HIV and HCV can be described as quintessential diseases of exclusion; pandemics with enormous impacts on poor and vulnerable populations; for many, transmitted not just by behaviours alone, but also by an overall greater proximity to illness in general.

By the end of 2002, Health Canada estimated that 56,000 people in Canada or almost 2% percent of the population were living with HIV infection. Even advances in surveillance and care have not mitigated the sobering public health reality that even in a country as prosperous and advanced as Canada rates of HIV infection have risen 12% in the short time between 1999 and 2002. Injection drug users account for approximately 20% of all known HIV infections in Canada and for 30% of the 2,800-5,200 new HIV infections in Canada in 2002 alone (Health Canada, 2004a).

Rates of HIV infection in First Nations communities far exceed those of the wider Canadian population, an estimated four times as many infections per capita. The proportion of recent Aboriginal HIV seroconverters who report injection drug use as the most likely mode of infection is more than twice that of other Canadians: 63% compared to 30% (Health Canada, 2004b). While the Canadian census is not without limitations (for example, it tends to underestimate the size of subpopulations), its news is serious: in 2001, Health Canada estimated that 3.3% of the Canadian population is Aboriginal, yet in 2002, it estimates that 5%-8% of prevalent HIV infections and 6%-12% of incident infections were among Aboriginals.

The facts regarding HCV or hepatitis C are equally stark. Approximately 240,000 individuals in Canada are thought to be infected with the hepatitis C virus, with an estimated 5,000 new infections each year. The last national HCV surveillance (1993-95) concluded rates were between approximately 3 and 4 per 100,000 people, with the overwhelmingly greatest risk factor being a history of injection drug use (ElSaadany et al., 2002). Of the estimated 4,000 new cases of HCV infection in Canada each year, almost two-thirds will be related to injection drug use (Zou et al., 2000).

Social exclusion, in its shorthand form, is "what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown" (Drugs\Scope and Drugs Prevention Advisory Service, 3). A person can be considered excluded if she or he is resident of a society, but for reasons beyond individual control cannot participate in the normal activities of citizens in that society (Stegemen & Costongs, 2003). Some have suggested that modern
exclusion rhetoric is little more than a re-labelling of what used to be called poverty. Although there's no doubt a close association between economic stratification and the phenomenon of exclusion within a society exists, it seems clear that in principle social exclusion can occur between groups that are not significantly distinguished from one another economically (Barry, 1998).

At its simplest, social inclusion can be conceived as the opposite of social exclusion. Essentially, the modern usage of the concept was developed in industrialized countries to describe processes that shifted marginalized groups away from deprivation within a developed country (Stegeman & Costongs, 2003). Anthony Giddens (1998) has defined social inclusion as a "third way," somewhere between post-war socialism and neo-liberalism; a return to a more traditional social democracy embodying a much greater promise of equal access to opportunity (Omidvar and Richmond, 2003). For Giddens, social inclusion is not about equality as much as it is about reversing mechanisms that act to detach groups of people from the social mainstream (Centre for Economic and Social Inclusion, 2004).

In her book *The Inclusive Society? Social Exclusion and New Labour*, Ruth Levitas asks the central question: "What is the significance of talking about inclusion and exclusion rather than equality, inequality and poverty?" (1998 p. 2). According to Levitas, in the early days of the discourse, social exclusion was primarily seen as a problem of the separation of individuals and communities from labour markets, leading to an emphasis on improving opportunities for paid employment. In Britain this was also influenced by "an indigenous tradition of poverty research" linking poverty and exclusion, and oriented towards "marginal groups, such as rough sleepers, truants, pregnant teenagers, and 'problem estates'" (Canadian Council on Social Development, 2003).

Levitas (2003) has suggested that modern policies of social inclusion are not constructed so much around a linear model of exclusion to inclusion (structural inequality to equality or economic necessity to well-being) but that instead existing policies tend to become "legitimized in terms of the rhetoric." For her, positioning social exclusion and social inclusion as a linear dichotomy risks distracting from the real nature and extent of inequalities: The danger of the inclusion/exclusion metaphor is that it evokes a dichotomous image of society, in which there are insiders and outsiders, and only the very marginal are a problem. If the idea of social inclusion is understood simply as the opposite of exclusion...it is in Mannheim's terms ideological. It is part of a discursive legitimation of the status quo. It implies lifting or coercing some marginal groups over a threshold above which inequalities are deemed to be the outcome of individual attributes, whether innate or acquired. The primary division in society is seen as between small groups of marginalised outsiders, and the included majority (Levitas, 2003).

Of the two, it would seem that the social inclusion agenda has the greater potential because it does not envision its rhetoric as being the opposite of the rhetoric of social exclusion. Rather, the discourse of inclusion tends to give much more attention to different kinds of inequality" (Canada Council on Social Development, 2003), in that it tends to avoid one of the central tendencies of the exclusion thesis, which is to gloss over what should be a very central question: that is, in what kind of a community and in what kind of a society are the socially excluded meant to be socially included? The social inclusion rhetoric attempts to address this question
It can lead to the question of what kind of Canadian society we want for those excluded by drug use that is positioned as illicit, and the implications such positioning has in terms of proximity to infection; for in Canada the HIV and HCV epidemics are not only quintessentially about behaviour or poverty or social exclusion, they are also clearly about race, about historical, institutional inequity, and about illicit drug use.

Framed by an increasingly secular society, a breakdown of traditional family ties, growing individualism, and strained government action in the face of these dual viruses, the realities that those on the margins of society face with regard to their health and well-being can leave them far from any socially included core. Structural problems associated with drug use are well documented: poor housing, unemployment, family breakdown, and yes, poverty. Illicit drug users most at risk of structural inequality are those who are politically, economically, and socially marginalized and most disaffected from family, school, and work life (Neale, 2002).

Nationally and internationally, stigma and discrimination continue to pose enormous challenges for consumers of illicit substances, because illicit drug-related stigma and discrimination - beyond drug use itself - tend to impact negatively on physical and mental health as well as on individuals' social worlds and human interactions. The rhetoric of the war on drugs, so influenced by Canada's inescapable proximity to America, serves to isolate, demonize, and discriminate against drug users". The result is that many illicit drug users internalize harsh and detrimental stereotypes which can impact on confidence, self-esteem, and life aspirations." (Buchanan &Young, 2000).

Our wealth of natural resources aside, the reality is that Canada is not and never has been a Nottingham-like forest, and there is not, nor has there ever been, a truly effective Canadian Robin Hood. A pre-packaged, one-size-fits-all social inclusion argument risks leading us into a hollow fold that can be a sign of the rhetoric of the modern age. In other words, social policy for social equality that is built upon either moral grounds or preconceived notions of health and well-being regarding illicit drug use and drug-related harm is arguably a no-win situation.

The solution may not be anti-discriminatory equality or even necessarily socially-integrative inclusion. Instead, the solution may well be a post-Giddens fourth way - a valuing (or revaluing) of diversity that recognizes that a lived experience that includes a safe consumption of illicit drugs should have as much right to be included in Canada's social mosaic as the lived experience of those who safely traverse our national landscape under the influence of socially constructed licit substances such as caffeine or alcohol. Truly valuing diversity within communities of substance use or race or poverty - valuing through action as opposed to rhetoric - is one way of fracturing the inexcusable relationship between HIV and HCV and Canada's historically socially excluded.

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