et al., 2011). Intersectionality provides a framework that helps to realize the socioeconomic, political, cultural and health factors that contribute to mental health vulnerabilities, and, whilst engaging a life course perspective can bridge the gap between pre-immigration and post-immigration, or settlement-related, emotional and psychosocial effects of living with HIV (Acevedo-Garcia *et al.*, 2012). As with any other aspect of identity HIV status plays an important role in how individuals choose friends, housing, employment, and partners.

The value of community relates both to employment and to accessing social and HIV-related services in providing the social capital and networks for locating work and supporting access to informal systems of health monitoring and care (Magalhaes *et al.*, 2009). Immigrants often move to locations where there are established diasporas: facilitating the process of settlement through common language, culture and customs (Dunn and Dyck, 2000). Communities of ethnicity, language and faith are shown to have positive mental health correlations for newcomers living with HIV (Lam *et al.*, 2007). The taboo nature of HIV in many endemic countries means that confidentiality and discretion are maintained as essential factors in allowing immigrations to feel comfortable in accessing healthcare (Lawson *et al.*, 2006). Crenshaw (1991) discusses the important of activism and social movements in developing intersectional discourses on race and gender, however HIV-related stigma exists to such an extent that a unified movement to end HIV focuses on sexual and behavioural modifications without addressing the social structures and systemic barriers, including HIV criminalization and cultural taboos on HIV-related discourse in sex education.

4.3.3 The Right to a Healthy Working Environment

Once someone has found an appropriate community to live in, the security of their livelihoods comes from their employment. This attempt to break the cycle of poverty and discrimination

experienced by many refugee and immigrant newcomers is threatened by the stigmatising environments found in workplaces and healthcare facilities as discussed below.

The right to a healthy environment (ICESCR, Canadian Charter of Rights and Freedoms) is a rather precarious right in both breadth and its openness to interpretation. Environment here refers not just to the ecological surroundings in which individuals find themselves, but also to the physical and emotional surroundings that are created by places of employment, communities, and socioeconomic security. In Canada, people living with HIV are protected from indiscriminate dismissal from their place of employment based on their health status under the Canadian Human Rights Act of 1977 (CHRA). This is one of the only instances in Canadian legislations that explicitly states the protection of human rights based on health status. PHAs reserve the same protections of medical anonymity and freedom from discriminatory hiring practices in nearly all professions as well; the standard exceptions are in professions where there a PHA would be working in close contact with open wounds in small spaces, such as an oral surgeon.

The CHRA also guarantees an equality of income for people who are employed with the same skills, effort, responsibilities and working conditions (Equal Wages Guidelines, 1986) however marginalized people continue to not have their education and experience valued at the same level due to their immigration status or country of (educational) origin. These guidelines would benefit from being supplemented through ratification of the International Migrants Convention. Not only is it difficult for HIV-positive migrants to find work due to systems of structural racism and the devaluing of migrant skills, the experience of working in Canada as a PHA can be quite traumatizing (Magalhaes et al, 2002). It is not uncommon for employers and colleagues to feel that they have the right to know if they are working with someone who is living with HIV (Lawson *et al*, 2006). In all but few professions this information is irrelevant as the opportunity for the transmission of HIV-containing bodily fluids does not readily occur.

Stigma experienced by PHAs in the workplace can take many forms, for example: being asked to unnecessarily include their HIV status on paperwork; being asked not to use the same utensils and kitchen supplies as colleagues; and receiving requests by patients or costumers to be seen by another professional who does not have HIV (Taylor, 2001). These instances have both emotional and psychological effects that can negatively affect job

retention and mental health, but without specific legislation that references the UDHR, Canada fails to provide adequate pathways to compensation for such instances of discrimination. Gagnon (2014) identifies these instances as *episodic stigma*, for their temporary and recurring nature often arising from misinformation attributed to media, policy, and other forms of systemic stigma (see the section below).

The cycle of fear and stigma that was introduced in the last decades of the twentieth century is proving to have long-term effects on the attitudes of people who are not living with HIV - particularly in older, heterosexual, and ethnic minority communities – towards those who are (Ekos Research Associates, 2012). The Attitudinal Survey conducted in collaboration with the Public Health Agency of Canada shows that people reported having quite good knowledge of HIV, and responded with apparent comfort to the idea of working with and sharing spaces with people who are known to have the virus (Calzavara et al, 2012). The discourse used in the survey about *attitude* as opposed to *behavior* does little to offer possible mechanisms for eliminating traumatizing experiences for PHAs in their workplaces; suggesting that tolerance and awareness are sufficiently close to acceptance.

4.3.4 The Right to Freedom from Discrimination

Gagnon (2014) highlights three different types of stigma that are present in the healthcare system and regularly faced by people living with HIV. Those are episodic stigma: instances of momentary stigma when HIV-status is not in question but made relevant; symbolic stigma: times when HIV-status dictates an altered standard of care; and systemic stigma: the institutional practices and barriers that marginalize PHAs. Each of these forms of stigma exists individually but they also exist in unison and compound the negative effects of dealing with medical professionals and institutions (White and Globerman, 2015). For vulnerable groups that have intersecting identities such as refugees, migrants, women, or sexual minorities, the extent to which stigma and discrimination affects them reaches much farther than an examination room.

Universal precautions are a standard of care invoked in the Canadian medical system that are intended to protect healthcare professionals from disease exposure and transmission, particularly when dealing with open wounds and bodily fluids. These standardized precautions are often replaced with excessive layers of barriers, disinfectants and other

unnecessary additional protocol that, rather than offering judgment-free care to PHAs, contribute to feelings of being defined by their illness (White and Globerman, 2015). The resulting stigma is often unspoken but has a direct impact on the likelihood of a PHA to return to or feel comfortable accessing that medical facility (Dunn and Dyck, 2000).

Canada's obligations under CEDAW, CERD, ICCPR and ICESCR include offering special protection from discrimination for minorities where their livelihoods or personhoods are at stake; however immigration proceedings do not explicitly state such protection nor offer accommodations for people according to these backgrounds. For people from endemic countries, the opportunities for discrimination are magnified by the physical manifestations of their race and socially constructed stereotypes regarding socio-economic status and education. Each of the Immigration and Refugee Protection Act and Canadian Human Rights Act include clauses about freedom from discrimination, however much like the above-mentioned international conventions, neither definition explicitly includes health status or HIV as marginalizing factor that requires specific protection.

In order to fully understand vulnerabilities, the immigration process must contextualize the environment at origin, particularly for refugees and asylum seekers coming from violent or conflict-driven countries. The testing and screening procedures that migrants are required to undergo during immigration put people in positions of power differentials that may be exploited for money, more power, or social status (Bisaillon, 2010; Grace, 2013). In this regard, an immigration professional (including in this case medical examiners, border control, refugee assistants, and immigration service providers) has an opportunity to leverage an individual's HIV status in a way that is both discriminatory and disadvantageous to the PHA and can reinforce patient-professional power dynamics that inhibit trust in healthcare and immigration systems (Bisaillon and Ells, 2014). According to the Immigration and Refugee Protection Act the immigration process should look the same for each individual applying in each category. Their assessments, testing and decisions should be made in parallel comparison to all others applying for the same type of entry and not be contingent on HIV-status (Bisaillon, 2010). This must ensure that their serostatus does not have a negative role in determining admissibility and that sensitivity training ensures protection from such discrimination.

4.4 Settling with HIV: Accessing Human Rights as a Newcomer in Canada

Undoubtedly for most people the process of picking up and leaving your home country begins with a difficult decision and does not get easier afterwards. Figure 1 below highlights some of the factors that influence the decision to immigrate (Acevedo-Garcia *et al.*, 2012). An intersectional application of the life course model applied as a simple cost-benefit analysis of push and pull factors does not begin to realize the complexity of immigrating with HIV.

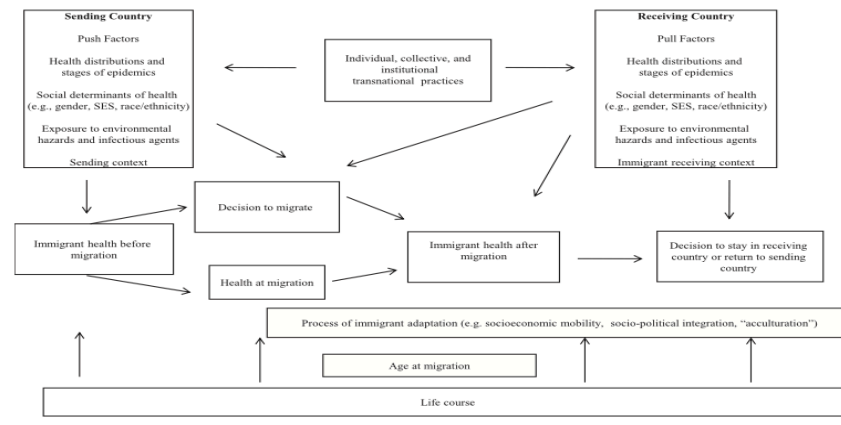


Fig. 1. Cross-national framework for research on immigrant health.

(Acevedo-Garcia et al, 2012:2061)

Intersectionality provides a platform for addressing the ways in which peoples' lived experiences contribute not only to HIV risk behaviors, but also to the risks inherent with being a part of an ethnic community, economic class, or sexual minority (Smooth, 2013). Across Canada newcomers often settle in communities of people who have emigrated from the same country or region of origin, and have dealt with many of the same challenges and reasons for emigration. Social support from people that identify with cultural, political and religious practices similar to those in the country of origin of an immigrant have been proven to have positive effects on their settlement process (Dunn and Dyck, 2000). There are, however, circumstances under which entry into these existing communities poses a challenge, particularly for people who are living with HIV. Such locations of socialization construct the learned behaviours, attitudes and discourses that can perpetuate negative perceptions of living with HIV and its connection to race, education and moral identity; instilling guilt and self-blame.

When newcomers arrive from countries where there are religious and cultural practices that prevent conversations around sexual health and the control of sexual infections; that

stigmatise certain types of sexual relations; or that expressly stigmatise HIV through an association with sex work, drugs and sexuality; individuals are forced to remain quiet and unassuming in their sexual health (Viruell-Fuentes *et al.*, 2012). This disconnect from the sexual health information that is available in Canada is a violation of the right to freedom of expression through the ability to seek, receive, and impart information as is outlined in the International Convention on Civil and Political Rights, Article 19 (UN General Assembly, 1966). To protect this right, and to ensure the full realization of their right to health, newcomers should be made aware of the technological options for sexual health that are available in Canada: this includes both preventative and treatment options for HIV in particular (Gellert, 1993; McMichael and Gifford, 2009).

Disparities in international and local health contribute to the increased vulnerabilities faced by PHA newcomers in their communities of settlement through unequal access to health technologies and prevention information (Grace, 2013). It cannot be expected that immigrants know the entire context of HIV in Canada, its relative risks or the resources that are available to them: this holds true both for people living with HIV and for those who are currently seronegative (McMichael and Gifford, 2009). The right to the highest attainable standard of physical and mental health in the Canadian context must include access to both the medical and intellectual knowledge shared by all Canadians in the pursuit of maintaining or improving their individual and communal health. In order to achieve this, Canada must recognize the rights of migrants to participate in their cultures in accordance with ICESCR Article 15, including accessing the benefits of scientific progress.

This same set of rights is threatened when information is not made available in a language that is accessible to newcomers (OHTN, 2014). Sexual health services should be able to provide translation and interpretation services that facilitate the dissemination of intelligible healthcare whilst protecting the privacy and dignity of the immigrant, with particular regard for the complexity of their multiple identities (McMichael and Gifford, 2009). Educational attainment and literacy should not impede migrants from achieving their highest attainable standard of health. Not only is it necessary that we are able to provide services in a language that matches a mother tongue, but also that that language be sensitive to life course of a client or newcomer.

The discourse used by service providers is often quite different to that used by medical professionals and the resulting gap in understanding can pose serious challenges for immigrants. Each of these linguistic interactions provides an opportunity for discrimination and may prove to distance the PHA from accessing services in the future (OHTN, 2014). This is evident in comparing *R. v. Mabior*'s use of "significant risk" as a legal base for criminal culpability to examples such as Wilton (2012) and Challacombe (2016) which, as leading writers for Canada's national resource centre for HIV-related information, CATIE, do not use the term "significant" to identify a risk level once. This creates problematic miscommunications between public education and the legal responsibilities involved with engaging in sex as a PHA.

Although the ability to pursue retribution for discrimination based on HIV status is available through the Canadian Human Rights Tribunal, there are very few cases that progress to that stage, and even fewer that will successfully win compensation (Elliott and Gold, 2005). The result is a helplessness characterized by a lack of faith in the justice system and an eventual dissociation from the structures that are meant to protect and provide for human rights. Again the relevance of country of origin is brought into consideration where trust in judiciary and legal services have been socially constructed in Canada but may not be given blind faith by migrants from countries with corrupt or undemocratic and unaccountable institutions.

5. ANALYSING HIV AND HUMAN RIGHTS IN CANADIAN POLICY

5.1 Canadian Policies on Immigration, Testing and Disclosure

Three broad policy areas affecting PHAs human rights during migration to Canada can be identified for their lack of commitment to the UN Conventions and upholding the Canadian Charter of Rights and Freedoms. These categories need to be further broken down by their intersections with gender, age and socioeconomic status among other factors. Furthermore, immigrant health policy is necessarily a multidimensional issue requiring the input of healthcare, social welfare and the immigration legal framework (Grace, 2013).

5.1.1 Immigration Policy

In 2002, Citizenship and Immigration Canada, in consultation with Health Canada, passed the

Immigration and Refugee Protection Act that would see all applicants for permanent residence and some temporary resident applicants screened for HIV¹⁷. The Immigration Medical Exam (IME) is a common process in many countries for documented migrants arriving through formal immigration procedures. These tests are carried out in government approved health centres in Canada or abroad, and require serological screening for HIV, TB and syphilis. The introduction of HIV onto this health roster came only in 2002 and was the first marked change to the official process in a half century. There is no explicit mention of HIV in the policies relating to refugee immigration to Canada, however applicants who are living with HIV have their entrance eligibility evaluated for medical inadmissibility, unlike people who are not living with HIV (Bisaillon, 2010).

Hoffmaster and Shrecker (2006) analyse the ethical considerations for mandatory testing and introduce the chasm between PHAs as a threat to public health and PHAs as an excessive demand on the healthcare or social service institutions. Although PHAs are not considered a public health risk based on their serostatus, they can be deemed medically inadmissible based on their projected financial healthcare burden. Coyte and Thavorn (2010) detail the economic requirements for an immigrant to be qualified as an excessive burden in purely financial terms and deem the CIC allocation of \$4,867.40 (in 2007; \$6,655.00 in 2017)¹⁸ to be unjustly low. These contributions are, as Coyte and Thavorn (2010) argue, fundamental to justifying the term “excessive demand” yet remain absent from Canadian immigration policy. Furthermore, because HIV is an incurable virus associated with significant medical care costs, the maximum allowable coverage for PHA migrants is calculated over 10 years, rather than the 5 year period for *healthy* migrants. This policy loop discriminates against PHAs by knowingly lengthening the calculated timeline to include a period during which most PHAs would decide to start taking ARVs.

The strategic use of the term “excessive demand” intonates a neediness of PHAs in requiring state care, a blame-laying technique that chastises individual health and the decision of a PHA to protect public health interests by minimizing the likelihood of HIV transmission through treatment as prevention (TasP). By including a “legislative threshold” of \$33,275 per migrant over 5 years, it explicitly states the perceived worth without reference to the economic, cultural and diversity benefits offered. This dehumanizing process minimizes self-worth and

¹⁷ See IRPA; S.C., 2001, c. 27; JUS, 2001 for the full Act.

¹⁸ As of January 1, 2017. Accessed from <http://www.cic.gc.ca/english/resources/tools/medic/admiss/excessive.asp>

dignity, expressing worth as a burden rather than a contribution. Even with admission granted to Canada, a migrant is now hyper aware of their perceived cost burdens and may not access healthcare for fear of removal from the country.

5.1.2 Mandatory HIV-Screening Policy

The right to health obliges governments to ensure that “health facilities, goods and services are accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds” (General Comment 14, 2000) paragraph 12 (b). In the context of health, these grounds are “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status” (General Comment 14, 2000: paragraph 18). State obligations to protect and promote health must therefore include all such dimensions as well as the social spaces in which they are constructed and lived out.

International Organisations including UNAIDS, the ILO, and HRW, advocate for the integration of both medical and social sciences into evidence-based policy making. The process of mandatory screening for HIV introduces an additional layer of stigma to both immigration and to PHAs whilst blatantly disregarding a call for human rights and the equal treatment of people, regardless of country of origin or health status (HRW, 2009; UNAIDS and IOM, 2004; WHO, 1987). The allocation of a disease burden through mandatory screening policies in Canada implicates both newcomers and landed immigrants that they have a limited stake in Canadian society and that their participation is being measured against the opportunity cost of allowing them residency. This type of process-driven self-evaluation may cause migrants to refrain from accessing healthcare or other social services, increasing their vulnerabilities to both illness and other human rights violations.

Mandatory testing policies use a discourse of “surveillance and notification” which suggests that PHAs cannot take responsibility for their individual health and must be watched at all times. The lack of trust in these social structures inhibits the full enjoyment of freedom under the threat that you will be reported for your actions and designated consequences. Mandatory screening policy continues to use a discourse that favours public health over self-determination and reflects the Citizenship and Immigration Canada policies aimed at reducing the prospective cost and consequence of PHAs individual behaviours.

5.1.3 HIV Non-Disclosure Policy

The process of mandatory HIV screening during immigration is not the only public health-based policy that has questionable ethical grounds in relation to people living with HIV in Canada. Although there is a protection of the right to privacy under international human rights law, in the interest of education, public health, and individual wellbeing, this research does not suggest that HIV-nondisclosure is a human right.

In 2012 the laws implicating criminal culpability for PHAs who did not disclose their HIV status prior to sexual intercourse were altered slightly from their 1998 version to integrate new evidence of (lowered) HIV-related transmission risks when using a condom and having a low viral load¹⁹. This thesis does not seek to expand on the implications surrounding the use of condoms or the forms of sexual engagement which the law covers, only that the law continues to contribute to stigma and discrimination against PHAs (Maluwa *et al.*, 2002). The Canadian HIV/AIDS Legal Network suggests immigrants arriving to Canada should be made aware of this law, in combination with public health law that suggests disclosure to *all* sexual partners, and the implications of partner notification outside of the immigration context (Aidslaw.ca, 2015). In order for the law to be relevant, migrants must also be engaged with and participate in the development of new technologies and information for the promotion of HIV-related health.

The challenges associated with HIV disclosure and the implications of that decision, whether to a sexual partner, a health practitioner, a prospective employer, or immigration official can have detrimental effects on the mental and emotional state of a person (Lam *et al.*, 2007; Vanable *et al.*, 2006). Mawar *et al.* (2005) suggest the third wave of the HIV pandemic is founded in stigma and discrimination, and health outcomes that result from social isolation. These fears associated with rejection and discrimination have negative impacts on community health as the criminalization of HIV encourages individuals to avert responsibility by not being tested. People living with HIV require the protection of the law from stigma and discrimination, not a fear of it for the potential criminal consequences of being HIV-positive.

¹⁹ For more information see <http://www.aidslaw.ca/site/our-work/criminalization/>

5.2 Making Human Rights Explicit

Hankivsky et al.'s Intersectionality-Based Policy Analysis Framework requires that we ask the transformative question "What needs to be done to improve this approach to the problem?" (2012: 176), where the problem is a set of discriminatory immigration and public health laws and the current approach is a cost-prevention system of power and marginalization.

The protection of displaced persons is an incredibly important part of participation in the United Nations, as well as in upholding the constitution of Canada. There are both moral and legal responsibilities that the state must acknowledge if it is to maintain the respect that it current has from countries, and perhaps more importantly from Canadians themselves. Territoriality and the application of universality in the discourse on human rights provides a difficult route for understanding the role of receiving states in international migration, however it is without question that the duty to protect is one that the Canadian people have signed on to.

The Canadian Charter of Rights and Freedoms protects the rights of all citizens, including those of newcomers, landed immigrants and refugees. Specific legislation for the rights of PHAs can be found through the Canadian Human Rights Commission and a number of provincial and territorial acts, codes and charters that offer similar protection from discrimination. Explicit reference to the UN Conventions both in national policy and criminal court rulings, as well as the signing of the International Migrants Convention would validate Canada's stance on supporting the economic, social and cultural development of migrant workers and their families while providing indiscriminate access to health services for those marginalized by HIV.

The Canadian Human Rights Act (1985) states "that every individual should have an equal opportunity with other individuals to make for himself or herself the life that he or she is able and wishes to have, consistent with his or her duties and obligations as a member of society, without being hindered in or prevented from doing so by discriminatory practices based on race, national or ethnic origin, colour, religion, age, sex ... " and specifically highlights the individual characteristics and identities that put a person at increased risk for discrimination. Citizenship and Immigration Canada, in all of their information on HIV testing and screening

policy, recommendations and guidelines fails to explicitly engage this same discourse on human rights in order to protect on the basis of health (HIV) status. Each of the rights outlined in Chapter 4 provides a set of explicit opportunities in which both the government and service providers are able to take specific measures to utilize health to ensure that human rights are protected (Farmer and Gastineau, 2002).

The Immigration and Refugee Protection Act and Canadian Human Rights Act both require individuals to identify their own vulnerabilities in order for them to be addressed, as a result undocumented immigrants remain particularly vulnerable to human rights abuses and a failure to realize their right to health during precarious immigration status approval and a lack of anonymous health services (Magalhaes *et al*, 2009). Although some programs exist to provide medical care for undocumented migrants, there are few opportunities to provide adequate HIV-related care and social support amongst these communities (Rousseau *et al*, 2008). Applying intersectionality to migration policy will highlight the fundamental gaps that require these populations to suppress their individual health in order to avoid geopolitical repercussions.

Human rights education is a crucial piece of this work and the introduction of specific and explicit human rights language would ensure that practitioners and professionals are made aware that their actions have consequences greater than for the individual themselves. This education provides an explicit platform to eliminate misinformation elaborated through the use of purely quantitative data to portray the realities of HIV prevalence in immigrant and minority communities. Education also serves to address the social structures that perpetuate low income, social isolation and declining health among immigrants, effectively breaking the cycles that have institutionalized marginalization through stereotypes and racism. A health-based approach to education and human rights ensures the embodiment of physical, mental and social identities for their contribution to unequal access to health and social services, and the resulting disparities in health across socioeconomic and ethnic communities.

6. CONCLUSIONS

Not all people are affected by diseases equally, neither in their physical nor social outcomes. Global disparities in healthcare and access to medicines can mean that the most fatal aspect of an HIV diagnosis is not always the virus. In an HIV-endemic country with limited access to

ARVs the spread of the virus and overwhelming of immune functions are significant threats to individual wellbeing. In Canada however, where access to ARVs is widespread, the stigma and discrimination associated with an HIV diagnosis can make the mental and psychosocial health outcomes more fatal than the virus itself. Not only has HIV been associated with an unprecedented stigma and social bias since it was first identified, the people that have been most affected by it continue to be those who are socially the most marginalized. Engaging intersectionality both as a theoretical perspective and as a methodology requires that we approach policy, power and migrants' social interactions with recognition of their inherent hierarchies and how they are affected by identity and privilege (MacKinnon, 2013). Assumptions about appropriate language and behavior, and knowledge on health promotion and best-practices must be reviewed as a function of culture specific to each individual migrant. Pre-migration exposure to violence and trauma have been linked to economic deprivation and poverty during migration, as well as increased likelihoods of depression and psychosocial illness during settlement (Gushulak, 2006:E956). Health must therefore be considered as both longitudinal and intersectional; studied as an immediate representation of physical health, and as a dynamic and inclusive summation of lived experiences, behaviours and environmental factors.

The Canadian immigration process fails to adequately address the rights of people living with HIV by permitting numerous opportunities for discrimination and a failure to adequately protect the privacy of PHAs. The 2012 amendment of the Interim Federal Health Program to restrict access to essential health services for asylum seekers exploited an already vulnerable population, further marginalizing them and highlighting the ways in which the Canadian immigration screening fails to link individuals to a continuum of care outside of immediate healthcare needs. These amendments were deemed unconstitutional as “cruel and unusual treatment”, however systemic discrimination in access to healthcare continues to exist for irregular migrants through the adoption of Bill C-31. Bill C-31 changed the Immigration and Refugee Protection Act in order to restrict the rights of refugees to appeal their detention based on the human rights track record of their country of origin. This is a clear violation of the 1951 Refugee Convention recommendation on the principle of unity of the family and the UN Declaration on Human Rights Article 14, which sets out to ensure that all people, regardless of their country of origin, should be able to seek asylum without arbitrary discrimination.

The legal situation in which medical testing is conducted only accounts for the physical and financial aspects of a person's medical admissibility; missing out on opportunities to identify future stigma and discrimination, and inequalities in access to social and medical services. Racism and structural inequalities have become entrenched in not only the Canadian immigration process, but also in the cities and localities into which newcomers settle. An longitudinal understanding of immigration including the pre-immigration context of a home nation and the settlement components of arrival in a receiving country highlight the issues faced by PHAs arriving as economic or sponsored immigrants, refugees and asylum seekers.

Medical ethics in the immigration process need to extend beyond the incorporation of confidentiality and non-discrimination to include compassion and respect for human rights. Sympathetic care provision creates environments of comfort that increase patient retention and promote engagement with a continuum of care that can address the longitudinal health of immigrant PHAs. Understanding the cross-sectoral issues that face people living with HIV and how those are exacerbated by unequal access to healthcare, rural dispersion, income inequality, communicative barriers, and overrepresentation in disease epidemiology "requires a shift in focus from individual-level cultural explanations to research that provides a broader, more in-depth analysis of racism as a structural factor that intersects with other dimensions of inequality, such as gender and class, to impact immigrant health outcomes" (Viruell-Fuentes et al., 2012).

The Canadian immigration process affects vulnerabilities to human rights violations by introducing migrants to institutions and processes that utilize positions of power to monitor and control the movement of people living with HIV into Canada. Canada's requiring the legal disclosure of a migrant's serostatus to previous and current sexual partners violates a right to privacy outlined in the United Nations Declaration of Human Rights Article 12 by arbitrarily establishing HIV, syphilis and tuberculosis as notifiable diseases, without sufficient regard for recent advancements in treatment technologies. The immigration process further increases vulnerabilities to rights violations by removing migrants from their social support networks and failing to provide adequate access to health-related information, medical care and economic means to substantiate settlement in Canada. Failure by Canada to recognize the education of professionals in highly skilled fields such as medicine results in migrants receiving lower incomes and fewer opportunities than similarly educated Canadians. The result is such that economic disparity continues to penetrate cultural and racial communities,

making it particularly difficult for immigrants to remove themselves and their future generations from cycles of economic deprivation and social exclusion.

This thesis has identified structural and political locations in which power dynamics and discriminatory policies are furthering racism, sexism and stigma. They include physical locations such as Immigration Medical Centres, international borders, places of employment, hospitals and healthcare facilities, rural communities, and courtrooms. They further exist in less visible spaces such as in race and ethnicity, religious and cultural taboos, (lack of) education, access to medicines and contraceptives, physician-patient privilege, privacy, mental health and social isolation.

The complexities of being a person of colour, fleeing war and political turbulence, and entering a society that does not recognize your education and or professional credentials do not fit the linear programming of most refugee settlement agencies (Kenny *et al*, 2010; Rousseau *et al*, 2008). The cost of resources used to get to Canada often forces individuals and families to enter a lower economic class than in their home country, with limited access to culturally and linguistically appropriate resources and creates a situation that compounds the effects of wealth on health and healthcare access (Gagnon, 2002).

The migration of people also means the migration of knowledge, politics and cultural practices; the result is that culturally appropriate HIV education, prevention and treatment programs must be made available for PHAs moving to Canada in order to protect their personal health, as well as that of the rest of the Canadian population. Studying the life course of health in immigrant PHAs completes a picture of the compounding effects of pre-immigration socioeconomic and political climates with the effects of settlement and exposure to new communities, new illnesses and new stigmas. Securing the rights of immigrants living with HIV requires addressing the systemic and interpersonal vulnerabilities attributed to holding the identities of 'immigrant' and 'PHA'.

The application of an intersectionality-based framework for addressing the vulnerability to human rights violations for people living with HIV during the Canadian immigration process ensures that the immigration process itself can be defined as the lifetime of a migrant. Canadian policy, most particularly the Immigration Medical Exam and Immigration and Refugee Protection Act, must state explicit it's obligations to protect asylum seekers and

refugee claimants from all countries until a complete, unbiased and non-discriminatory evaluation of their application can be made. Such an evaluation must include a recognition of the educational, economic, political and cultural backgrounds of migrants, with particular attention to women and children for the important and unique experiences they have as migrants, in accordance with the UN Conventions on the Rights of the Child and the Elimination of All Forms of Discrimination Against Women.

Commitments to such conventions are not about prioritizing the care or accommodation of one gender or age over another but rather implementing services that adequately address the unique needs of women and children in relation to their experiences with migration, health, and HIV. Basing policy and programming in intersectionality ensures that a migrant PHA can find resources as a migrant and as a PHA; but also as a person of colour; a female; a mother; an English-language learner; a minority; a survivor of trauma; a diabetic; a university graduate; and each of those lived and perceived identities in any combination possible, based on their most prominent needs at any given time. Intersectionality engages with the exponential growth of risk associated with having multiple marginalized identities rather than the cumulative aspects of stigma in relation to identifying solely as a migrant or a PHA.

7. RECOMMENDATIONS

- 1) Explicit recognition of the role of human rights in writing and implementing policies in immigration and health. A human rights discourse seeks to inform people of their rights, but also provides a platform for solidarity within the communities associated with plural identities. The social benefits of rights-awareness include capacity building and human rights defense, while promoting the legal obligations of the Canadian state under the international conventions to which it is party.
- 2) Utilise Intersectionality-Based Policy Analysis as a tool for identifying locations and spaces in the immigration process that intensify the experience of stigma based on immigrant PHAs' multiple identities. Highlighting these locations in an immigrant's life course reveals the systemic factors that contribute to inequality and discrimination both in the sending and receiving countries. Programs, services and policies should be adapted to create a continuum of care that addresses each of these factors. Understand health beyond physical and mental health, but structurally and environmentally as well.

- 3) Providing space in the immigration medical exam for psychological and emotional counseling that relate not only to the mandatory HIV-testing process but also to the realities of living with HIV as a person from an endemic country, and the multiple barriers that they may face in finding community, accessing healthcare services and developing safe social networks.
- 4) Introducing competency and cultural sensitivity training that is regulated for all immigration professionals working with the Citizenship and Immigration Canada, from in-country medical representatives taking HIV-tests in refugee camps to Canada-based immigrant-serving and AIDS service organisations that provide services for newcomers.
- 5) Remove the medical inadmissibility requirement for PHAs based on anticipated financial burden with recognition that it is a discriminatory policy that does not take into consideration the economic benefits of experience, knowledge and cultural diversity that Canada has been built on.
- 6) Reconsider the context of public health law in Canada to reflect the recognition that HIV is not an inherent public health risk and the mixed messaging that this differentiation causes when it comes to non-disclosure; simultaneously providing a platform to address structural racism in the judicial system that accounts for a disproportionate number of HIV-related assault charges being filed against ethnically non-white men.
- 7) Define “significant risk” in the context of HIV-transmission and continue to update HIV non-disclosure laws to reflect advancements in medicine, prevention and treatment technologies.
- 8) The Canadian Human Rights Act should be amended to explicitly include the prohibition of discrimination based on HIV-status as a contributor to health status.
- 9) Ratify the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families in order to entrust accountability for supporting the economic and developmental contributions of labour migrants, their knowledge and skills, regardless of their countries of origin, ethnic, economic, political or health status.
- 10) Recognise public health as a complimentary framework for upholding the Immigration and Refugee Protection Act, through the provision of health promotion and education that addresses not only disease but also the social determinants of health.

Public health must function as an instrument in employment structures, relocation decisions, community-based healthcare access, and economic empowerment programming. An intersectional approach to healthcare provision means moving from services that are culturally sensitive to ones that are culturally inclusive. Immigrants and refugees should not bear the burden of their health as a result of cultural difference: this gap can be addressed through information sharing and ensuring equal access to health-affirming technologies.

Immigrants should be made aware of the resources that are available to them in order to determine their own health, including harm reduction based decision making for sexual health. The immigration process must seek to eliminate the discomforts for migrants associated with power differentials between patients and practitioners in migrant sending countries as a variable for determining trust in Canadian medical practices and immigrant-serving organisations. Immigration health must refer not only to the physical health of the migrants themselves, but also to a healthy and discrimination-free environment for immigration (including but not limited to opportunities for employment, education, economic stability, social security, access to healthcare, and a sense of community and belonging).

Intersectionality provides a platform on which research that attempts to isolate a single dimension of the reasons for migration and contextualizes it within the externalities that drive migrant mobility and adaptation (Acevedo-Garcia *et al*, 2012). A longitudinal study addressing which factors migrants feel have contributing to self-reported declining post-migration health would open space for dialogue on the economic, social and cultural considerations that impact employment, income stability, community development, and participation in continuums of care.

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APPENDICES

Appendix 1: List of HIV Endemic Countries

Africa:

Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Cape Verde
Central African Republic
Chad
Democratic Republic of Congo (formerly Zaïre)
Djibouti
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Ivory Coast
Kenya
Lesotho
Liberia
Malawi
Mali
Mozambique
Namibia
Niger
Nigeria
Republic of the Congo
Rwanda
Senegal
Sierra Leone
Somalia
South Africa
Sudan
Swaziland
Tanzania
Togo
Uganda
Zambia
Zimbabwe

Caribbean, Bermuda and Central/South

America:

Anguilla
Antigua and Barbuda
Bahamas
Barbados
Bermuda
British Virgin Islands
Cayman Islands
Dominica
Dominican Republic
French Guiana
Grenada
Guadeloupe
Guyana
Haiti
Honduras
Jamaica
Martinique
Montserrat
Netherland Antilles
St. Lucia
St. Kitts and Nevis
St. Vincent and the Grenadines
Suriname
Trinidad and Tobago
Turks and Caicos Islands
U.S. Virgin Islands

Asia:

Cambodia
Myanmar/Burma
Thailand

Source: PHAC, HIV/AIDS Epi Updates 2007

Appendix 2: Estimated Size of Key Populations in Canada (2011)

| Population | Estimated number of new HIV infections (range) | Estimated rate per 100,000 population (range) | Rate ratio |
|--|---|--|-------------------|
| Men who have sex with men (age 15 years and older) | 369,500 (312,700 - 426,300) | 2.6% (2.2% - 3.0%) | Ref 12-15 |
| Other men (aged 15 year and older) | 13,843,287 | 97.4% | |
| People who inject drugs (age 15 years and older) | 112,900 (90,000 - 135,800) | 0.39% (0.31% - 0.47%) | Ref 14-18 |
| People who do not injected drugs (age 15 years and older) | 28,736,169 | 99.6% | |
| Aboriginal people (all ages) | 1,310,391 | 3.8% | Ref 10 |
| People of other ethnicities (all ages) | 33,173,584 | 96.2% | |
| People from HIV-endemic countries (all ages) | 758,647 | 2.2% | Ref 11 |
| People born in Canada or non-endemic countries (all ages) | 33,725,328 | | |
| Female (all ages) | 17,377,018 | 50.4% | Ref 9 |
| Male (all ages) | 17,106,957 | 49.6% | Ref 9 |
| Total population (all ages) | 34,483,975 | 100.0% | Ref 9 |

Source: Public Health Agency of Canada (2014) HIV/AIDS Epi Updates, July 2010, Surveillance and Risk Assessment Division, Centre for Communicable Diseases and Infection Control. Ottawa: Public Health Agency of Canada.

Appendix 3: Estimated HIV incidence number (range of uncertainty omitted), rate per 100,000, rate ratio for different sub-populations, by exposure category, ethnicity, origin and sex, Canada, 2011

| Population | Estimated number of new HIV infections (range) | Estimated rate per 100,000 population (range) | Rate ratio |
|--|---|--|-------------------|
| Men who have sex with men (age 15 years and older) | 1,480 (1060 - 1900) | 443 (317 - 569) | 71 |
| Other men (aged 15 year and older) | 860 (630 - 1090) | 6.2 (4.5 - 7.9) | (Ref) |
| People who inject drugs (age 15 years and older) | 435 (300 - 570) | 431 (297 - 565) | 46 |
| People who do not injected drugs (age 15 years and older) | 2,660 (1900 - 3420) | 9.3 (6.6 - 11.9) | (Ref) |
| Aboriginal people (all ages) | 390 (280 - 500) | 29.9 (21.5 - 38.3) | 3.6 |
| People of other ethnicities (all ages) | 2,785 (1970 - 3600) | 8.4 (6.0 - 10.9) | (Ref) |
| People from HIV-endemic countries (all ages) | 535 (370 - 700) | 71.5 (49.5 - 93.6) | 9.2 |
| People born in Canada or non-endemic countries (all | 2,640 (1880 - 3400) | 7.8 (5.6 - 10.1) | (Ref) |
| Male (all ages) | 2,420 (1740 - 3100) | 14.2 (10.2 - 18.2) | 3.3 |
| Female (all ages) | 755 (510 - 1000) | 4.3 (2.9 - 5.8) | (Ref) |
| Total (all age) | 3175 (2250 - 4100) | 9.2 (6.5 - 11.9) | |

Source: Public Health Agency of Canada (2014) HIV/AIDS Epi Updates, July 2010, Surveillance and Risk Assessment Division, Centre for Communicable Diseases and Infection Control. Ottawa: Public Health Agency of Canada.