



Abstract

Findings that detail the social organization of day-to-day practices associated with the Canadian government policy of mandatory HIV testing of permanent residence applicants to Canada are reported. Institutional ethnography was used to investigate interactions between HIV-positive applicants and immigration physicians during the immigration medical examination. A composite narrative recounts details of a woman applicant's discovery through immigration testing that she was living with HIV. Mandatory HIV testing gives rise to serious difficulties for applicants to Canada living with HIV. Applicant, physician and federal state employee work practices associated with mandatory HIV testing are analysed. These practices contribute to the ideological work of the Canadian state, where interests bound up in the examination serve the state and not the applicant. Findings should be useful for Canadian immigration policy makers who wish to develop constructive and functional strategies to address issues that matter in people's lives.

Key Words empirical research, ethnography, health policy, HIV/AIDS, immigration, HIV testing

Mandatory HIV Screening Policy & Everyday Life: A Look Inside the Canadian Immigration Medical Examination

LAURA BISAILLON

Introduction

Story and science are interrelated, interactive, and ultimately constitute each other ... The natural world and the cultural worlds share the burden of creating disease realities.[1]

... I had grasped well that there are situations in life where our body is our entire self and our fate. I was in my body and nothing else ... My body and nothing else ... My body ... was my calamity. My body ... was my physical and metaphysical dignity.[2]

In this article, I report findings from research using institutional ethnography that detail the practices associated with mandatory HIV (human immunodeficiency virus) screening of refugee and immigrant applicants to Canada. Specifically, I interrogate the interactions between HIV-positive immigrant and refugee applicants and federal government appointed immigration physicians, called Designated Medical Practitioners (DMP), during the official immigration medical examination (IME). What are some features of the everyday activities of applicants living with HIV in relation to this examination? What happens during the IME? What are some of the social organizers of the official medical visit and what happens there? These are the underlying questions of this inquiry.

I make two arguments. First, there is relevance and practical value in investigating public policy from within people's concerns and the material circumstances of their everyday activities. Empirical accounts circumvent speculative, abstract and ideological knowledge and understandings about the side effects of policy. Second, the mandatory HIV

testing policy and associated practices give rise to serious and significant challenges in the lives of HIV-positive immigrant and refugee applicants, which must be understood as socially produced and set within broader social and political contexts of which they are a part. Until now, what happens during the IME has been undocumented and has never been the object of critical analysis; its practices are taken-for-granted and unexamined because they are among the activities that ‘just must happen’ to immigrant and refugee applicants.

On reading this article, nurses and other health providers, policy makers, civil society actors, citizens, and others will learn about and reflect on several points, thus being better poised to know about some experiences of immigrant and refugee people living with HIV in Canada, as well as being better placed to consider advocating on their behalf. Readers will gain an appreciation for some of the efforts and time-consuming work that immigrant and refugee applicants with HIV engage in and sustain during their immigration application process. They will also learn that the social organization of the IME and the broader process of seeking official status in Canada reveal the distinctive treatment and place of HIV within the Canadian immigration program.

Context of mandatory HIV screening of immigrants

Since 2002, Canada has required HIV testing of all persons aged 15 years and above who request Canadian permanent resident status (such as immigrant and refugee persons) and temporary resident status (such as migrant workers, students, and long-term visitors from certain countries). Citizenship and Immigration Canada (CIC) manages the testing program. DMPs work under contract to CIC and arrange HIV testing as part of the IME. About 1,200 DMPs carry out IMEs in domestic and foreign medical offices; up to 550,000 examinations are conducted annually.[3] Tuberculosis, syphilis and HIV are the three tests conditions for which screening is required.[4,5,6] The mandatory HIV policy has not been examined since it was introduced nearly a decade ago.

The rationale for Canada’s mandatory HIV testing policy is not clearly articulated, and it remains unclear why the HIV test was singled out as the only addition to the IME in over fifty years. Before 2002, there was no blanket immigration screening for HIV. How and why the absence of an openly stated purpose is problematic has been argued elsewhere.[7] “The promise and implications of a policy are not transparent and easily evident in its text . . . the ‘architecture of meaning’ of a policy is revealed by the systematic investigation of policy categories and labels, metaphors and narratives,

programs and institutional places.”[8] As with all public policy, Canada’s mandatory HIV testing policy is neither value neutral nor without intended effect.

The overall number of HIV-positive applicants admitted to Canada is very small relative to the population increase through immigration and the resident HIV-positive population. Since mandatory immigration HIV screening was introduced in 2002, 4,374 persons have tested HIV-positive during the IME.[9] CIC agents deemed 453 of these people inadmissible for a Canadian visa based on a hypothetical estimate of costs for their care over a ten-year period. For the person living with HIV, the cost matrix is based on anticipated future participation in the pharmaceutical industry (i.e. likelihood of taking antiretroviral medication).[10] However, most immigrants with HIV who end up acquiring a visa to remain in Canada are persons who cannot be excluded on this basis under the law: those people who apply as refugee or family class applicants. In 2006 and 2007, 1,050 HIV-positive applicants sought permanent residence, of which 994 were refugee or family class applicants.[11]

Discovery of a disturbing disjuncture

An article appearing in the *International Journal of STD and AIDS* four years after the HIV testing policy came into effect reported on the functioning of the screening program in its first two years.[12] The authors wrote that all refugee and immigrant persons who tested HIV-positive through Canadian immigration medical screening consented to testing; received pre- and post-HIV test counselling; and, on positive diagnosis, received referrals to specialty facilities. I knew that these claims were inconsistent with the material circumstances of the lives of people who test HIV-positive through immigration screening; the story had to be nuanced, at best; and, furthermore, applicants to Canada have no choice but to be screened for HIV, so there is absolutely no informed consent process. Refugee and immigrant persons living with HIV and health providers among whom I worked, notably nurses, social workers, and community lawyers working *pro bono* with immigrants with HIV, told a different story.[13,14,15]

The dissonance between official and experiential knowledge was problematic, not least of which because we know that ideological accounts shape what and how people can know about HIV and other diseases that are not necessarily readable on a person’s social skin.[16-19] Disjunctures stemming from competing forms of knowledge have been starting places for valuable, critical anthropological fieldwork focused on creating a knowledge base set in bodily experience of people

living with HIV and serious diseases of inequality and poverty who occupy places of social marginality.[20-25] Academic reports were divorced from people's embodied experience with immigration HIV screening; they did not reflect what was actually happening in people's lives. Left unchallenged, these became the accepted representations or evidence. This disjuncture was the analytic entry point for the larger doctoral project in which this article is set; work structured to uncover and disturb knowledge embedded in the official explanations Canada's mandatory HIV screening of applicants; the explicit goals of which are to establish a "scientific basis for the political strategy of grass-roots community organizing" and generate knowledge in the interests of and for immigrant and refugee people living with HIV in Canada.[26]

A materialist approach to the social

The findings reported herein emerge from an empirical study where I used institutional ethnography as a method.[27-30] I also drew from wider methodological literatures with consistent ontological, theoretical, and epistemological commitments such as activist ethnography[26,31] and ethnographies within medical anthropology.[32,33,34] The approach explores the organizational processes and relations of power in which we conduct our lives, and the institutions within which those processes and ruling relations operate. Research using this method produces "formal, empirically based scholarly" explications of the happenings of everyday life as understood to be relational and socially produced.[35] Consistent with the method's feminist origins, the standpoint of applicants with HIV informed this research.[36,37] Findings discussed below are presented from within the material events related to the HIV-positive diagnosis of a standpoint informant; a woman who applied as a refugee applicant to Canada whose diagnosis stems from Canada's policy of mandatory immigration HIV screening.

Sociologist George Smith called institutional ethnography a "new paradigm for sociology" because it offers both a method and a theorized way of seeing and thinking about the world that produces useable, contextualized knowledge from people's sensual and material experiences within the world.[26] In this way, I focused close, careful ethnographic investigation to understanding the social organization of people's everyday activities to produce explications of what happens there so that awareness could be brought and changes introduced where problems were detected.[38,39] "[R]ecognition or validation of experiential knowledge can facilitate a critique of prevailing institutional norms that may be contributing to the marginalization of groups or

perspectives".[40] For example, attention to people's day-to-day practices led psychiatrist and anthropologist Robert Barrett[32] to generate contextualized understandings of how the discursively and institutionally organized work practices of clinical staff (of which he was one) in an Australian psychiatric facility intersect to shape how people with schizophrenia are understood, with consequences for the health of the latter. Timothy Diamond's[41] extensive, empathetic (and unsettling) observations from his social location as a clandestine sociologist and nursing home assistant in nursing homes in the United States reveals insights into how staff and resident lives are governed by extra-local or external public and private sector interests. Such Interest in "daily practice" produced understandings of how Canadian nurses experience ethical tensions in their day-to-day working life.[42] Institutional ethnography as a mode of critical inquiry is used in Canadian nursing research and university curriculum,[43] and it could have been one of the methods Joan Anderson was referring to when she observed the assortment of "innovative approaches [that] have found a place in the construction of nursing science." [44]

Ethnographic fieldwork

I gathered data during two tranches of fieldwork and using analysis of numerous documents and texts. The first tranche of fieldwork involved interview, focus group and participant observation research with thirty-three persons, mainly in Toronto and Montreal, between fall 2009 and winter 2010. Informants were recruited through AIDS service organizations, HIV clinics, listserves, and by word-of-mouth.

Twenty-nine informants were HIV-positive, and four persons were HIV-negative. Interviews were conducted in English and French, with additional interviews done through interpretation in Amharic, Cantonese, Mandarin, and Mongolian. Informants were citizens of twenty-four countries, and all had arrived in Canada since the mandatory HIV testing policy was introduced. Most informants were refugee applicants at various stages in their immigration application process. The conceptual organization of interview dialogue was around the work that people living with HIV engage in to immigrate to Canada; consisting of a myriad of activities that take a lot effort, thinking, planning, and investment in time and financial resources. Research drawing from institutional ethnography uses the notion of work as a metaphor to direct attention to day-to-day practices in which people engage and that their labour produces.[45,46]

Second phase data were gathered in twenty-eight bilingual interviews in Toronto, Montreal and Ottawa from winter

2010 to spring 2011. Interviewees included people in occupational roles identified by informants living with HIV as important to their immigration application process. These included lawyers, DMPs, HIV physicians, social workers, nurses, AIDS service organization case workers, shelter and public health personnel, Canadian Border Services Agency employees, and government advisors and officials from CIC. These informants were directly recruited. Informant selection in both phases emphasized a broad range of experiences and social circumstances with the mandatory HIV testing policy.

During both tranches of fieldwork I reviewed official and informant documents, legislation, forms, and other publicly available texts such as Canada's Immigration and Refugee Protection Act[47] and Regulations;[48] Canada's HIV Testing Policy;[5,6] Handbook for Designated Medical Practitioners (hereafter DMP Handbook);[42,50,51] and, Personal Identification Form for refugee applicants (http://www.irb-cisr.gc.ca/eng/tribunal/form/Documents/form189_e.pdf). This study received ethics approval from the University of Ottawa and respected standards in Canada's Tri-Council policy statement on research practice (http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS2_FINAL_Web.pdf).

Discussion of findings: Everyday work and textual practices

Applicants for Canadian residency who live with HIV engage in considerable amounts of work to immigrate to Canada. The root of this is the firm desire to become a Canadian citizen, which they see as a privilege and an opportunity. Thus, applicants acquiesce to all that is required of them to become Canadians; including submitting to whatever health screening is mandated. There is, however, a disjuncture: notions of privilege are not part of their everyday experience. That experience is rather a matter of waiting, wondering, hoping, and coping with their HIV diagnosis. Such tensions are discussed below. The explications presented emerge from within the activities associated with the Canadian IME and are framed within the standpoint of Patience (pseudonym), a woman refugee applicant to Canada. Woven into and interspersed in this analysis are the immigration application work practices of other standpoint informants; a narrative strategy that emphasizes that there are common features of the social organization of Patience's experiences that make what happens to her generalizable beyond any single account. In this way, the analytic story that is the framework for this chapter is a composite of the activities of various standpoint informants as they were recounted to me.

"Urgent: Contact the doctor immediately"

Patience, a doctor in her country, mentioned her earliest days in Canada where she lived in a shelter for several months. She said that a memorable feature about the shelter was that it was while she lived there that she learned that she was living with HIV.

At the Canadian border, Patience was instructed to see a DMP. She left the border with an information package, which included a list of state-affiliated immigration doctors. Promptly, Patience reported to one of the doctors on this list, choosing the one closest to the shelter. He did a brief examination of her body, and his nurse drew her blood. The doctor told her that if there were problems, his office would contact her.

Ten days later, a note bearing her name and a hand written inscription appeared on the communal bulletin board of the shelter. It read, "*Patience. Urgent: Contacter le médecin tout de suite (contact the doctor immediately)*". She quickly removed the note. Since arriving in the shelter, Patience learned that the general chatter among residents, all people recently arrived in Canada from developing world societies, was that if a person received a call back from the DMPs office, this signaled HIV. Patience's heart sank. The announcement made her feel exposed.

Patience described her second visit to the DMP. She was distressed by the brevity of the visit; how little they spoke after her diagnosis. Patience had a good deal of expectation and knowledge about what the visit could have involved. She walked away from the physician's office with a slip of paper bearing the name of a clinic treating people living with HIV. Patience was told to report to that hospital, and later that day, she made her way to there.

"Of course they took blood for HIV"

The IME is one of the first steps that applicants who apply for immigration from within Canada carry out. They place considerable importance on this examination in part because they come to realize that the Canadian government likewise places a lot of importance on it. Applicants want to 'pass' the medical examination and be screened forward through immigration procedures. An informant who applied as a refugee from within Canada said,

At the YMCA [Young Men's Christian Association; temporary residential shelter] they gave us an information package that contained the steps we had to go to complete steps to immigrate. For example, go to the medical visit, take the immigration course; go to the refugee-receiving centre; fill out the Personal Information Form. With that piece of paper, you check off the list. In that way, you know what you have to do, and you know what you have done. You know how much time you have to do each activity.

In her first visit to the DMP, Patience said,

You just had to fill in the normal paperwork, answering such questions as, 'has anyone in your family had HIV or AIDS? Have you ever had HIV?' At that time, of course, I knew I was clean. Negative.

I was very sure of myself because I had had my last HIV test one year prior to that. I knew I wasn't sick. I did the HIV test and lots of other medical tests including x-rays. Of course they took blood for HIV. Immigration did not tell me they were doing an HIV test.

Patience had not been told, in the context of Canadian government testing, that she was being tested for HIV. About this a DMP said,

You are supposed to advise patients, 'we are doing these tests, and we are doing an HIV screen.' You do a bit of a screen to see if that is a concern before hand; so that they are aware why we are testing. If it is [HIV] positive, we will call them in. There is supposed to be pre- and post-test counselling [for HIV]. I suppose you could call it pre-test 'notification'.

The DMPs statement focuses analytic attention to several points. The parameters for what the DMPs' work "is supposed to" consist of, as above, and the theoretical framework for how this work is carried out, is outlined in the DMP Handbook and periodic operational updates, all issued by CIC. Physicians can test for conditions other than the mandatory three, but these are "not part of the routine tests", said a DMP.

Review of the forms and instructions in the 2009 edition of the DMP Handbook shows that the Canadian government places theoretical importance on the delivery "pre- and post-test counselling" since specific forms and instructions were additions from the previous edition of the Handbook. We discover that the amount for which DMPs can invoice CIC for delivering post-test counselling to refugee applicants to Canada is more than the cost of the IME itself.

In the above quote by the DMP the doctor qualifies that "notification" is how applicants might be advised that their blood will be checked for HIV antibodies. The applicant does not consent to an HIV test because the person has no choice but to be tested. Of note is that in Canada, mandatory HIV testing of Canadian permanent residents and citizens is unconstitutional except under very rare circumstances.[52,53] Thus a practice that Canadians would very exceptionally experience is practiced on prospective foreign nationals.

"I began asking questions of him, and he became friendlier"

As requested on the note tacked to the shelter bulletin board, Patience called the doctor's office. The nurse said, 'There is something wrong with your medicals. We need to see you again.'" Patience pressed to know more. "When you come here it is quite confidential; we will let you know."

This is the moment where the trajectory of the HIV-positive applicant departs from that of the HIV-negative applicant.

An anxious week passed, and Patience presented for her second visit with the DMP. "I sat there with the doctor," she said. "We were the only ones in the room. He said, 'I have some bad news for you. Did you know that you were HIV-positive?'" She did not. Her mind raced and she wondered: What will the doctor do with the results? Who will know? Will it be possible for me to stay in Canada? Where will he send the record of my HIV-positive diagnosis?

Patience maintained her silence. This absence of talk draws attention to strategies that informants actively practice to influence medical visits with DMPs with the intention of engaging physicians on their terms. These strategies take several forms and might include talking when prompted; asking few questions; offering deliberate silence; and, responding to questions with short answers. One informant used both deliberative talk and silence in the moments after the DMP announced to him that he was living with HIV.

The first question was, 'do you have sex with men?' [The DMP] asked me if I was having sex with men in Canada. I said [to myself], Oh my God! He is inquiring to see if I am spreading this in Canada. When he asked me the question about my behaviour, whether I have sex with men, his indirect manner of coming to the point of me being HIV-positive, I knew, without a doubt, that I was HIV-positive. After that, I began asking questions of him, and he became friendlier. I began asking him about things in Canada. I said to him, 'so, what next?'

DMPs puzzle at the silence of some applicants living with HIV. They also ask whether the applicants might have known their HIV status. "There is a good number [of immigrant and refugee people] who are diagnosed at the moment of immigration. Sometimes I wonder if they knew before and just do not say so at their entrance to Canada," said a DMP. However, the directed talk and deliberative silence of applicants living with HIV are meaningful, and less mysterious, if seen as consequences of the social circumstances and relations embedded within the organization of the medical visit; the interests tied up in the work of the DMP; and, the stakes of receiving a problematic bill of health.

“We are the guys in the trenches”

DMPs emphasize that they are not decision-makers. “I am a fact finder; gathering information; giving it to a higher level that has a protocol to make a decision. We are the guys in the trenches,” said a DMP. However, despite their role in front line service and doctor’s positioning of themselves as low in the decision-making hierarchy, the DMP and her or his function should not be understated: these physicians are critical actors in the life of applicants to Canada precisely because they are the people who are responsible for detecting specific blood and lung conditions (and others at her or his discretion), and reporting these findings and their observations to government. On receiving DMP reports, medical officers employed at CIC proceed to anticipate how much the applicant is expected to cost the Canadian public purse. Hence the organizational ethos and intention that prevails in the workplace of the DMP is actually one of discovering costly conditions that will render the applicant ineligible for Canadian immigration.

“My work is with Immigration [CIC]; with Ottawa; the federal government, principally,” said a DMP. Applicants living with HIV cannot readily know that the physician actually serves state interests, not theirs. The relationship between themselves and the DMP is not a therapeutic one. The moment applicants with HIV might realize this is when they are told of their HIV status. Here, they might receive a referral to an HIV specialist with whom they are required by CIC to follow-up. Informants report feeling confused, conflicted, and experiencing anxiety through the IME process, which often consists of two visits to the same DMP. However, these feelings are not bewildering when understood to be coherent responses to the social relations of the IME and the allegiances of the practices associated with the DMPs work.

DMPs in Montreal and Toronto report that they have developed referral systems and are networked with facilities that specialize in care for people living with HIV. Informants with HIV generally report that the DMP provided them with the name and address of an HIV clinic or specialized department within a hospital with the recommendation to seek care there. Post-test care in Canada is shifted to specialist doctors and persons within the AIDS milieu. A lawyer advocate with a clientele of immigrant and refugee applicants living with HIV wrote to CIC to ask about the responsibility of counselling applicants because his clients generally did not receive this form of care. CIC responded,[54]

Based on these provisions [on post-test counselling, as per the DMP Handbook, 2003], it is clearly the DMP’s duty to provide HIV post-test counselling to

all HIV positive applicants and to sign the Post-Test Counselling form . . . the form should be signed by the DMP . . . We will also create a reminder to all DMPs on our website on this subject.

DMPs’ communication with CIC is irregular. “We have a protocol. If you do your work, you will not hear from CIC. I have very limited communication with CIC. We do our job, and that is it,” said DMP. The effectiveness of transmitting the above-noted message to DMPs via the CIC website is thus questionable.

“I eased his job. Or, maybe I made it more difficult”

Patience talked about her second visit to the DMP and what happened after she found out that she was living with HIV.

He gave me a piece of paper that I had to sign that stated that I acknowledged that I was HIV-positive; that I am aware that I am HIV-positive; and that I had been educated about the means of transmission. I had not been educated through this doctor. Probably he was going to give me that talk. I read through his paper, and agreed with everything it said. It said, ‘you cannot donate blood, protect yourself when engaging in sex, cannot give organs.’ That was the attempt at counselling. I eased his job. Or, maybe I made it more difficult.

Patience’s statement points to interface between bodily experience and institutional processes when a “piece of paper” enters into her experience. In outlining details of the immigration HIV testing program prior to its implementation in 2002, the then Minister of Immigration, Elinor Caplan, stated that counselling for HIV would be a part of service delivered to applicants, as per Canadian and international guidelines.[52] The “Acknowledgement of HIV Post-Test Counselling” form to which Patience refers is a standardized, one-page government document bearing a four-line text written in the first-person. In signing, the person agrees that she or he received counselling “on several topics” related to the “HIV-positive condition”.

When the applicant living with HIV receives this acknowledgement form, she or he has just received a diagnosis with HIV. Whether or not this is a first diagnosis (perhaps the person has tested HIV-positive in other circumstances), all applicants living with HIV describe diagnosis as instilling fear, loss, worry; concerns for bodily survival. An informant talked candidly about his thoughts in the wake of his HIV-positive diagnosis through Canadian immigration screening.

I kind of expected the results. I think that every gay man expects, or is ready, or assumes, you can get it. It was still really, really hard. It is so shocking.

About this acknowledgement form, a DMP said,

Immigration Canada asks us to fill out a form called “Acknowledgement of HIV Post-Test Counselling” form. This is in the [DMP] Handbook. This is to acknowledge that people have been counselled. I sign, and the client also has to sign. It is mandatory for us to do counselling. It is mandatory to submit this signed form to Immigration when we submit the [medical] file; the client acknowledges having received counselling.

However, there is a sharp and stark contradiction between informants’ bodily accounts of this acknowledgement form and how DMPs use it, what government does with it, and what the latter claims happens in relation to it. In practice, the form does not appear to be routinely integrated into the work practices of DMPs with an applicant living with HIV; few of the latter reported knowing about or putting their signature to this document. At the same time, the government frames the form as an important administrative and accountability tool. In the 2009 edition of the DMP Handbook this form was included “to at least have a control record that they were actually receiving post-counselling,” said a government advisor interviewed for this research. As part of their review work associated with medical files of HIV-positive applicants, CIC medical officers are said to ensure that this acknowledgement form is included in the submission. This is empirically unconfirmed because I did not have access to these medical officers.

Informants living with HIV indicate that DMPs do not do the work of education and counselling very well. For applicants to Canada, the DMP is the first face that they associate with Canadian health service and delivery. The two visits are similarly at odds with what people expect from a medical examination by a Canadian or by a person affiliated with the Canadian government. Informants are disappointed that they are not cared for in certain ways; surprised that the medical visits are short, that dialogue is limited, and that messages emphasize population health rather than their well-being. On the CIC website, applicants discover a DMPs name, contact details and languages spoken; choosing a doctor who either speaks their mother tongue or a language they speak well, and whose office is close to where they live. An informant whose first language is Spanish spoke about his choice of DMP.

The immigration office gave me a paper for the medical exam. They gave me a list of the number for the doctors. The list explain about who’s the doctor, what language he speaks. One doctor said ‘Spanish and Portuguese’, so I choose this doctor. When I went to the doctor, he didn’t speak Spanish. He spoke Portuguese. I said, ‘what happened’, and he tells me,

‘it’s the same language’. But, it was not the same. I didn’t understand what he was doing. He explained everything, but it was in Portuguese. Maybe I understood forty percent, but it was not enough.

“If you are starting off, it is likely an important tool”

While CIC has researched, updated and produced a DMP Handbook, and availed DMPs of successive editions, DMPs report not using this manual in their IME work activities. Rather, doctors mobilize their common sense working knowledge in encounters with applicants who test HIV-positive. About this manual a DMP said,

If you are starting off, it is likely an important tool. It encompasses everything a DMP should know about his job. Because I have been doing this for so long, there is not much that is enlightening.

Within this DMPs statement, another feature shaping the immigration medical visit comes to light: the physician’s formal education and current knowledge about HIV. Canadian DMPs are most often general practitioners, who generally have had four years of medical training and three years residency. Training might or might not have equipped the doctor with the skills to communicate information and care that people diagnosed with HIV need or might expect. An HIV specialist commented that his DMP colleagues were generally around or above retirement age, which directs attention to the timeline of the epidemic that appeared in the early 1980s in North America; HIV education would not have been part of formal medical education of Canadian DMPs of a certain age. While it is unreasonable to suggest that DMPs be specialists in care to people living with HIV, because Canada obliges applicants to submit to HIV testing, it is reasonable to expect that DMPs be both inclined and able deliver support to applicants after they deliver a positive HIV test result.

Conclusion

I have explored the social organization of routine processes associated with Canada’s mandatory HIV testing policy and scratched beneath the surface of official interpretations of what goes on for HIV-positive applicants through the IME. The production of a DMP Handbook is a text through which CIC references its “standards” as these are said to govern the IME and the work practices of the DMP.[3] In a presentation to the Association québécoise des avocats et avocates en droit de l’immigration (Quebec Immigration Lawyer’s Association), “providing appropriate counselling” was listed as one of the “five duties” of DMPs.[3] Public education and the public availability of the DMP Handbook promote

the notion that certain practices are happening during the IME; despite that empirical reports show that counselling, for example, is an exception rather than a rule. The notion that DMPs are informed about counselling conventions is also reinforced through this work. These are ideological positions that contribute to the work of the Canadian state that cultivates images of itself as a state receiving refugee persons motivated by its “humanitarian tradition” that rewards “legitimate refugees” with a “safe haven”, as per early 2011 statements by the current Minister of Immigration and Citizenship Canada, Jason Kenney.[54]

Vested in the IME are socially mediated interests that serve state rather than applicant interests. That there generally is no pre- and post-testing counselling after an HIV-positive diagnosis is not mysterious when the social relations embedded within the IME are investigated and opened up. If Canadian health providers are aware of these less overt features of the social organization of applicant (and their own) experience, they can in turn explicate to their client, with enlightened nuance, how things are socially organized to occur as they do.

Canadian nurses and other health providers who work with immigrant and refugee applicants with HIV are well positioned to identify irregularities in the conduct of the IME because they hear (and can query) details of their client's immigration processes. In the interest of their clients, health providers who are inclined toward activism, such as the lawyer advocate referenced in this article, can consider reporting such irregularities to CIC; the federal department responsible for ensuring that its own “standards” of care and service within the HIV testing program are met within the everyday activities and textual work practices of DMPs who test applicants for HIV in Canadian and overseas medical offices. The shortcomings highlighted and discussed in this article have serious and tangible implications for applicants who test HIV-positive. In making these lacunae visible and explaining how they are organized to happen in people's day-to-day work practices, it is my sincere hope that those who oversee immigration medical health screening improvements and state policy makers more broadly will use the contextualized understandings of people's everyday knowledge and experience presented here as a springboard for brining out improvements to the health-related service delivery to applicants to Canada who are diagnosed HIV-positive through the country's mandatory imposition of immigration HIV testing.

References

1. Goldstein D. *Once upon a virus: AIDS legends and vernacular risk perception*. Logan: Utah State University; 2004.
2. Jean Améry in Langer L. *Holocaust testimonies: The ruins of memory*. New Haven: Yale University Press; 1991.
3. Citizenship and Immigration Canada (2010, April 27). *Immigration medical assessment and inadmissibility under health grounds [Power Point Slides]*. Association québécoise des avocats et avocates en droit de l'immigration (Quebec Immigration Lawyer's Association). Montreal. On file with author.
4. Canadian HIV/AIDS Legal Network. *Canada's immigration policy as it affects people living with HIV/AIDS*. Toronto: Canadian HIV/AIDS Legal Network, 2011; 1-8.
5. Citizenship & Immigration Canada. *Operational processing instruction 2002-004. Medical assessment of HIV positive applicants*. Ottawa: Government of Canada, 2002; 1-7.
6. Citizenship and Immigration Canada (2011, January 12). *Citizenship and Immigration Canada HIV Policy: Background information [PowerPoint slides]*. On file with author.
7. Bisailon L. *Human rights consequences of mandatory HIV screening policy of newcomers to Canada*. *Health & Human Rights: An International Journal* 2010; 12(2): 119-134.
8. Yanow D. *Conducting interpretive policy analysis*. Thousand Oaks: Sage; 2000.
9. Citizenship and Immigration Canada (2010, July 5). *Access to Information and Privacy Division, Health Management Branch Database on HIV as of May 15, 2010 [in response to author's request for data on HIV-positive applicants to Canada]*.
10. Coyte P, Thavorn K. *When does an immigrant with HIV represent an excessive demand on Canadian health or social services?* *Aporia* 2010; 2(3): 6-17.
11. Citizenship and Immigration Canada (2008, May 12). *Access to Information and Privacy Division, Health Management Branch Database on HIV as of January 16, 2008 [in response to Michael Battista's request for data on HIV-positive applicants to Canada]*.
12. Zencovich M, Kennedy K, MacPherson D, Gushulak B. *Immigration medical screening and HIV infection in Canada*. *International Journal of STD and AIDS* 2006; 17: 813-816.
13. Bisailon L. *Refugee plus support project*. Network 2008;

10(2): 25-26.

14. Bisailon L. Working from within endemic HIV stigma: Developing Canadian social workers' understanding of the challenges faced by newcomers managing HIV. *Canadian Social Work* 2010; 12(1): 32-44. A

15. Duchesneau C. Lessons learned in working with HIV/AIDS African refugees and illegal immigrants in an out-patient hospital setting. *Intervention* 2004; 120: 47-53.

16. Fassin D, Rechtman R. *The empire of trauma: An inquiry into the condition of victimhood*. Princeton and Oxford: Princeton University Press; 2009.

17. Treichler P. *How to have a theory in an epidemic: Cultural chronicles of AIDS*. Durham: Duke University Press; 1999.

18. Walby C. *AIDS and the body politic: Biomedicine and sexual difference*. London: Routledge; 1996.

19. Young A. A description of how ideology shapes knowledge of a mental disorder (posttraumatic stress disorder). In: Lindenbaum S, Lock M, editors. *Knowledge, power, and practice: The anthropology of medicine and everyday life*. Berkeley: University of California Press; 1993. p. 108-128.

20. Bieh J. Technologies of invisibility. In: Xavier Inda J. editor. *Anthropologies of modernity: Foucault, governmentality, and life politics*. West Sussex: Blackwell Publishing; 2005. 248-271.

21. Biehl J, Moran-Thomas A. Symptom: Subjectivities, social ills, technologies. *Annual Review of Anthropology* 2009; 38: 267-288.

22. Farmer P, Kleinman A. AIDS and human suffering. In: Brown P. *Understanding and applying medical anthropology*. Mountain View: Mayfield Publishing; 1998. p. 333-342.

23. Lock, M, Nguyen VK. *An anthropology of biomedicine*. West Sussex: Wiley-Blackwell; 2010.

24. Nguyen VK, Peschard K. Anthropology, inequality, and disease: A review. *Annual Review of Anthropology* 2003; 32: 447-474.

25. Scheper-Hughes N. *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press; 1992.

26. Smith G. Political activist as ethnographer. *Social Problems* 1990; 37(4): 629-648.

27. Smith D. *The conceptual practices of power. A feminist sociology of knowledge*. Toronto: University of Toronto Press; 1990.

28. Smith D. (Ed.). *Institutional ethnography as practice*. Oxford: Rowman & Littlefield; 2006.

29. Campbell M. Institutional ethnography. In: Bourgeault I, Dingwall R, de Vrier R, editors. *The Sage handbook of qualitative methods in health research*. Los Angeles: Sage; 2010. p. 497-512.

30. Campbell M, Manicom A, editors. *Knowledge, experience, and ruling relations: Studies in the social organization of knowledge*. Toronto: University of Toronto Press; 1995.

31. Frampton C, Kinsman G, Thompson A, Tilleczeck K, editors. *Sociology for changing the world: Social movements/social research*. Black Point: Fernwood Press; 2006.

32. Barrett R. *The psychiatric team and the social definition of schizophrenia: An anthropological study of person and illness*. Cambridge: University of Cambridge Press; 1996.

33. Fassin D. Le sens de la santé. *Anthropologie des politiques de la vie (The Meaning of health. An anthropology of the politics of life; my translation)*. In: Saillant F, Genest S, editors. *Anthropologie médicale: Ancrages locaux, défis globaux (Medical anthropology: Local ties, global challenges; my translation)* Québec: Presse Université Laval, 2005; p. 283-389.

34. Scheper-Hughes N. The primacy of the ethical: Propositions for a militant anthropology. *Current Anthropology* 1995; 36(3): 409-440.

35. Mykhalovskiy E, McCoy L. Troubling ruling discourses of health: Using institutional ethnography in community-based research. *Critical Public Health* 2002; 12(1): 17-37.

36. Smith D. *Feminism and Marxism: A place to begin. A way to go*. Vancouver: New Star Books, 1977.

37. Smith D. Sociology from women's experience: A reaffirmation. *Sociological Theory* 1992; 10(1): 88-98.

38. Carroll W. Marx's method and the contributions of institutional ethnography. In: Frampton C, Kinsman G, Thompson A, Tilleczeck K, editors. *Sociology for changing the world: Social movements/social research*. Black Point: Fernwood Press, 2006; p. 232-245.

39. Marx K, Engels F. *The German Ideology, Part One*. Arthur C, editor. New York: International Publishers, 1846, 1970.

40. Orsini M, Scala F. "Every virus tells a story": Toward a narrative-centered approach to health policy. *Policy and Society* 2006; 25(2): 125-150.

41. Diamond T. *Making grey gold: Narratives of nursing home*

care. Chicago: University of Chicago Press, 1992.

42. Beagan B, Ells C. Values that matter, barriers that interfere: The struggle of Canadian nurses to enact their values. *Canadian Journal of Nursing Research* 2009; 41(1): 86-107.

43. Rankin J, Campbell M. *Managing to nurse: Inside Canada's health care reform*. Toronto: University of Toronto Press, 2006.

44. Anderson J. Looking back, looking forward: Conceptual and methodological trends in nursing research in Canada over the past decade. *Canadian Journal of Nursing Research* 2009; 41(1): 47-55.

45. Smith D. *The everyday world as problematic: A feminist sociology*. Toronto: University of Toronto Press, 1987.

46. Smith D. *Institutional ethnography. A sociology for people*. Oxford: AltaMira Press, 2005.

47. Immigration and Refugee Protection Act, c 27, 2001. Ottawa: Department of Justice Canada, Available from URL <http://laws.justice.gc.ca/eng/l-2.5/page-1.html>. Accessed 12 September 2011.

48. Immigration and Refugee Protection Regulations, SOR/2002-227, as amended by 29 Aug 2011. Ottawa: Department of Justice Canada. Available from URL <http://laws.justice.gc.ca/eng/SOR-2002-227/index.html>. Accessed 12 September 2011.

49. Minister of Public Works and Government Services Canada. *Handbook for designated medical practitioners*, 2009. Ottawa: Health Management Branch, Citizenship and Immigration Canada. Available from URL <http://www.cic.gc.ca/English/pdf/pub/dmp-handbook2009.pdf>. Accessed 12 September 2011.

50. Minister of Public Works and Government Services Canada. *Designated medical practitioner handbook*, 2003. Ottawa: Medical Services Branch, Citizenship and Immigration Canada. Available from URL <http://cndstyle.com/files/handbook.pdf>. Accessed 12 September 2011.

51. Minister of Public Works and Government Services Canada (1992). *Designated medical practitioners' handbook*. Ottawa: Immigration and Overseas Health Services.

52. Klein A. *HIV/AIDS and immigration: Final report*. Toronto: Canadian HIV/AIDS Legal Network, 2000. Available from URL <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=853>. Accessed 12 September 2011.

53. Canadian HIV/AIDS Legal Network. *Consent to HIV testing*. Toronto: Canadian HIV/AIDS Legal Network, 2007;

9-12.

54. Citizenship and Immigration Canada. *HIV post-test counselling*. Personal communication [in response to David Thompson's request for information about official procedures relating to HIV-post test counselling for HIV, 2009]; on file with author.

55. Citizenship and Immigration Canada. *Canada welcomes highest number of legal immigrants in 50 Years while taking action to maintain the integrity of Canada's immigration system*. Marketwire. 2011 Feb 13. Available from URL <http://www.marketwire.com/press-release/Canada-Welcomes-Highest-Number-Legal-Immigrants-50-Years-While-Taking-Action-Maintain-1394803.htm>. Accessed 12 September 2011.

Acknowledgements

I thank the informants who participated in this research. I also thank two anonymous reviewers for their constructive commentaries on this article.

Funding

I disclose receipt of the following financial support for the research of this article: Canadian Institutes of Health Research [grant number 200810IDR-198192-172991]; les Fonds de la recherche en santé du Québec [grant number 16588]; and, Ontario Metropolis Centre [2009 Graduate Student Award].

Contact Information for Author:

*Laura Bisailon, Ph.D.(c)
University of Ottawa
Institute of Population Health
1 Stewart Street
Ottawa, Ontario, K1N6N5
Canada
Email: lbisa082@uottawa.ca*