Pathos, AIDS, and Public Policy: An Analysis of The Canadian Strategy on HIV/AIDS: Moving Forward Together

Joyce Parsons
University of Waterloo

Le gouvernement fédéral canadien insiste sur le caractère inclusif des consultations qu'il a menées pour la préparation de son document, La stratégie canadienne sur le VIH/sida : ensemble nous irons plus loin. Toutefois, la base épidémiologique sur laquelle repose ce texte a comme effet inévitable de présenter les personnes atteintes du VIH ou du sida comme étant « différentes » de la population générale. Les connotations négatives associées au VIH/sida depuis les années 80 rendent une telle « différence » inacceptable auprès du grand public. Donc, au lieu d'intégrer le VIH et le SIDA dans une politique générale de santé publique, la stratégie fédérale finit par créer une distance entre la population générale, d'une part, et la maladie et les personnes qui en sont atteintes, d'autre part. Par conséquent, elle contribue à l'aliénation des personnes atteintes du VIH/sida, tout en permettant au grand public de se considérer à l'écart des effets de la maladie.

Thomas Yingling, in his "AIDS in America: Postmodern Governance, Identity, and Experience," says that the amount of information published about AIDS induces "a vertigo that recalls Kant's category of the mathematical sublime: an overwhelming series of numbers and/or sheer magnitude of information defeats comprehension and induces an abysmal intellectual and epistemological encounter that we mark as the sublime" (1991, 291). In the nearly ten years since Yingling made this observation, the proliferation of material has only continued. Grass-roots organizations have continued to help HIV/AIDS sufferers cope with the disease, have fought consistently for governmentally funded research, and demanded human rights; cultural theorists have struggled with the ways in which the disease has been represented; research scientists have discussed various etiologies for AIDS, its viral and clinical components, tracked its progress, and suggested new treatments; governments have reflected upon what policies would facilitate responsible research, how to coordinate their efforts with those of various interest groups, and on how to contain this epidemic. All of these groups have written proposals, critiques, analyses, and policies at each stage of this continuing complex disease. This complicated mix has created an intricate web, weaving together scientific expertise with pre-existing, emotionally charged metaphors and the experience of AIDS sufferers. When developing public policy on HIV/AIDS, governments must address the scientific data, the experience of those directly affected by the disease and the societal values that have been attached to it. This analysis focuses on the Canadian government's most recent response to HIV/AIDS and investigates the ways in which the Canadian political community informs itself about medical/social issues, how this information is translated into policy documents, and how such policy impacts upon different groups in Canadian society.

A Brief History of Canadian Federal Governmental Strategies on AIDS

If we are to locate the present government in the position of rhetor and define the groups that constitute its audience, in relation to *The Canadian Strategy on HIV/AIDS: Moving Forward Together* of 1998, it is necessary to look at the disease's history in Canada and past government initiatives regarding it. This history recognizes that the audience does not receive policy "in a vacuum," but has already established beliefs concerning HIV/AIDS. It also realizes that the rhetor needs to be aware of these beliefs if s/he hopes to appeal to the audience's emotions. Likewise, to understand these concepts is to acknowledge that there is a timeliness or *kairos* to the release of any political policy.

Although the first case of AIDS in Canada was documented in January 1982, the 1981 rash of outbreaks in San Francisco and New York City had already led to its being linked to homosexual men. It soon became evident that hemophiliacs, intravenous drug users, and blood transfusion recipients were also contracting this frightening and deadly disease. In Canada, gays and recent Haitian immigrants were readily identified as carriers and transmitters of AIDS. Previous social discourses surrounding homosexuality, and the disease's continued prevalence in gay men, spawned discourses that enabled the disease to be linked to the corrupt. Anyone who contracted the disease was seen as not only physically, but morally, contagious.

Early arguments speculated that all affected groups had "like male homosexuals been exposed to frequent immunostimulatory doses of foreign proteins and tissue antigens" (Essex, 1997, p. 3). Essex's and many other researcher's concentration on gays allowed these speculations to further link the moral discourses which surrounded gay men to all other infected groups. Researchers had few answers, although they searched diligently for the causes of what came to be known as Acquired Immunodeficiency Syndrome. Continued investigation led to the isolation of HIV-1 and, consequently, the finding that infection with HIV "induces an insidious, progressive loss of immune system function, which ultimately results in the opportunistic infections and malignancies" (Saag, 1997, p. 203).

While researchers in virology, immunology and epidemiology contributed the necessary information to make advances in understanding what caused the disease and how it spread within an individual, they also facilitated an understanding of how it infected the social order. Epidemiology, especially, associated AIDS with particular groups in society, taking "the models of immunocompetence and immunocompromise up one more level of scale, using them as a basis for distinctions between degrees of infectious risk associated with different sexual identities, considered as homogeneous 'sub-populations'" (Waldby, 1996, p. 59). While the epidemiological studies provide the tools to track and predict who would be affected, they paradoxically also labelled those groups. In the early/mid-years of the disease, this labelling enabled all infected groups to be marginalized and tagged as physical and moral degenerates.

The media gave little information beyond the number of deaths and the segments of the population who appeared to contract the mysterious disease. But often, fuelled by the horrific suffering of those infected, the media's words and images presented the disease and its carriers as things to be feared. And the media's coverage lacked consistency. AIDS cropped up on the news when some well known celebrity died or when a particularly pathetic case (of a wife, a child, or some other "innocent" victim) was diagnosed. The disease itself was not necessarily a news story after its first appearance. So while mystery, panic, and ostracism of the identified carriers marked the early months and years after the first cases were reported, much of the research went unreported. The sufferers were shoved to the background of the public imagination.

In Canada, as in much of the world, the rapidly forming and multiple AIDS grass-roots organizations lobbied for political funding for research and tried to dispel the myths that particular sexual orientations were pathological. Peter Aggleton, Jeffrey Weeks and Austin Taylor-Laybourn state, in relation to Britain, that these

> voluntary agencies ... had a central role to play in responding to HIV and AIDS — in shaping attitudes ... and in servicing the needs of people directly affected by the epidemic. Their activities have included fundraising,

> campaigning to raise public awareness of issues relating to the epidemic, health promotion, the provision of information services and support networks, political lobbying, casework and service delivery. (1993, p. 131)

They have served, in many cases, to personalize the disease, forcing general populations to realize that AIDS sufferers are human beings who deserve respect, care and support from governing bodies.

Initially, the Canadian government through Health Canada "supported a variety of research, surveillance and community development activities" (Health Canada, 1998b, p. 2), a sort of wartime-measures approach to the disease. As knowledge and numbers of infected increased, the Canadian government recognized that this crisis needed a more proactive type of management. In 1990, Health Canada responded by launching Phase I of the National AIDS Strategy. This was followed, three years later, by Phase II. According to Health Canada, these programs "enabled a wide spectrum of activities and initiatives to be undertaken" and "provided a vehicle and framework for federal leadership on this new and complex challenge to the health of Canadians" (Health Canada, 1998b, p. 2). According to the Canadian AIDS Society (CAS)1, these efforts, while producing valuable information, were "hampered by the absence of secure, sustained funding, poor federal leadership and a lack of clarity on research priorities" (CAS, 1997d, p. 20). The Canadian Association for HIV Research (CAHR) concurred. In its report, *AIDS Research in Canada*, the organization states that "funding ... has more or less remained static for the last 7 years" (CAHR, 1997, p. 2), "money from within Health Canada has been directed through contract or contribution toward specific projects" making it difficult to assess as to how "the aims of the[se] studies relate back to the National AIDS Strategy"(CAHR, 1997, p. 3). The absence of peer reviewed investigations result in their impact being "very difficult to measure since the nature of the funded work may be unknown to many interested Canadians" (CAHR, 1997, p. 2).

In spite of such opposing viewpoints, there were advances in knowledge, treatment, and care. By January 1991, the Canadian HIV Trials Network (CTN) had opened its doors to administer and store data generated by its clinical trials. Its base was and continues to be medical/scientific but its board includes members of the AIDS community who "advise on priorities, needs, and concerns of HIV positive Canadians as they relate to clinical trials" (CTN, 1998, p. 4). Government interest has focused on searching for effective therapies and vaccines and promoting education in all segments of the Canadian population. Needle exchange programs have been initiated to reduce the risk of transmission in intravenous drug users; and community AIDS agencies have been funded.

Research, education and grass-roots community efforts seem to have paid off; progress has been made against the disease. As present federal Health Minister, Allan Rock[2] states in *The Canadian Strategy on HIV/AIDS: Moving Forward Together*, "thanks to better treatment, there were 33% fewer AIDS cases in 1996 than in 1995, and 36% fewer deaths related to HIV" (1998a, p. 4). This congratulatory statement recognizes that improved antiretroviral treatments and drug prophylaxis have provided hope for patients, although it fails to mention that these new treatments only delay the onset of the clinical presentations which define AIDS. Simultaneously, the statement alludes to the success of education efforts by all involved agencies, encouraging them to keep up their efforts. But Rock's statement does little to dispel the prejudices that the general population may feel toward the HIV/AIDS patient. Indeed, as the statement continues, "gay men and people infected through the blood supply" (1998a, p. 4) are selected for attention. This may be an attempt to alleviate the fears of Canadians who realize that HIV/AIDS has been increasingly diagnosed in women, men who identify as heterosexual, and children born to HIV positive mothers. If this is the case, the government is enabling the public to deny its susceptibility and is providing a false sense of security. While this type of statement may be applauded by those who want to believe in their own immortality, it can seriously damage the government's credibility with those who accept that HIV/AIDS respects no boundaries.

The consultation process which preceded the formation of the federal government's third phase of their strategy on AIDS acknowledges the extensive contributions of the AIDS-communities in all areas concerning the disease. This move can be seen as a positive and progressive step. Dennis Altman suggests that in consulting those most affected by the disease, the government "preserve[s] the autonomy of the individual, and protect[s] against discrimination to which the rest of us might be blind," and avails itself of the "knowledge ... and the cooperation of those to whom the policy is directed" (1993, p. 4). The process legitimizes experience as a site of knowledge. But, as Altman recognizes, this issue is somewhat troubled.

The government's document claims that the "Canadian Strategy is a result of extensive and unprecedented consultations ... in communities all across the country," and that "it builds on the advice and guidance we heard from those Canadians who know HIV/AIDS best" (Health Canada, 1998a, p. 1). These Canadians included such groups as the Canadian Aids Society (CAS), the Canadian Public Health Association (CPHA), the Canadian Hemophilia Society (CHS), the Canadian Foundation for AIDS Research (CANFAR), the Canadian Association for HIV Research (CAHR), business enterprises and various federal and provincial government departments — a long and seemingly inclusive list. Interestingly, it is difficult to discover any individual's contribution to the consultation process, suggesting that the government might not have been as interested in legitimating individual experience as their claims indicate.

Most of the named organizations submitted proposals that endorse such ideals as a simplified infrastructure with strong political leadership, cooperation and collaboration between different agencies, emphasis on the continuing importance and involvement of community-based AIDS organizations, and flexibility in approach and research toward the disease as it changes. Separately, different respondents reflected the particular concerns of their constituencies. For instance, CAS supports community action, education and prevention, research, treatment, care and support for all AIDS affected people — emphasizing special communities such as Aboriginals, inmates, women and youth. The CPHA provides national leadership and helps deliver public health policies that focus on prevention and care of those infected with AIDS. The CHS concerns itself with the safety of the blood supply, HIV transmission among women and teens, and supports care and treatment of both HIV/AIDS patients and their families. Finally, both CANFAR and CAHR are concerned about raising money for HIV/AIDS research and ensuring that research is conducted in a systematic way, safeguarding accountability, applicability to the national AIDS strategy, and acceptability to the national and international research communities. In both their particular concerns and general proposals, these organizations present the desire that the different groups afflicted with HIV/AIDS are treated respectfully, compassionately, and as members of the larger society.

As unified as their desires might be, the different emphases of their particular positions generate some tensions. One such problem arises between, on the one hand, the two research groups, CAHR and CANFAR, and on the other, CAS. While they agree on supporting research, CAHR and CANFAR stress the importance of funding research so as to facilitate communication between researchers and other communities. Further, CAHR suggests "Training and Career Awards" and "Legacy Funding". These programs promote "funding PhD students, post-doctoral fellows and scholars" and "creat[ing] new AIDS Research Chairs in Canadian Universities" (CAHR, 1997, p. 1). The suggested training awards are to be directed toward community-based researchers "who have demonstrated expertise in the development of targeted intervention or evaluation research" (1997, p. 2). While this incentive recognizes that there is valuable research being conducted outside universities and research institutes, it also exhibits a condescending attitude toward researchers who are not so affiliated. CAHR promotes the expertise of science as it is practiced within established research sites. This stance is vehemently opposed to CAS's position. In their proposal, they state that "community-based research efforts are hampered by limited resources and do not receive the same priority as those accorded to researcher[s] in academic settings" (CAS, 1997d, p. 21). They propose that this practice change saying, "community-based researchers and research projects must receive the same financial support and recognition as those based in academic settings" (1997d, p. 22).

This tension between the priorities set by research concerns and those of a group who represents community-based action exemplify the dispute surrounding who may be considered an expert on HIV/AIDS. As Dennis Altman says, about the organization of a conference on "AIDS in Asia and the Pacific,"

> community-based organizations ... have argued for a conference where the voices of the infected and of those groups most directly affected by the epidemic are heard. GPA (World Health Organization's Global Program on AIDS) on the other hand has been insistent on the need for a "scientific" conference, thus reinforcing the idea that "expertise" and "science" are synonymous, and that academic knowledge is always superior to the experiential. (1993, p. 1)

Canadian Conceptions of HIV/AIDS Analysis

The Canadian Strategy on HIV/AIDS demonstrates the federal government's political acumen and assessment of the two major components of their audience, those who are infected and the general population. The policy was announced on December 1, 1997, World AIDS Day, at the 519 Church Street Community Centre in Toronto, marking the government's recognition that AIDS is a global issue and the government's respect for the contributions of community-based organizations. Its content embraces most of the measures suggested by the interest groups involved in the consultative process. In addition, based on the attitudes revealed in the CAS survey, the government assumes that the general population will regard the policies as reasonable, will applaud the government for continuing its support and funding for HIV/AIDS, and will appreciate having HIV/AIDS made somewhat irrelevant to them. While the *Strategy* makes some attempt to persuade the public that HIV/AIDS does involve them, the government's cautiousness dilutes the impact that it could have had. The concentration on risk groups in the document authorizes the general public's denial that this disease has a direct association with them and continues to marginalize the identified groups.

The HIV/AIDS communities can be encouraged by the contents of this document. It embraces most of their recommendations, allowing them to believe that their experience has been valued and acted upon, and that they have achieved more political potency than they had before the consultation process. Thus, the government is perceived as an ally or friend; according to Aristotle, we incline toward those "who desire the same things as we desire" (*Rhetoric* 1381^b). The contents of the *Strategy* allow for the continued building of friendly relations.

Throughout the first part of the document, it is evident that the government understands these communities' concerns and appreciates their hard work. In a "Message from the Minister," attached to The *Strategy*, Allan Rock states that the government's approach "builds on the advice and guidance we heard from those Canadians who know HIV/AIDS best," offers his "sincere thanks to those who made the new Strategy richer and more relevant by their contributions" and expresses "that together we are wiser and stronger" (1998a, p. 1). This recognition consciously acknowledges the value of the contributors, includes them in a larger community and disposes them to think well of the *Strategy* and its creators — the government, themselves and each other. The document's continued stress on the identified risk groups and its focus on implementing measures which will ensure care, minimize "the adverse impact of HIV/AIDS on individuals and communities" (Health Canada, 1998a, p. 5) and mitigate the social and economic factors which affect HIV/AIDS sufferers, illustrate the government's sincere attempts to address the problems their collaborators identified.

The government's commitment to an ongoing strategy ensures flexibility and promises that funding difficulties between phases will cease to be a problem. Again, the government has listened; stakeholders can forgive any past budgetary lapses and look toward a future with more certainty, confidence, and hope. HIV/AIDS communities are encouraged to feel good about themselves, their government, and the future promised by the *Strategy*.

While most of the document addresses the concerns of the HIV/AIDS communities, there is an effort to appeal to the general population on the basis of a shared common value. Both the government and the consultation contributors have exhibited their concern for the well-being of their fellow Canadians, now the general public is invited to share in this good will. As Rock says, "Canada is a caring society. This is a national quality of which Canadians can be proud" (Health Canada, 1998a, p. 1) and "as a nation we are proud of our health care system's universality and wish to sustain it" (Health Canada, 1998a, p. 9). These appeals speak to our beliefs about virtue and to our national ideologies. If we endorse this policy we can regard ourselves as good people and Canadians; if we fail to do so, we may fall into the category of selfishness or fall short of a national trait.

Aristotle explains that there is a temporal dimension to emotion. As he puts it, the intensity of any felt emotion is greater when related events are "imminent: we do not fear things that are a very long way off: for instance, we all know we shall die, but we are not troubled thereby, because death is not close at hand". (*Rhetoric* 1382^a). The federal government tentatively tries to decrease the temporal distance between HIV/AIDS and the mainstream population and to discuss the fact that its members are not immune to the disease. They mention that "the disease respects no boundaries and discriminates against no one" (Health Canada, 1998a, p. 5), "every day approximately 11 Canadians become infected with HIV"(Health Canada, 1998a, 4) and "more new cases of AIDS will be diagnosed in the last five years of this century than were diagnosed during the first fifteen years of the epidemic" (Health Canada, 1998a, 3). While these statements are based on solid epidemiological predictions, they function emotionally to make the disease more imminent to the general population.

Interestingly, placed at the *Strategy*'s conclusion, there is a "call to arms" for all Canadians. In an effort to create some identification between the public and the groups that have been discussed for 16 pages, Rock states

> It's everyone's responsibility as individuals, citizens or members of an organization, to help contain and prevent the further spread of HIV/AIDS. The bulk of the work lies ahead of us. We must work together if we are to make progress (Health Canada, 1998a, p. 16).

This appeal is too little, too late. If the government had really desired to create an identification with the HIV/AIDS infected, it should have made a concentrated effort throughout the document. But Rock realized that this is not what the Canadian public wanted to hear. There might be a "high political cost" (CAS, 1997b, p. 3) if the government pushed identification too far.

These tentative appeals to national values and to the relevancy of HIV/AIDS to the general public are overshadowed by most of the document. There is an almost constant separation between the "healthy" population and those at risk. The categories "gay men, ... injection drug users, Aboriginal Peoples, gay youth, socially and economically vulnerable women" (Health Canada, 1998a, p. 7) are repeatedly used to talk about the people who are most concerned with this policy and with the disease. These categorizations preclude ready identification between the average healthy Canadian and the people discussed in the document. William A. Covino suggests that "persuasion can only take place within a community — that is, among people who already see themselves as sharing certain premises, beliefs, goals, needs, desires, histories, some margin of overlap" (1998, p. 78). I propose that the distinction made between healthy and afflicted is compounded by the moral separation which previous discourses have encouraged, making it almost impossible for the general population to identify on any level but an impersonal one with HIV/AIDS sufferers. *The Strategy* encourages the general population to view those infected, or likely to become infected, as "Others."

The disease is represented throughout the document as a continuing problem that needs to be controlled. Easier said than done: AIDS is complex, ever-changing and can remain hidden for years. Those infected may exhibit "no symptoms for a period exceeding ten years" (Health Canada, 1998a, p. 4). Its mysterious nature still causes fear and "there is stigma, ... ostracism" (Health Canada, 1998a, p. 12) and "discrimination" (Health Canada, 1998a, p. 13) associated with it. HIV/AIDS is figured as needing expanding surveillance. Although education and research have provided information about HIV/AIDS, it is still surrounded with many of the associations that it gathered during the first years of the epidemic. The government's new *Strategy* does little to dispel these prejudices. It is not surprising that Canadians wish to deny that the disease might affect them and allow the government to manage it for them.

The document discusses HIV/AIDS almost exclusively in terms of risk groups and high-risk behaviours as defined by epidemiology. But, according to Waldby, "in AIDS epidemiology the term 'general population' is habitually used as a synonym for the 'public health,' as an entity which its knowledge is dedicated to protect" (1996, p. 84). Epidemiology protects by surveillance — identifying, tracking and reporting on those who are affected by the disease to those whose mandate it is to protect the public. Thus, risk groups are separated from the general population and targeted as those who need special attention, education and further monitoring. The *Strategy*'s repetition of each risk group emphasizes the separation between them and the general population, excluding them from participating in "mainstream" society. Ironically, epidemiology generally and this document specifically concentrate attention on HIV/AIDS sufferers but, also segregate them, further marginalizing them from the society to which they belong.

Responses to the Strategy

The general population's response to HIV/AIDS is reflected in the ringing absence of its voice. There have been few comments on the Canadian government's new strategy on HIV/AIDS from the public sector. As Covino puts it, "silence says something about the emotional state, or *pathos*, of the audience" (1998, p. 68). The quiet response from the Canadian public reflects either their indifference toward the whole issue or "a kind of deference" (1998, p. 69) toward the government's comprehensive knowledge, ability and elaboration of a complex issue.

One public voice focuses on an overly optimistic view of current HIV infection rates. A June 26, 1998 editorial in *The Globe and Mail* states that "the HIV/AIDS epidemic ... has passed its peak in rich, industrialized countries such as Canada." This remark is doubly troublesome. It gives false information, reflecting an ignorance of the rising rates of infection and it transmits this to readers. This editorial, a reply not to the government's *Strategy* but to an announcement made on the eve of the 12th International AIDS conference, may encourage the general public to congratulate the government on its successful strategies; they may assume that the disease is no longer an important health issue in Canada.

The Canadian HIV/AIDS Legal Network takes the government's new HIV/AIDS *Strategy* to task on behalf of one of the *Strategy*'s targeted groups, inmates of correctional facilities. The *Strategy* states that there will be an "implementation of a national methadone maintenance treatment program in federal penitentiaries" (Health Canada, 1998a, p. 16). On December 1, 1997, the Correctional Service of Canada announced this program. But the Legal Network terms this "woefully inadequate" (1997/98, p. 1) and states that it is a reiteration of a three-and-one-half-year-old promise. As well, the "greater efforts to promote widespread HIV testing in federal penitentiaries" (Health Canada, 1998a, p. 16) is challenged because it actually is a "piloted [project] in one designated federal correctional instillation" (Legal Network, 1997/98, p. 1). These co-opted and narrow moves hardly fit the profile of proactive, extensive measures which the government promised.

The Canadian AIDS Society has given the *Strategy* a mixed review. On one hand, it applauds the Health Minister's efforts to address the majority of stakeholders' recommendations and the decision to renew the *Strategy* on an ongoing basis, rather than in five-year allotments. On the other hand, it is disappointed that the budget has not been increased over the 1996/97 levels and complains about the difficulty of moving "forward on a more comprehensive approach to HIV/AIDS within a static budget" (CAS, 1997c, p. 1). CAS condemns the government's drug approval program, administered through the Health Protection Branch (HPB), because of long delays in the approval process. Currently, there are five life-sustaining drugs, available in other countries, of which Canadians are being deprived. Their proposal had recommended that all research funding for epidemiology be distributed through an existing peer review agency rather than through HPB, but this recommendation has not been followed.

CAS also complains that the government paid little attention to recommendations concerning Aboriginal communities. The consultation process indicated that HIV/AIDS was a greater problem in off-reserve populations than in on-reserve ones. But the government is proposing to give the majority of funding for Aboriginal populations to the Medical Services Branch whose mandate is "to serve on-reserve Aboriginal populations" (CAS, 1997c, p. 1).

In short, as CAS states in one of its Advocacy Reports,

> overall, stakeholders felt that Health Canada had protected and increased their own internal funding while ... reducing those funds in Phase III that go to support work outside of government. This contradicts the rebalancing of priorities ... recommended by the stakeholders (CAS, 1997c, p. 3).

It is perhaps little wonder if CAS feels that its experience is devalued in favour of governmental self-interest and recognized scientific communities. This rebalancing failure slights the community-based recommendations and reduces the "friendly feelings" toward the government that had been previously engendered by the consultation process and the *Strategy*'s contents. CAS is restricted to retaliating through loud and frequent criticism of the government's actions.

Conclusion

The new *Canadian Strategy on AIDS: moving forward together* succeeds in making most Canadians feel good about themselves, their country and their federal government. But, in times when infection rates are expected to rise, it is not enough to feel good; more directed and specific actions need to be taken, and the disease must be figured so that the Canadian public feels that it does impact upon them. The responsibility for managing this disease falls to many government departments, scientific communities, and community-based activist organizations. The *Strategy* errs in failing to point out strongly that HIV infections are rising in groups that are considered to be the general population. Its emphasis on risk groups is not enough; this tactic allows Canadians to avoid confronting the disease on a personal, emotional basis. Thus, the federal government abdicates much of its responsibility to the public health.

Notes

1 The nature of the sources for this article are such that abbreviations are unavoidable. I define them upon the first instance, and strategically thereafter, but since a legend might be convenient to readers, I offer one here:

CAS	Canadian AIDS Society
CAHR	The Canadian Association for HIV Research
CTN	Canadian HIV Trials Network
CPHA	Canadian Public Health Association
CHS	Canadian Hemophilia Society
CANFAR	The Canadian Foundation for AIDS Research
GPA	(World Health Organization's) Global Program on AIDS
HPB	(Canadian government's) Health Protection Branch

2 As the minister responsible for the production of *The Canadian Strategy on HIV/AIDS: Moving Forward Together*, Allan Rock is most often referred to as its author. This assumption does not deny the many different voices contained within the document and the

various positions represented in it. The document exemplifies Bakhtin's notion of polyphony, not just because of the many anonymous policy writers who likely contributed to it, but because of the very many experts, analysts, victims, politicians and citizens whose concerns it variously encodes; The *Strategy* does not, nor should we expect it to, present an entirely resolved or harmonious viewpoint on HIV/AIDS and the disease's importance to the Canadian population.

References

Aggleton, P., Weeks, J., & Taylor-Laybourn, A. (1993). Voluntary sector responses to HIV and AIDS: a framework for analysis. In P. Aggleton, P. Davies & G. Hart (Ed.), AIDS*: facing the second decade* (pp. 131–40). London: Falmer Press.

Altman, D. (1993). Expertise, legitimacy and the centrality of community. In P. Aggleton, P. Davies & G. Hart (Ed.), *AIDS: facing the second decade* (pp. 1–2). London: Falmer Press.

Aristotle. *Rhetoric.* (1954). Rhys Roberts, Trans. New York: Modern Library.

Canadian AIDS Society. (1997a). Countdown to October 17. *Advocacy reports* [Online]. <www.cdnaids.ca/1-4-4-2e.html>

Canadian AIDS Society. (1997b). Key messages from public opinion research results. *Advocacy reports* [Online]. <www.cdnaids.ca/1-4-3-2e.html>

Canadian AIDS Society. (1997c). Minister makes comprehensive announcement on new Canadian HIV/AIDS strategy. *Advocacy reports* [Online]. <www.cdnaids.ca/1-4-3-10e.html>

Canadian AIDS Society. (1997d). *National AIDS strategy phase III: Critical components, draft for discussion* [Online]. <www.cdnaids.ca>

Canadian AIDS Society. (1997e). National AIDS Strategy Phase III: Your Questions Answered! *Advocacy reports* [Online]. <www.cdnaids.ca/1-4-3-5e.html>

Canadian Association for HIV Research. (1997). *AIDS research in Canada* [Online]. <www.hc-sc.gc.ca/hppb/nhrdp_OLD/resources/aids_research/aids_research>

Canadian HIV/AIDS legal network. (Winter 1997/98). Prisoners and HIV/AIDS methadone, but no needle exchange pilot in federal prisons. *Canadian HIV/ AIDS policy and law newsletter vol. 3, no. 4 & vol. 4, no 1* [Online]. <www.aidslaw.ca/elements/news03040401/21CSCE.html>

Canadian HIV trials network. (1998). *What is the Canadian HIV trials network*? [Online]. <www.hivnet.ubc.ca/BackgroundFrame.html>

Canadian Public Health Association. (1997). HIV/AIDS [Online]. <www.cpha.ca/National.Activities/Advocacy.eng>

Covino, William A. (1998). *The elements of persuasion.* Boston: Allyn & Bacon.

Essex, Myron E. (1997). Origin of acquired immunodeficiency syndrome. In V.T. DeVita, S. Hellman & S.A. Rosenberg (Ed.), *AIDS: etiology, diagnosis, treatment and prevention.* (4th ed., pp. 203–13). Philadelphia: Lippincott-Raven.

Halting the spread of a deadly disease. (1998, June 26). *The globe and mail.*

Health Canada. (1998a). *The Canadian strategy on HIV/AIDS: moving forward together* [Online]. <http://www.hc-sc.gc.ca/hppb/hiv_aids/strategy/strategy.html>

Health Canada. (1998b). *The Canadian strategy on HIV/AIDS: backgrounder* [Online]. <www.hc-sc.gc.ca/hppb/hiv_aids/strategy/background.htm>

Saag, Michael S. (1997). Clinical spectrum of human immunodeficiency virus syndrome. In V.T. DeVita, S. Hellman & S.A. Rosenberg (Ed.), *AIDS: etiology, diagnosis, treatment and prevention.* (4th ed., pp. 203–13). Philadelphia: Lippincott-Raven.

Waldby, Catherine. (1996). *AIDS and the body politic.* London: Routledge.

Yingling, Thomas. (1991). AIDS in America: postmodern governance, identity, and experience. In D. Fuss (Ed.), *Inside/out.* (pp. 291–310). New York: Routledge.