HIV/AIDS AND DISCRIMINATION
A Brief to the Sub-Committee on HIV/AIDS of the House of Commons

by the
Canadian HIV/AIDS Legal Network

prepared by

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> Safeguarding the human rights of persons with AIDS is vital not only on ethical and legal grounds but for pragmatic reasons. It is a necessity, not a luxury, and it is not a question of the "rights of the many" against the "rights of the few."1
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> Discrimination against, and stigmatization of, HIV-infected people and people with AIDS and population groups undermine public health and must be avoided.2
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> If one were to read the Universal Declaration of Human Rights with the aim of finding out which human rights have been affected by various responses to AIDS, one would see that most, if not all, basic human rights and freedoms, laid down as the common standard of achievement for humanity more than 40 years ago, have been challenged, violated, or denied in the context of HIV/AIDS. ... The core of human rights is the postulate that all human beings have equal rights. This has been challenged by denying human rights to people affected by AIDS.3
>
> How a government - local, regional, or national - chooses to confront the AIDS epidemic reflects its underlying interests, values, and systems, as well as those of the society it claims to serve. How it treats its own people with AIDS and HIV - or those at risk for HIV - thus reflects its general approach to human rights.4

I. INTRODUCTION

In 1989, the only study of discrimination against persons living with HIV/AIDS undertaken thus far in Canada concluded that "AIDS discrimination is a serious problem."5 Similarly, in 1992, the Canadian National Advisory Committee on AIDS reported that "[b]reaches to human rights in the context of HIV infection occur in Canada."

The Committee continued by saying:

> On the basis of specific cases heard under Human Rights codes as well as anecdotal

> information, they are widespread. Such breaches have occurred in relation to housing, workplace situations, access to medical care and the way in which this care is provided, custody of and access to one's children, insurance, and on the basis of disability, sexual orientation, sex and race. Injection drug users or prisoners can be particularly vulnerable to such breaches. Blatant incidents have occurred but many are more subtle. Poverty itself becomes an issue in relation to HIV infection - some people become poor because they have AIDS and people who are poor can be more at risk.6

Today, 15 years into the HIV/AIDS epidemic, discrimination against persons living with HIV/AIDS remains a primary concern in Canada: over 60 individuals and groups consulted during Phase I of the Project on Legal and Ethical Issues Raised by HIV/AIDS, jointly undertaken by the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society, expressed concern about the many instances of unjustified discrimination that persons living with HIV/AIDS and those otherwise affected by the disease are suffering in many areas of their lives, including employment, housing, access to services, etc. Everyone agreed that efforts to reduce discrimination must remain a priority, because "people are still loosing their jobs, are refused medical care, housing, childcare for their children, etc."

This paper outlines the extent of discrimination against persons living with or affected by HIV/AIDS in Canada and shows how discrimination impacts on Canada's efforts to prevent the spread of HIV and to provide care, treatment and support to those already infected.

It first provides some information about the Canadian HIV/AIDS Legal Network (Network), in particular, about its activities in the area of HIV/AIDS and discrimination.

It then summarizes the results of Phase I of the Project on Legal and Ethical Issues Raised by HIV/AIDS. During this phase of the Project, individuals and organizations consulted by the Project Coordinator expressed concern about the many instances of unjustified discrimination that persons living with or affected by HIV/AIDS are suffering in many areas of their lives. A literature review undertaken as part of Phase I of the Project showed that there is consensus in the literature that:

- HIV/AIDS -related discrimination is prevalent;
- it is often inseparable from and reinforces discrimination on other grounds;
- its effects are devastating not only for the individuals who are discriminated against themselves, but also for the community and, in particular, for efforts to prevent the spread of HIV; and
- efforts to combat HIV/AIDS-related discrimination need to be strengthened.

The paper then discusses the extent and impact of discrimination against some of the groups that have been most affected by HIV/AIDS in Canada: men who have sex with men, drug users, women, aboriginals and prisoners.

The paper concludes by emphasizing the importance of combatting discrimination against those living with or affected by HIV/AIDS.

The paper does not deal with the impact of poverty on the spread of HIV. The many links between poverty and HIV/AIDS have been well described in HIV/AIDS and Poverty: A Submission to the Honourable Lloyd Axworthy, Minister of Human Resources Development (see Appendix 1).7

II. CANADIAN HIV/AIDS LEGAL NETWORK

The Network is the only national, community-based, charitable organization in Canada working in the area of policy and legal issues raised by HIV/AIDS. It was formed in November 1992 with the mandate to advance education and knowledge about legal, ethical, and policy issues raised by HIV/AIDS, and to promote responses to HIV infection and AIDS that respect human rights.

The Network provides services to persons living with HIV/AIDS, to those affected by the disease, and to persons working in the area by educating about, facilitating access to, and creating accurate and up-to-date legal materials on HIV/AIDS. It links people working with or concerned by relevant social and legal issues in order to limit the spread of HIV and to reduce the impact on those affected by HIV infection and AIDS.

In October 1994, the Network launched the Canadian HIV/AIDS Policy & Law Newsletter, devoted to addressing the many legal, ethical and policy issues raised by HIV/AIDS. The Newsletter serves as a means of educating policymakers, lawyers and any other people with an interest in issues raised by HIV/AIDS about legal and policy developments, but also as a means of stimulating much-needed discussion about these issues.

III. NETWORK ACTIVITIES ON DISCRIMINATION

A. Canadian HIV/AIDS Policy and Law Newsletter

The editorial committee of the Newsletter regularly solicits contributions in the area of HIV/AIDS and discrimination, resulting in the publication of numerous articles and case reviews providing evidence of the extent of HIV/AIDS-related discrimination in Canada.

B. HIV/AIDS Policy & Law Seminar Series

So far, two of the seminars in the Network's seminar series have dealt with the impact of discrimination on the spread of HIV.

C. Joint Network/CAS Project on Legal and Ethical Issues Raised by HIV/AIDS

The Joint Project on Legal and Ethical Issues Raised by HIV/AIDS started in January 1995 with a five-month development initiative and entered into its second phase in June 1995.

During Phase I of the Project, key legal and ethical issues raised by HIV/AIDS in Canada have been assessed and prioritized. After extensive meetings with over 60 persons living with HIV/AIDS, representatives from community-based organizations, lawyers, academics and government policy analysts active in the HIV/AIDS area, a list of eight topics was drawn up that includes legal and ethical issues identified as immediate priorities by the persons and organizations consulted. This list includes:

(1) testing and confidentiality;
(2) discrimination;
(3) access to healthcare;
(4) HIV/AIDS and homosexuality;
(5) criminalization of HIV transmission;
(6) drug laws and policies and their impact on the spread of HIV;
(7) laws and policies regulating prostitution and their impact on the spread of HIV;
(8) legal issues raised by HIV/AIDS in prisons.

With regard to HIV/AIDS and discrimination, individuals and groups consulted expressed concern about the many instances of unjustified discrimination that persons living with HIV/AIDS and those otherwise affected by the disease are suffering in many areas of their lives, including employment, housing, access to services, etc. Everyone agreed that efforts to reduce discrimination must remain a priority, because "people are still loosing their jobs, are refused medical care, housing, childcare for their children, etc."

IV. HIV/AIDS AND DISCRIMINATION: A LITERATURE REVIEW 8

As part of Phase I of the Project, existing resources addressing legal and ethical issues raised by HIV/AIDS have been researched and documented. Resources have been evaluated, listed in an annotated bibliography, and included in a literature review.

A. Prevalence of HIV/AIDS-Related Discrimination

> Persons with HIV/AIDS face double jeopardy: they face death, and while they are fighting for their lives, they often face discrimination. This discrimination is manifested in all areas of life -- from health care to housing, from education to work to travel. It is generally based on ignorance and prejudice and is expressed in particularly harsh forms against the most vulnerable: homosexual men, women, children, prisoners, and refugees among them. Whereas most illnesses produce sympathy and support from family, friends and neighbors, persons with AIDS are frequently feared and shunned.9

1. Discrimination: A Widespread Phenomenon

There is consensus in the literature that discrimination against persons living with HIV/AIDS and those otherwise affected by the disease is widespread.

In Canada, the British Columbia Civil Liberties Association, the National Advisory Committee on AIDS, and the over 60 individuals and groups consulted in 1995 were all able to provide many examples of such discrimination. Nevertheless, the need to undertake further research on the extent of HIV/AIDS discrimination has been stressed: "In order to have knowledge of current patterns of discrimination and so to be able to pinpoint areas of concern and respond to them, an ongoing Canada-wide study is needed. The study would ... track the incidence of AIDS discrimination on an annual or bi-annual basis, and make recommendations to respond to them."10

The following are examples of two of the many areas in which persons living with or affected by HIV/AIDS experience discrimination: employment and education.

2. Discrimination in Employment
According to the study on HIV/AIDS-related discrimination in Canada, by far the largest number of incidents of discrimination reported were in the area of employment.11 The complaints included:

- an HIV- positive man who was told by his physician that unless he quit his job, the physician would inform his employer about his HIV status;

- the mother of an HIV-positive hemophiliac child who was told by her employer that she would be fired if she did not get tested;

- a person dismissed from a job after his employer learned of his volunteer work for an AIDS advocacy group; and

- a man living with AIDS who was dismissed when his health began to deteriorate (although the employer admitted that the worker could still perform his duties, he was concerned that the presence of the worker would hurt business).

However, the extent of discrimination reported in the study and confirmed by anecdotal accounts is in no way reflected by the number of cases of HIV/AIDS-related employment discrimination decided by courts, tribunals and arbitration boards in Canada. One commentator has said that, despite the fact that the "substantive body of law capable of remedying HIV-related employment discrimination exists in Canada today ... the number of decided cases of HIV-related employment discrimination is shockingly small."12 According to the commentator, the fact that the actual extent of HIV/AIDS-related discrimination is not reflected by the number of decided cases "begs the question whether HIV-related employment discrimination is a problem beyond the reach of the law." In addition to the procedural shortcomings of the current human rights apparatus, it seems that instances of discrimination by employers have become much more subtle, and therefore difficult to prove, than in the few cases decided by the courts and tribunals.

3. Discrimination in Public Education
Canada has not been without its incidents of AIDS hysteria: In the fall of 1987, Eric Smith, a teacher living with HIV, was removed from his classroom and reassigned to nonteaching duties after a medical secretary disclosed that Smith had tested positive for HIV. While Smith immediately refused the reassignment, he eventually accepted a three-year educative position on the Nova Scotia Task Force on AIDS.13 At the end of the three-year period, a group of parents in Nova Scotia threatened to set up their own school system if Smith was allowed back into the classroom. While the parents recognized that HIV is not spread through casual contact, they objected to having their children exposed to a gay "role model."14 More recently, in January 1994, "Baby J" , a two-year-old girl, was expelled from a Montréal daycare centre when it was discovered that her serostatus was positive. Although "Baby J" had to take an unidentified syrup every six hours, her mother had not disclosed her daughter's state of health. When the daycare centre's management discovered that the medication in question was AZT, they almost

immediately expelled the child.15

4. Discrimination: A Worldwide Phenomenon
According to Cohen and Wiseberg, prejudice, stigmatization and even violence against those living with HIV/AIDS "are a worldwide phenomenon," and "AIDS has been successively used to direct blame, stigmatisation and prejudice at homosexual men, prostitutes, intravenous drug users, Haitians, African students in the USSR and India, blacks and Hispanics in the United States, US seamen in the Philippines, foreigners in Japan, Europeans in Africa."16

Generally, it is believed that discrimination is more prevalent than is reflected in official statistics; further, and although the potential consequences of HIV-related discrimination were clearly identified early in the course of the pandemic and possible strategies for responding to these have been repeatedly identified and advocated by national and international authorities, there is some evidence that HIV/AIDS-related discrimination is becoming more extensive, more sophisticated and more strongly entrenched.17

B. Nature of HIV/AIDS-Related Discrimination

> HIV infection and AIDS may compound existing and overt patterns of discrimination against people from, or perceived to be from, those groups that have suffered from wrongful discrimination in the past, especially that ancient, traditionally dispossessed group, 'the diseased'.18

Discrimination on the basis of HIV/AIDS is often inseparable from and reinforces discrimination on other grounds. According to Garmaise, one cannot "talk about discrimination based on HIV or AIDS without talking about many other forms of discrimination," particularly against gay men, drug users, women, prostitutes, and generally, the poor and marginalized.19 HIV-related discrimination is thus based both on fears of the disease and on pre-existing punitive attitudes toward those believed to be responsible for the spread of HIV. Many persons living with HIV/AIDS have experienced intensive discrimination in the past: "AIDS is different from polio, cancer, and heart disease. It is different because AIDS has a predilection for minorities, men and women who have consistently experienced discrimination in the most basic areas of human life. The fact that the HIV epidemic has descended upon these particular communities is the crucial difference between this disease and others. ... [T]his difference demands special consideration by the medical and legal communities."20

C. Effects of HIV/AIDS-Related Discrimination

> In the context of AIDS, respect for human rights and dignity is not only a moral and legal imperative, but the basis for effective policies. There can no longer be any doubt that respect for human rights saves lives. It is widely recognized that laws and practices that discriminate against people with HIV or AIDS or those considered likely to be at risk of infection, or that in other ways violate human rights, are both morally indefensible and impede effective public health efforts.21

The effects of discrimination against persons living with HIV/AIDS and those otherwise affected by the disease are devastating not only for the individuals themselves, but also for the community and, in particular, for efforts to prevent the spread of HIV. Discrimination causes considerable economic cost to the community, producing both individual distress and social disruption: "Those who could continue in employment may find themselves forced onto social security. Those who could maintain private accommodation may find themselves forced into public housing."22 Even more importantly, discrimination hurts the fight against AIDS: in the context of HIV/AIDS it has been recognized that there is a strong public health rationale not to interfere with human rights. Indeed, there has been a realization that protection of human rights is a necessary component of HIV/AIDS prevention and care, and that health and human rights are inextricably linked.

According to the British Columbia Civil Liberties Association, "[i]n the case of AIDS, the consequences of unfair discrimination against the infected are so seriously damaging to our best efforts to fight the disease, that we simply cannot afford to permit it."23 Resolution WHA 41.24 of the Forty-first World Health Assembly, adopted on 13 May 1988, stresses the danger to the health of all discriminatory action against and stigmatization of persons living with HIV/AIDS as well as "members of population groups."24 According to the resolution, the Assembly urges Member States to:

- foster a spirit of understanding and compassion for persons living with HIV/AIDS through information, education and social support programs;

- protect the human rights and dignity of persons living with HIV/AIDS and of members of population groups, and to avoid discriminatory action against and stigmatization of them in provision of services, employment and travel;

- ensure the confidentiality of HIV testing and to promote the availability of confidential counselling and other support services to persons living with HIV/AIDS; and

- include in any reports to WHO on national AIDS strategies information on measures being taken to protect the human rights and dignity of persons living with HIV/AIDS.

Recognizing that there is a "strong and clear public health rationale for this emphasis on the protection of the human rights and dignity of HIV-infected persons, including people with AIDS, the World Health Assembly has stated that this policy is critical to the success of national and international AIDS prevention programs. Therefore the protection of the rights and dignity of HIV-infected persons is an integral part of the Global AIDS Strategy."25

Mann called discrimination a danger to public health: if HIV infection leads to stigmatization and discrimination, those affected will actively avoid detection and contact with health and social services. The result will be that those most needing information, education and counselling will be "driven underground." He identified four reasons why human rights must be protected:

- because "it is right to do so";

- because preventing discrimination helps ensure a more effective HIV prevention program;

- because social marginalization intensifies the risk of HIV infection; and

- because "a community can only respond effectively to HIV/AIDS by expressing the basic right of people to participate in decisions which affect them."

Therefore, Mann concludes, it is "essential and inevitable that we look to the insights and guidance of human rights, ethical and humanitarian values as we consider - as public health experts - how to move ahead and advance in policy and program in the 1990s."26
In summary, safeguarding the human rights of persons with AIDS is vital not only on ethical and legal grounds but for pragmatic reasons. It is a necessity, not a luxury, and it is not a question of the "rights of the many" against the "rights of the few": "the protection of the uninfected majority depends upon and is inextricably bound with the protection of the rights and dignity of the infected persons."27 As expressed by the New South Wales Anti-Discrimination Board, "an effective response to HIV and AIDS related discrimination is not just about a fair go for the victims of discrimination; it is about a fair go for the whole community. The community response must be to fight the virus, not those infected with it" [emphasis in the original].28 To act to protect people from HIV/AIDS or other diseases, and to address the deeper health and social problems that HIV/AIDS unveils, requires the protection and promotion of human rights. As stated by Stoddard, "[i]n all cultures and everywhere around the world, the most effective and efficient AIDS policies are those that accord fundamental, personal respect to people in need."29

D. Preventing and Redressing Discrimination

> HIV and AIDS related discrimination will not simply go away if it is ignored. It will not cease simply because people become better informed about the virus and its means of transmission. A carefully planned and appropriately resourced strategy is necessary if such discrimination is to be minimized and its adverse effect on the whole ... community reduced.30

In 1992 the National Advisory Committee on AIDS stated that, despite Canada's commitment to human rights, "protection of people with HIV infection is not always adequate: For example, human rights of persons are protected in most jurisdictions on the grounds that AIDS is considered a disability, but it is less clear whether HIV infection is equally deemed a disability."31 Various national bodies, stressing the importance of protection of human rights of persons living with or affected by HIV/AIDS, have recommended that all human rights legislation be amended to prohibit discrimination based on evidence of HIV infection or perceived HIV infection.32 This recommendation has not been implemented, but the federal and several provincial human rights commissions have adopted policies interpreting disability provisions to protect people living with HIV against discrimination and, in November 1993, a Canadian court ruled for the first time that asymptomatic HIV infection qualifies as a handicap for the purposes of

discrimination law. In the case of Hamel v Malaxos,33 the plaintiff, a 25-year-old man with asymptomatic HIV infection, succeeded in an action in small claims court against a dentist who allegedly refused to treat him because of his HIV infection. The Court observed that a seropositive person experiences real disadvantages even at the asymptomatic stage of the disease, and that asymptomatic HIV infection should therefore not be considered a period of "true biological latency."34 In another case,35 on 11 April 1995, the Québec Human Rights Tribunal confirmed that the fact of being an asymptomatic HIV carrier constituted a handicap within the meaning of the Québec Charter of Human Rights and Freedoms.

Apart from urging that all persons living with HIV/AIDS, including those with asymptomatic infection, be protected against discrimination, a variety of other measures have been recommended, ranging from making changes in the area of enforcement of human rights legislation, to ensuring that "unbiased presentation of homosexuality becomes an integral part of sex education and AIDS education in our schools," to creating a more supportive environment for persons living with HIV/AIDS as well as the groups most affected by the disease.36

Garmaise stresses that there are numerous barriers to the effective enforcement of the rights of persons living with HIV/AIDS, and suggests that federal and provincial human rights commissions in Canada develop and implement strategies to improve the enforcement of the rights of people living with HIV/AIDS: "These strategies should include measures to speed up the processing of complaints, educational efforts to encourage people to bring complaints, and measures to ensure that the identity of the complainant is kept confidential."37 This is consistent with the recommendations made by the over 60 individuals and groups consulted in 1995, who agreed that the extent of discrimination is not reflected in the number of complaints received by human rights commissions across Canada. According to many of those consulted, "there is no redress for those discriminated against: the commissions are useless, experience with them has been negative, delays and bureaucracy are incredible, and the understanding of the issues is appalling." People insisted that complaints need to be "faster-tracked." Another issue raised was that persons living with HIV/AIDS often lack information about how to access the justice system and seek redress for the injustices suffered. According to many, people need to be better educated about their rights.

In the US, the American Civil Liberties Union identified five priority areas for addressing discrimination and makes the following recommendations - applicable also to the Canadian context - for future anti-discrimination efforts:

- strengthen anti-discrimination laws;
- upgrade enforcement of anti-discrimination laws;
- expand legal services;
- increase oversight of insurance practices; and
- target education about the law for health-care providers.38

Worldwide, many suggestions have been made for combatting HIV/AIDS-related discrimination. Particular importance is given to efforts to prevent, rather than redress, discrimination, in view of the realization that, for people living with HIV/AIDS, there are often compelling disincentives to seeking

redress for discrimination through the courts:

Going to court takes time and resources - diminishing commodities for most people with HIV/AIDS. Going to court may entail publicity and the accompanying risk of further exposure to discrimination.39

Reasons for barriers to redress include: failing health, lack of financial resources, and scepticism regarding the eventual outcome. Doubts about the efficacy of litigation embrace a multitude of concerns, including:

- the belief that publicity would lead to loss of confidentiality;
- fear of further discrimination and reprisal; and
- fear that the litigation process would be lengthy, stressful, and ultimately futile.

Lack of protection by existing laws and statutes is also a commonly cited barrier. It has been concluded that persons living with AIDS have neither the time nor the energy it takes to complain. Anyone seeking redress for HIV-related discrimination must have both the physical strength and emotional willingness to enter what can be an arduous process. Many persons living with AIDS just do not want the burden of a legal battle in what may be the final months or years of their lives. Litigation, in the view of most, takes far too long. People largely agree that effective methods of reducing litigation time for complainants with HIV/AIDS are necessary if discrimination is to be reduced.40

E. Conclusion

The importance of proactive responses that seek to identify the causes of discrimination and to deal with these before conflict arises, rather than reactive responses that depend upon those who are discriminated against seeking redress after the event, must be stressed. Such positive responses can and should include legislative responses, advocacy, public declarations by influential individuals or groups, proactive ethical approaches, and educational responses. As Tindall and Tillett have said, "words are not enough," and efforts to combat discrimination need to be "backed by commitment, by implementation and by financial resources. The latter need to be directed to funding research that will identify the most appropriate strategies for resolving HIV-related conflict and to the establishment of services that will implement and evaluate such strategies."41

V. HIV/AIDS AND DISCRIMINATION: VULNERABLE POPULATIONS

HIV/AIDS has disproportionally affected groups of the population that have suffered a long history of discrimination: most notably, men who have sex with men, drug users, and increasingly women, aboriginals, prisoners and, generally, the poor.

Over the years, the number of cases of AIDS among men having sex with men, as a percentage of the total, has declined slightly, but this group still represents three-quarters of all adult AIDS diagnoses to date. Recently, the communities experiencing the greatest percentage increase, year after year, have been injection drug users, women and aboriginals.

The following paragraphs discuss the extent of discrimination against some of the populations most affected by HIV/AIDS,42 as well as the impact of discrimination on efforts to prevent the spread of HIV.

A. Men Who Have Sex with Men

> What does homophobia have to do with AIDS? Everything.43

Research has shown that there is a public perception that fighting HIV/AIDS or helping those infected with HIV means that one is encouraging, promoting, or endorsing the disease's stigmatized populations or behaviours, or that supporting HIV/AIDS care and prevention is tantamount to giving "special rights" to stigmatized groups.44

The underlying crisis of homophobia is especially problematic in relation to HIV/AIDS because homophobia has never been directly addressed through an open, public dialogue, and because a social consensus condemning homophobia has never formed in the same way that a consensus has been formed condemning racism, sexism, and other forms of discrimination.45

1. Introduction
In a survey of 5,000 gay and bisexual men interviewed in gay venues in 1991, 12 percent reported they were HIV-positive. While incidence rates of HIV infection among men having sex with men declined fairly steadily in the last half of the 1980s, they started to rise again in the 1990s: the rate in Montréal is now between 2 and 3 percent per year, and is even higher among young men having sex with men.46

In the last decades, there have been some positive legal developments for gays and lesbians in Canada. During the 1980s and early 1990s, most Canadian provinces have amended their human rights acts to extend antidiscrimination protection to gays and lesbians, and on 9 May 1996, the Canadian Human Rights Act, after ten years of unkept promises, was also amended. In the context of HIV/AIDS, such protection is seen as a necessary corollary to the protection against discrimination on the basis of physical disability, including HIV infection. As stated by the National Advisory Committee on AIDS,

> [o]ne should not be able to defend discrimination against persons with HIV infection on the grounds that it was in fact discrimination related to a person's sexual orientation and thus not expressly prohibited.47

Further, while sexual orientation was not included as a prohibited ground of discrimination in the equality rights provision (section 15) of the Canadian Charter of Rights and Freedoms, in 1983 the government took the position that section 15 was open-ended: it could be taken as understood that equal protection covered sexual orientation. Since then, sexual orientation has been accepted by the courts as a protected ground of discrimination. Lesbians and gay men are increasingly invoking the assistance of the courts to counter legal discrimination, and have obtained some significant victories for lesbian and gay

rights.48Canadian statute that fails to recognize such relationships as equal is subject to constitutional challenge: The Supreme Court has truly opened the door to a new era of litigation. Federal and provincial governments must accept that every law that creates inequalities between heterosexual and same-sex relationships is discriminatory. And both public and private employers refusing to extend same-sex benefits will have to demonstrate compelling reasons for the distinction if they are to avoid legal liability under human rights codes" (Supreme Court Rules on Same-Sex Benefits. Canadian HIV/AIDS Policy & Law Newsletter 1995; 1(4): 5).

Nevertheless, discrimination against gays and lesbians in Canada is endemic. The fact that it took ten years to include sexual orientation as a protected ground of discrimination in the Canadian Human Rights Act, and that members of parliament - some of them without being called to order by their party - on many occasions made statements directed against gays that would never have been tolerated had they been directed against members of other minority groups, is perhaps the best evidence of the need of gays and lesbians for protection against widespread prejudice and discrimination. In the context of HIV/AIDS, it is particularly relevant that, in the minds of many Canadians, homophobia and AIDS are inseparable. Negative perceptions and attitudes about the gay community have been identified as the biggest barrier to a coordinated, compassionate response to AIDS. As Brian Huskins, Chair of the Canadian AIDS Society, stated, "[i]n the minds of many Canadians, AIDS equals gay, and gay equals AIDS--the two continue to be intrinsically linked."49 Linking AIDS with homosexuality has created serious barriers to prevention and education initiatives, falsely leading many Canadians to believe that if they are not gay, they are not at risk of contracting HIV. This has had a negative impact on the quality of care received by persons living with HIV/AIDS.

2. The Joint Network/CAS Project

Research has shown that an individual's attitude toward gay rights, and not his or her level of AIDS-related education, remains the single most reliable predictor of whether that individual will fear direct contact with a person living with HIV/AIDS.50

In 1995, in Phase 1 of the Joint Project on Legal and Ethical Issues Raised by HIV/AIDS, gay and lesbian legal issues were identified as one of the eight "top priority" legal and ethical issues raised by HIV/AIDS. Most individuals and groups consulted expressed concern about the link between discrimination against gays and their higher susceptibility to contracting HIV. In particular, they were troubled by

- the refusal of school systems to provide positive education about homosexuality and gay and lesbian sexuality;

- the reluctance to legally recognize the existence of relationships between two men or women; and

- the lack of self-esteem often observed among lesbians and gay men.

At Canada's first workshop on gay and lesbian legal issues and the impact of discrimination on the spread of HIV, organized by the Joint Project in March 1996, 25 participants from across Canada

analyzed the following questions:

- How is homophobia impacting on government and institutional responses to HIV/AIDS?

- What are the implications of homophobia and discrimination on individuals' ability to protect themselves?

- What are the implications of homophobia and discrimination on care, support and treatment?

Participants pointed out there are many ways in which homophobia is impacting on government and institutional responses to HIV/AIDS:

- commitment: because HIV/AIDS primarily affects marginalized populations, governments are less committed to fighting the disease. fifteen years into the epidemic, there is a widespread feeling that one of the main reasons for the virtual disappearance of HIV/AIDS from the political agendas is the fact that is has affected white heterosexuals less than was anticipated in the mid-1980s and is still disproportionately affecting gay men, drug users, and other minorities.

- provincial and federal funding: the dwindling commitment is having a major impact on the willingness of provincial and federal governments to allocate dedicated and sufficient funding for HIV/AIDS-related activities. Another concern is that inappropriate and misleading comparisons with other diseases, such as cancer, are often used by those who claim that AIDS receives adequate or even too much funding. Closer analysis of these comparisons reveals that they are flawed: often AIDS, a preventable disease, is compared with non-preventable diseases; in many cases, the total AIDS Strategy funding, which includes funding for prevention efforts, is compared with research-related funding for other diseases, without including funding for prevention efforts that may come out of different budgets.

- school systems: the refusal of school systems to provide positive education about homosexuality and gay and lesbian sexuality is a clear example of how homophobia impacts on young gay and lesbian's ability to protect themselves from contracting HIV;

- prison systems: the refusal of many provincial - and, until 1992, also the federal - prisons to make condoms available to prisoners has at least in part been justified by the unwillingness of authorities to "condone homosexual activity." As a result, prisoners and their partners outside prison are unnecessarily exposed to the risk of contracting HIV.

Participants at the workshop then discussed the implications of homophobia and discrimination on individuals' ability to protect themselves, emphasizing that, as a result of discrimination encountered by gays and lesbians, many are afraid of "coming out" and of accessing existing services and the support the gay and lesbian communities can provide. Studies have consistently shown that these people are at increased risk of contracting HIV. Other implications of homophobia on individuals' ability to protect themselves (and others) include the fact that some people, particularly in smaller communities, refrain from undergoing testing for antibodies to HIV because they are afraid of being identified as gay - and thus discriminated against.

Finally, there are implications of homophobia and discrimination on care, support and treatment. These include:

- some people don't seek care, support and treatment for fear of being identified as gay; and

- many instances have been reported in which gay men have received less optimal care because of biases among health-care professionals.

3. Gays and HIV/AIDS: A Literature Review
A literature review undertaken as part of phase 1 of the Network / CAS joint project found numerous references in the literature to discrimination against gay men and lesbians and its impact on the spread of HIV/AIDS. In particular, the literature shows that:

- Gay men and lesbians have traditionally faced extensive prejudice and discrimination. In Canada, it has been said that "[t]he experience of homophobia and heterosexism is inextricably a part of being gay, lesbian or bisexual in this country. To be gay, lesbian or bisexual is to be discriminated against, both by other individuals and by institutions. To be gay or lesbian is to be defined as 'other,' 'sick,' 'deviant,' 'abnormal,' 'criminal'."51

- The HIV/AIDS epidemic has intensified and extended discrimination against gay men, usually on assumptions like "All gay men have AIDS and are infectious," or "Gay men are to blame for AIDS."52

- Gay men with AIDS attract considerable blame and little sympathy. In a study undertaken in Australia, the view was expressed that gay men were to blame for their disease and that gay men with HIV/AIDS should pay for their own health care.53 Generally, there has been a dominant undercurrent of hostility toward many people with HIV disease, as if they are somehow to blame. People with HIV infection or AIDS have been divided into two categories - the "guilty majority" of gay men and injection drug users, and the "innocent minority" of hemophiliacs or transfusion cases.54

In Canada, as in most western industrialized countries, the response to HIV/AIDS has oscillated between periods when policy has been, officially or implicitly, to recognize gay men as the most affected population, and periods when the threat of HIV/AIDS to the general population has been emphasized. In many ways, gay men have found themselves in a no-win situation. Initially, they had to argue that AIDS was not a gay disease, so that governments would take the disease seriously and allocate funding to research and prevention efforts. They feared even greater discrimination and coercive measures directed against them if AIDS continued to be perceived as a gay disease. In recent years, gay men have had to "reclaim" AIDS, because efforts were being increasingly and disproportionally directed at other groups of the population, leaving them with still by far the highest number of new infections, but relatively little funding for prevention efforts. AIDS has never been a gay disease, but one that in Canada has affected gay men more than any other group of the population, and continues to do so.

While some HIV discrimination is based solely on an irrational fear of transmission, there are clear links with homophobia: "People with HIV are often discriminated against because of their assumed homosexuality, whether they are gay or not. Further, the historic and very real links between gay men

and HIV have generalised some aspects of homophobia to HIV, so that even if gay men stopped getting HIV altogether, homophobic reactions to HIV issues and to people living with HIV would stay in the public mind for a long time. So in effect all people with HIV ... encounter homophobia and homophobic discrimination."55

Homophobia also has a severe impact on prevention and education efforts:

[I]f I live in a world that is homophobic and heterosexist, which does its very best to isolate me from my peers and keep me from any knowledge or acknowledgment that my gayness is valid, or even exists outside of my head and heart, then of course I am going to feel worthless and have low self esteem. I will believe that I am fundamentally flawed or bad or wrong, and alas too often become involved in self destructive behaviour ranging from isolating myself from people, through to drug and alcohol abuse, and suicide. ...

One of the strongest examples of homophobia impacting on the lives of gay men, including HIV prevention, is the lack of basic information about gay issues, gay identity, gay sex, and gay community in schools, including a lack of information about HIV and safer sex issues relevant to gay youth.56

The loss of focus on men who have sex with men with respect to prevention priorities in the last years may also have been a result of homophobia, which acts as a barrier to objective and effective policy, resource allocation, and other decision-making by government and community bodies. Dejowski, talking about the situation in the US, has pointed out how legislation to prevent the transmission of AIDS in the US has sometimes become enmeshed in the political agendas and personal moral philosophies of legislators. According to him, the result has been the shaping of a prevention strategy that is at odds with the findings of health behaviour research, and that forces the implementation of programs that are likely to have minimal effect on the population most at risk of contracting the disease - gay men.57

4. Conclusion
It is important to address the issue of homophobia in the context of HIV/AIDS: preventing discrimination against gays will help prevent the spread of HIV. However, homophobia should also be addressed in its own right. Otherwise, it has been argued, a subtle but strong message could be sent that gay identity, sexuality, and sex are not important issues in their own right, and that only gay men's identity as potential "AIDS victims" has relevance.58 While in Canada and in many other Western industrialized countries HIV/AIDS has become inseparable from gay life, there are many other reasons why discrimination against gay men and lesbians should end, regardless of HIV/AIDS.

B. Injection Drug Users

> Major improvement in professional and public attitudes to injection drug use and injection drug users is necessary since policies and actions which fail to respect the human rights and dignity of injection drug users may promote the hidden use of drugs and impair the effectiveness of measures to combat the spread of HIV.59

Studies in 1988-1989 estimated seroprevalence rates to be 4 to 10 percent among injection drug user populations in Toronto and Montréal respectively.60 Thanks to early establishment of needle exchange programs in many urban centres, these rates remained fairly constant until a few years ago. Recently, however, a marked increase has been noticed: in Toronto, in one group of injection or intravenous drug users (IVDUs) who were receiving treatment for their addiction, 9 percent were HIV-positive; in Montréal, seroprevalence among IVDUs has been estimated to have exceeded 10 percent and may be as high as 20 percent; two studies undertaken in Montréal have shown incidence rates of 6 percent; in Vancouver, between the summer of 1993 and the summer of 1994, the number of HIV-positive IVDUs tripled, and similar increases have been noted in other parts of British Columbia.61

The sudden increase is recognized as a sign that providing needles to drug users is not enough, and that Canada needs to do more to prevent the spread of HIV among IVDUs before seroprevalence rates reach levels seen in some cities in the US and in southern European countries. Among the initiatives being proposed are:

- increased access to methadone maintenance programs and to sterile needles;

- more and better treatment options; and

- changes to existing drug laws which are perceived as having a negative impact on efforts to prevent HIV infection and to care for HIV- positive drug users.

In particular, there is concern that:

- drug users, rather than being offered easy access to treatment for both their drug use and HIV/AIDS, are being "driven underground";

- existing and proposed new laws and policies make it difficult to reach and educate them; and

- drug use is treated as a criminal activity rather than a health issue.

According to Riley and Oscapella, there are many reasons why "Canadian drug laws are contributing to the deaths of thousands of people through the preventable spread of HIV and other infections such as hepatitis and TB": they have

- created a culture of marginalized people, driving them away from traditional social support networks;

- fostered a reluctance to provide education about safe drug-use practices, for fear of condoning or encouraging the use of illegal drugs;

- provoked public attitudes that are "vehemently anti-drug user," creating a climate "in which it is difficult to persuade Canadians to care about what happens to their fellow citizens who use drugs"; and

- focused too much attention on punishing Canadians who use drugs, "thereby downplaying critically important issues such as why people use drugs and what can be done to help stop unsafe drug-use

practices."62

Many Canadians are suggesting that this should be a time to re-evaluate Canada's drug laws and to draft new ones based on public health and harm-reduction principles: Canada should move toward treating drugs as a health, rather than criminal, issue. In particular, there is recognition of the fact that "the spread of HIV is a greater danger to individual and public health than injection drug use itself," and that "major improvement in professional and public attitudes to injection drug use and injection drug users is necessary since policies and actions which fail to respect the human rights and dignity of injection drug users may promote the hidden use of drugs and impair the effectiveness of measures to combat the spread of HIV."63

As emphasized by Justice Michael Kirby, President of the Court of Appeal, New South Wales, Australia, and President of the International Commission of Jurists, drug laws and policies must be not only pragmatic, but also respectful of the human rights of persons using drugs. According to Kirby, the human rights of drug-dependent persons and of recreational drug users is a subject that has been ignored until now by most lawyers and virtually all judges:

We have all become caught up in the drug control prohibitionist model. ... The advent of the AIDS pandemic requires a completely fresh consideration of this strategy both at a global and at a national level. The matter must be addressed both in pragmatic and human rights terms. Putting it quite bluntly, it is an uncivilised act to punish people, with long periods of imprisonment, who are addicted to particular drugs. The problem is, and should be treated as, one of public health concern, not one of law and order. ... Drug use ... is here to stay. A sensible legal strategy will be targeted at harm minimisation. Not the elusive chimera of total legal prohibition. HIV/AIDS will eventually teach us this.64

McCarthy65 and Silvis et al66 also emphasize that the human rights of persons using drugs have been ignored. McCarthy points out that, for a variety of reasons, attempting to reduce discrimination against injection drug users is even more difficult than attempting to reduce discrimination experienced by persons living with HIV/AIDS or by gay men. In her view, it has become apparent that society generally justifies discriminating against drug users "because the principle of fairness does not apply." Injection drug use is seen as a mere lifestyle choice, something that can be stopped, amended or changed, and people take the attitude that "[i]f they [drug users] don't like the way they're treated they can stop." McCarthy points out that experiences of discrimination are so common among injection drug users that most of them do not realize they are being discriminated against. For them, it has become "normal" to be treated badly and vilified, and fear of poor treatment is a major barrier to accessing needed services. For McCarthy, it was a "shock" to discover just how widespread discrimination against injection drug users is. She concludes:

I find it a sad comment on society when a group that is often most in need of services is denied access or actively discouraged from accessing these services. Even more disturbing is that this treatment of injectors seems so acceptable to society.67

C. Women

> The pandemic ... simply cannot be separated from fundamental problems in the social, economic and political roles and status of women. In the 1990s, HIV/AIDS will become, increasingly, a health problem affecting women. Thus, women's social, cultural, economic and political role--the societal and historical dimensions of gender and health--lead us to recognize that a male dominated society cannot be good enough--is not acceptable--and a male dominated society is a danger to public health.68

The first Canadian case of AIDS in a woman was diagnosed in 1981. By December 1994, women made up 5.4 percent of all reported AIDS cases in Canada. Of these, nearly 60 percent were infected through unprotected sex with HIV-infected men, 13.5 percent were infected through blood or blood products, and 14 percent were injection drug users who were infected by sharing contaminated needles. Nearly half of all Canadian women with AIDS resided in the province of Québec at the time of diagnosis.69 While women still represent a small proportion of the total number of AIDS cases in Canada, their proportion among those testing HIV positive has risen steadily. For example, in Ontario, 15 percent of those currently testing positive are women.70

In Canada as elsewhere, the HIV/AIDS pandemic has highlighted the world's most pervasive inequality--that of women. Therefore, it should be no surprise that the legal issues facing women affected by HIV/AIDS are, in many respects, more complicated than those experienced by men affected by HIV/AIDS: "They reflect a systemic breakdown that women experienced long before AIDS ever entered their lives. For that reason, the legal solutions that we can provide them are not that easy and often don't solve all the problems in their lives or in the lives of other people around them."71

One striking feature of the debate on women and HIV/AIDS is its frequent preoccupation with women as mothers or as future mothers; it is comparatively rarely concerned about the women themselves and the many problems they face in dealing with HIV/AIDS. For example, while the issue of compulsory testing of pregnant women or of women of childbearing age is hotly debated, women who are not pregnant or of childbearing age still report that they find it difficult to access HIV testing. This raises the issue of whether there is less concern about the welfare of women than for that of their children or potential children. It will be necessary to ensure that women's needs and their "knowledge and ... varying life situations are systematically taken into consideration in the formulation of responses to the epidemic": so far, few, if any, policies and programs developed in response to HIV/AIDS "are related to women's real-life situations."72

D. Aboriginal People

> The rapidly increasing incidence of HIV infection within this age group [young adults or adolescents], and the Aboriginal population as a whole ... represents a serious threat to the resurgence of cultural, political and social strength among Aboriginal communities in Canada.73

AIDS cases among Canadian aboriginal people are increasing rapidly: from 24 reported cases in 1990 to

153 in 1995. The actual numbers are probably much higher, front-line workers estimating that there may be more than 1,000 aboriginal people living with HIV. Such estimates are based on the case loads of aboriginal AIDS-service organizations, the known prevalence of risk factors--in particular, injection drug use--among aboriginal populations, and the fact that many aboriginals may unwittingly be living with HIV because HIV testing in remote aboriginal communities is still uncommon. As the Royal Commission on Aboriginal Peoples pointed out, many aboriginals remain unaware and at high risk of contracting HIV because of the absence of an organized prevention campaign. As indicated by Matiation, who undertook the only study to date of legal issues relating to HIV/AIDS in aboriginal communities in Canada,

Aboriginal people have suffered a history of increasing marginalization and social dislocation since the time of European contact. In recent years, the process of cultural disintegration that has accompanied the marginalization of Aboriginal people has abated and even reversed in many communities and regions of Canada with the rise of the Aboriginal movement towards self-government. Despite increasing political and cultural consciousness, however, the effects of colonization are so deeply ingrained in the community life, social norms, health, and economic conditions of Aboriginal groups that these effects will not disappear easily, if at all. The factors that contribute to a higher risk of the transmission of HIV continue to be over-represented among the Aboriginal population of Canada.74

E. Prisoners

> The general principles adopted by national AIDS programs should apply as much to prisons as to the general community.75
>
> All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community.76

Given the increasing dangers posed by HIV and hepatitis in prisons, brought into focus by cases of seroconversion in custody, there is more reason than ever to utilize a legal approach ... in the attempt to achieve substantive change in correctional policy: prisoners may be able to demonstrate the need for changes in prison authorities' and governments' behaviour by instituting an action in negligence. Prisoners could also raise important constitutional law arguments based on Canadian Charter of Rights and Freedoms violations.77

In November 1995, only eighteen months after the release of the Final Report of the Expert Committee on AIDS and Prisons (ECAP),78 a new Discussion Paper on HIV/AIDS in prisons was released (see Appendix 2).79 The Paper points out that many of ECAP's recommendations - including some recommendations the Correctional Service of Canada (CSC) agreed with in its response to ECAP's Report - have not been implemented, putting prisoners, staff, and members of the public at risk of their lives.

1. Background
Issues raised by HIV/AIDS in prisons have been extensively studied in Canada, in particular by ECAP

and the Prisoners with HIV/AIDS Support Action Network (PASAN). Nevertheless, individuals and organizations consulted during Phase I of the Joint Project on Legal and Ethical Issues Raised by HIV/AIDS indicated that issues raised by HIV/AIDS in prisons remain a priority in Canada. In particular, they expressed concern about CSC's reluctance to implement some of ECAP's major recommendations, such as the recommendation to undertake a pilot study of needle distribution in at least one prison.

They suggested that the Joint Network/CAS Project examine whether governments and prison systems have a legal obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV, even if they "voluntarily" engage in illegal or forbidden behaviours (drug use and sexual activity), and address the issue of potential liability for not providing condoms, bleach, and sterile needles, with the resulting transmission of HIV in prisons.

2. New Developments
The Discussion Paper reviews a variety of new developments related to HIV/AIDS and drug use in Canadian federal prisons, which occurred since 1994:

- a 40 percent increase in the number of known cases of HIV/AIDS in federal correctional institutions over a period of 18 months;

- an increase in the number of prisoners living with symptomatic HIV infection or AIDS in prisons, requiring more extensive and costly medical care;

- increasing evidence of high-risk behaviours in prisons;

- increasing evidence that, as a result of such behaviours, HIV is being transmitted in prisons;

- the rapid spread of hepatitis C in prisons, as evidenced by three recent studies that revealed hepatitis C seroprevalence rates of between 28 and 40 percent;

- legal action undertaken by prisoners in two Australian states against their prison systems for failing to provide measures to prevent the spread of HIV;

- reports on HIV/AIDS in prisons issued in other countries, reinforcing the consensus that more needs to be done to prevent the spread of HIV in prisons, and to care for prisoners living with HIV/AIDS; and

- a pilot project for needle distribution in prisons in Switzerland, demonstrating that sterile needles can be distributed in prisons safely and with the support of inmates, staff, prison administrations, politicians, and the public.

The Paper concludes that, although the prevalence of HIV among Canadian prisoners is more than 10 times higher than in the general community, far from enough is being done to prevent the spread of HIV infection in prisons and to provide prisoners living with HIV or AIDS with treatment, support and care equivalent to that available outside:

Provincial and federal prison systems have taken steps in the right direction, and there can be no

question that the situation with regard to HIV/AIDS in prisons in Canada has improved over the years. However, many of ECAP's and PASAN's recommendations - including some recommendations CSC agreed with in its response to ECAP's report - have not been implemented, putting prisoners, staff, and members of the public at risk of their lives.

The Paper points out that, if federal and provincial prison systems want to fulfil their moral and legal obligations, they need to reconsider their response (or lack of response) to the recommendations made, and will have to adopt a more pragmatic approach to drug use in prisons. It emphasizes that the idea of a drug-free prison does not seem to be any more realistic than the idea of a drug-free society, and that stability may actually be better achieved by moving beyond this concept:80

Because of HIV/AIDS, prisons cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy. While reduction of drug use is an important goal, reduction of the spread of HIV and other infections is more important: unless prison systems act aggressively to reduce the spread of HIV, there may be slightly reduced rates of drug use in prisons, but many more prisoners living with HIV/AIDS and/or hepatitis C and other infections.

According to the Paper, making available to inmates the means that are necessary to protect them from HIV transmission does not mean condoning drug use in prisons: rather, it is a pragmatic measure acknowledging that protection of prisoners' health needs to be the primary objective of drug policy in prisons. The Paper continues by saying that introducing harm-reduction measures is not incompatible with a goal to reduce drug use in prisons:

> making sterile needles available to drug users has not led to an increase in drug use, but to a decrease in the number of injection drug users contracting HIV and other infections.81 Similarly, making methadone available to some users does not mean giving up on the ultimate goal of getting people off drugs: rather, it is a realistic acknowledgment that for some users this requires time, and that they need an option that will allow them to break the drug-and-crime cycle, reduce their contact with the black market, link with needed services, and reduce the risk of their becoming infected with HIV.

The Paper concludes by saying that:

> Clearly, prison systems also have a moral and legal responsibility to do whatever they can to prevent the spread of infectious diseases among inmates and to staff and the public, and to care for inmates living with HIV and other infections. Currently, they are failing to meet this responsibility, because they are not doing all they could: measures that have been successfully undertaken outside prison with government funding and support, such as making sterile injection equipment and methadone maintenance available to injection drug users, are not being undertaken in Canadian prisons, although other prison systems have shown that they can be introduced successfully, and receive support from prisoners, staff, prison administrations, politicians and the public.

The Paper expresses the hope that governments and the prison systems in Canada will act without prisoners having to undertake legal action holding them responsible for the harm resulting from their refusal to provide adequate preventative means. It emphasizes that

> prisoners, even though they live behind the walls of a prison, are still part of our communities and deserve the same level of care and protection that people outside prison get: they are sentenced to prison, not to be infected.

3. Conclusion

Much could be done to reduce the risk of HIV transmission in Canadian prisons. In particular, making sterile needles available to prisoners injecting drugs, and offering methadone maintenance programs and better treatment for drug use would help prevent the spread of HIV in prisons. By doing so, Canadian prison systems would follow the recommendations of national and international experts and organizations such as the World Health Organization which has established guidelines emphasizing "the link between prisons and the world outside." As stated by Dr Michael Merson, then Director of WHO's Global Programme on AIDS, "[i]ndividuals have the right to health care, including preventive care, whether they are incarcerated or not" and "if prisoners have access to the same effective prevention methods that are available outside prison, this will benefit everyone."82 Generally, prisoners retain all civil rights that are not taken away expressly or by necessary implication of their loss of liberty. In particular, there is agreement that prisoners have a right to health care, and in the context of HIV/AIDS, this includes giving prisoners the means to protect themselves from exposure to HIV. As prisoners have reduced possibilities to protect their health, and this results from state action, the state has special responsibility for the health of prisoners. This responsibility is reinforced by basic principles of protection of human rights of persons in the custody of the state.

VI. CONCLUSION

This Brief has shown that: (1) HIV/AIDS -related discrimination in Canada is prevalent; (2) it is often inseparable from and reinforces discrimination on other grounds; (3) its effects are devastating not only for the individuals who are discriminated against themselves, but also for the community and, in particular, for efforts to prevent the spread of HIV; and (4) efforts to combat HIV/AIDS-related discrimination need to be strengthened: safeguarding the human rights of persons with AIDS is vital not only on ethical and legal grounds but for pragmatic reasons.

As Tindall and Tillett have said, "words are not enough," and efforts to combat discrimination need to be

> backed by commitment, by implementation and by financial resources. The latter need to be directed to funding research that will identify the most appropriate strategies for resolving HIV-related conflict and to the establishment of services that will implement and evaluate such strategies.83

Canada has adopted two national AIDS strategies and has successfully prevented an explosion of HIV/AIDS cases. However, it is faced with a continuing epidemic among men who have sex with men, an increasing rate of infection in some populations, such as aboriginal people, injection drug users, and prisoners, and a continuing epidemic of discrimination. As Canada evaluates its National AIDS Strategy, Phase II, and makes a decision about whether there should be a third phase, it should take into consideration that there are continuing and emerging HIV/AIDS epidemics in our country, and that HIV/AIDS is different from other diseases: whereas most illnesses produce sympathy and support from family, friends and neighbours, persons with AIDS are frequently feared and shunned. Many persons living with HIV/AIDS have experienced intensive discrimination in the past:

AIDS is different from polio, cancer, and heart disease. It is different because AIDS has a predilection for minorities, men and women who have consistently experienced discrimination in the most basic areas of human life. The fact that the HIV epidemic has descended upon these particular communities is the crucial difference between this disease and others. ... [T]his difference demands special consideration.84

Fifteen years into the epidemic, HIV/AIDS still provoke fear, misunderstandings and irrational responses, and discrimination against people living with or associated with the disease is still endemic. Unless a concerted effort is made to confront the HIV/AIDS epidemic and the epidemic of fear, prejudice, and discrimination, the gains and the investment to date may be lost. A National AIDS Strategy, Phase III, can be an efficient use of public resources. Abandoning the AIDS Strategy and cutting AIDS funding now would only, if at all, have short-term budgetary benefits. In the long term, it would result in the preventable infection and death of many Canadians, in continued discrimination against those infected and affected, and entail enormous human and financial costs.

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