POSITION STATEMENT ON HARM REDUCTION

Winnipeg Regional Health Authority

Office régional de la santé de Winnipeg

Caring for Health

À l'écoute de notre santé

SUMMARY

In 2008, the Winnipeg Regional Health Authority (WRHA) endorsed the principles of harm reduction in a position statement. Harm reduction generally refers to services for people who use drugs. These services aim to reduce harms—for example, the spread of infections like HIV and hepatitis C—rather than trying to reduce drug use itself. This perspective is supported by evidence, is cost-effective, and works with other approaches, like prevention and compassionate treatment.

In 2016, the Harm Reduction Position Statement has been revised in two important ways. First, the Statement explicitly moves away from focusing on programs and services for individuals. Second, it reaffirms the WRHA's commitment to evidence-informed approaches to working with people who use drugs, while extending this perspective to sex work and the non-disclosure of HIV status.

This Position Statement acknowledges the harms caused by stigma and criminalization. In particular, it acknowledges that the harms of criminalization are borne disproportionally by Indigenous peoples in Canada. The Statement recognizes that while people make their own health decisions, these decisions are only one factor influencing health outcomes. It also confirms harm reduction as an effective and viable approach throughout the organization.

The Harm Reduction Position Statement reflects the WRHA Strategic Plan's commitment to better engage with communities. It responds to the WRHA's pledge to address the Truth and Reconciliation Commission of Canada's Calls to Action. Finally, it aligns with the WRHA's goal of reducing inequitable health gaps, so that no community unnecessarily suffers poorer health than others.

HARM REDUCTION

Harm Reduction is a perspective that focuses on reducing the adverse health, social, and economic consequences of psychoactive drug use, and its Principles can be equally applied to other stigmatized and/or criminalized practices and behaviours related to substance use and sex.

Supported by local, national, and international evidence, this Position Statement articulates client-centered, non-judgmental, and practical applications of harm reduction to issues related to drugs, sex work, and HIV non-disclosure. The Statement recognizes that sex and drug-related harms derive from social and material conditions, such as structural disadvantage, criminalization, and stigma (Rhodes 2002; 2009). It therefore focuses not only on client services, but extends to considering the social and structural factors that create the conditions for harm.

PRINCIPLES OF HARM REDUCTION

(International Harm Reduction Association, 2010)

HARM REDUCTION

Is client-centered, non-judgmental, and facilitative, rather than coercive.

Targets the causes of risks and harms.

Is evidence-informed, practical, feasible, effective, safe, and cost-effective.

Promotes autonomy and dignity.

Is transparent, and accountable. It values meaningful engagement and participation of affected communities in the program and policy decisions that affect them.

Challenges policies and practices that maximize harm. This includes criminalization, discrimination, abstinence-only services, and social inequities.

THE WRHA IS COMMITTED TO:

- Supporting policies, legislation, programs, services, and actions to reduce the harms experienced by people who use drugs, trade or sell sex, and are living with HIV. These harms are disproportionately borne by structurally disadvantaged communities, making these areas foundational priorities for addressing health inequities.

- Promoting health equity for people who use drugs, trade or sell sex, and are living with HIV. This entails implementing the 'Considerations for Action' contained in Health for All: Building Winnipeg's Health Equity Action Plan (WRHA, 2013), and continuing to explore the application of recommendations contained in the Truth and Reconciliation Commission of Canada's Calls to Action (TRCC, 2015a).

- Involving the community, families, and individuals with lived experience to inform policies, programs, and services, in line with the WRHA Strategic Plan (WRHA, 2016).

- Including harm reduction as an effective and viable approach wherever there may be direct or indirect harm from drug use, sex work, or HIV exposure.

- Acknowledging that people make their own decisions regarding health, and that individual choices are only one factor influencing health outcomes.

WITH RESPECT TO HIV NON-DISCLOSURE, THIS MEANS:

- Endorsing the Canadian Consensus Statement on HIV and its transmission in the context of criminal law (Loutfy et al., 2014), and opposing the criminalization of HIV non-disclosure except in cases of intentional or malicious HIV transmission (Global Commission on HIV and the Law, 2012).

- Consulting regularly with people living with HIV in order to prioritize their meaningful involvement in identifying and addressing the most salient harms related to HIV.

- Participating in consultations and other forums to contribute to evidence-informed policy-making concerning HIV non-disclosure.

- Advocating for policy, legal, environmental, and structural interventions consistent with a public health approach to HIV. These include approaches to HIV prevention, sero-status non-disclosure, and the possibility of using public health law rather than criminal law in non-malicious or non-intentional situations of non-disclosure and transmission.

- Collaborating with policing, justice, and other partners to build awareness of a public health approach to HIV non-disclosure.

- Increasing the accessibility of safer drug use and safer sex supplies to individuals and groups who need them.

- Educating and engaging with WRHA staff about HIV non-disclosure, in line with current evidence and health ethics.

WITH RESPECT TO DRUGS, THIS MEANS:

- Endorsing the Vienna Declaration.

- Consulting regularly with people who use drugs in order to prioritize the most salient harms related to prevention, harm reduction, and/or treatment.

- Participating in consultations and other forums to contribute to evidence-informed drug policy-making.

- Supporting legally-regulated drug markets, and the decriminalization of drug use. Legal regulation acknowledges the risks posed by drugs, bringing them in line with other regulated 'risky' products, including motor vehicles (seatbelts, speed limits), and psychoactive substances such as tobacco and alcohol.

- Advocating for policy, legal, environmental, and structural interventions that reduce the harms identified by people who use drugs. In the current context of

criminalization, there is an urgent need for 'Good Samaritan Immunity' legislation, which would allow overdose witnesses to seek medical help without fear of prosecution. New initiatives that could be explored, where appropriate, include a) overdose monitoring and response systems, b) heroin-assisted treatment programs, c) safer drug consumption spaces, d) provision of harm reduction supplies in correctional facilities, and e) managed alcohol programs. Finally, efforts may also be focused on making improvements to existing services, responding to media queries and other knowledge dissemination opportunities, and embarking on collaborations with coalitions and other sectors.

- With provincial and other partners, contributing to the forthcoming development of regulations governing the sale and distribution of cannabis in Canada.

- Collaborating with policing, justice,

and other partners to build an understanding of a public health approach to drugs.

- Increasing the accessibility of safer drug use supplies to individuals and groups who need them. This is consistent with the WRHA's history of providing services to people who use drugs: Winnipeg was one of the first jurisdictions to distribute safer crack use kits (Backé et al., 2012), and people who use injection drugs in Winnipeg report lower prevalence of hepatitis C than any other city included in the 2006 I-Track scan (PHAC, 2006).

- Monitoring gains and losses in health, in ways led by and/or acceptable to people who use drugs, and supporting the monitoring programs developed by the Canadian Centre on Substance Use (CCSA), the Canadian Community Epidemiology Network on Drug Use (CCENDU), and the Canadian Research Initiative in Substance Misuse (CRISM).

SEX WORK IS THE EXCHANGE OF SEX OR SEXUALIZED INTIMACY FOR SOMETHING OF VALUE.

Sex work can be informal or organized, and can take place in different venues, both indoor and outdoor. Unlike sex work, sexual exploitation involves the sexual misuse of a person by another. This could include forcing someone to sell sex or taking advantage of a sex worker. Trafficking can also be distinguished from sex work, as it involves the deceptive or coerced movement of an individual into a situation of forced labour. Conflating sex work with these crimes can lead to an overreaching of criminal justice solutions to social problems. Sex work that is 'forced' by structural factors (rather than individuals) is best addressed by confronting those factors.

WITH RESPECT TO SEX WORK, THIS MEANS:

- Consulting regularly with sex workers in order to prioritize the most salient harms.

- Participating in consultations and other forums to contribute to evidence-informed policy-making concerning sex work.

- Supporting the decriminalization of sex work, and the extension of labour regulations and protections governing workplace safety and health to sex work.

- Advocating for policy, legal, environmental, and structural interventions that reduce the harms identified by sex workers. These could include helping to develop new initiatives, making improvements to existing services, responding to media queries and other knowledge dissemination opportunities, and embarking on collaborations with coalitions and other sectors.

- Opposing regulatory approaches that mandate the surveillance of sex workers by public health. This includes, for example, STI-testing schedules that defy evidence (Wilson et al., 2010).

- Collaborating with policing, justice, social service, and other partners to build an understanding of a public health approach to sex work.

- Increasing the accessibility of safer sex supplies (condoms, lubricant, etc.) to individuals and groups who need them.

- Monitoring gains and losses in the health status of sex worker communities, in ways led by and/or acceptable to sex work communities.

BACKGROUND

The harm reduction movement originated in the 1980s in Europe as a response to the emergence of HIV transmission through intravenous drug use. Harm reduction was originally conceived as a humane, non-judgmental, evidence-informed approach to the use of psychoactive drugs, complementing enforcement, prevention, and rehabilitation/treatment approaches. It requires a cross-sectoral, integrated approach to ensure a continuum of care and support for individuals, their families, and their communities. Further, it is a pragmatic public health approach, recognizing that seeking altered states through psychoactive drugs is an enduring feature of human existence (International Harm Reduction Association, 2010). Psychoactive drug use is common in Canadian society and the majority of this use is not problematic (CCENDU, 2011; Health Canada, 2012).

Harm reduction focuses on problematic drug use, defined as use that has negative consequences for the individual, as well as their friends, family, and/or society (Carter & McPherson, 2013). Harm reduction recognizes that problematic use is often a response to physical, emotional, spiritual, and socially-inflicted pain, and that drug-related harms are shaped differently across power axes of race, social class, gender, and other categories. This necessarily expands the reach of harm reduction approaches beyond the prevention of blood-borne infections, in favour of working with affected populations to understand the complexity of harms from their perspective (Canadian HIV/AIDS Legal Network, 2005; International Activists who use Drugs, 2006; Rhodes, 2002; 2009). For instance, harm reduction strategies have been developed to address the risks of overdose, a leading cause of death among people who inject drugs (Carter & Graham, 2013; United Nations Office on Drugs and Crime, 2013). This attention

to community-defined harms, as well as to structural and societal contexts, make this approach applicable to discussions about sex work (CPHA, 2014b) and HIV non-disclosure (Loutfy et al., 2014).

In Canada, one important context is the systematic cultural oppression and marginalization of Indigenous peoples. This legacy has not only contributed to existing social and health inequities, but also continues to profoundly negatively impact on the health of Indigenous peoples (Allan & Smylie, 2015; Loppie Reading & Wien, 2009; Reading & Halseth, 2013). Redressing social dislocation, family separation, incarceration, poverty, and pain is key to reducing harms (Rhodes, 2002; 2009). Harm reduction approaches must therefore include Indigenous self-determination and leadership (Assembly of First Nations, 2011; AFN/NNAPF/Health Canada, 2011; Chiefs of Ontario, 2010), and must be context-specific, locally-informed, and culturally safe. Importantly, almost two-thirds of clients accessing the WRHA's Street Connections program for safer crack use kits self-identified as Indigenous (Ross, 2015).

Harm reduction is widely endorsed by national and international organizations, including the World Health Organization (2004), the United Nations Office on Drugs and Crime (2013), the Public Health Physicians of Canada (2009), the Public Health Agency of Canada (PHAC, 2012), and the Canadian Nurses Association, jointly with the Canadian Association of Nurses in HIV/AIDS Care (2012).

APPENDIX A
LITERATURE REVIEW

A harm reduction approach focuses on the broad social context that shapes harms, and seeks to promote health equity. It recognizes that risk is shaped by social, structural, and historic factors. Examples include inadequate housing, poverty, unemployment, lack of social support, sexism, racism, and colonialism. These determinants promote the use of drugs, push individuals into survival sex work, and discourage HIV disclosure, while simultaneously making these activities more dangerous.
Structurally-disadvantaged groups are pushed into street economies—including drug and sex work markets— by marginalization and constrained choices, and their experiences largely do not resemble those of individuals with a range of options available to them. There is therefore a diversity of experiences based on gender, race, class, and other determinants, among people who use drugs, sex workers, and people living with HIV. Legal considerations may be especially complex in situations where youth are involved (World Health Organization, 2015).

Understanding risk as a social phenomenon shifts the burden of responsibility for harms off of individuals and towards social context, including unique local contexts

(Rhodes 2002; 2009). Harm reduction seeks to redress the conditions that amplify harms and works to strengthen existing resources that promote the health of populations (Duff, 2010).

Societal responses to drug use, sex work, and HIV (e.g., stigma, criminalization) often inflict harms greater than those they purport to alleviate. Criminalization in particular has led to the de facto regulation of drug and sex work markets by criminal organizations and violence, and the worsening of stigma and discrimination experienced by people who use drugs, sex workers, and people living with HIV. In addition, UNAIDS' 2016-2021 Strategy, On the Fast-Track to end AIDS, outlines evidence that responses to HIV are explicitly impeded by the overly broad criminalization of same-sex sexual relations, sex work, and drug use, as well as HIV-specific criminalization (exposure, non-disclosure, and transmission) (UNAIDS, 2015a). Of these, only same-sex sex has been decriminalized in Canada, compelling public health bodies to confront the harms caused by the criminalization of the others, particularly when it contributes to the overrepresentation of Indigenous people in Canadian prisons.

A PUBLIC HEALTH APPROACH TO DRUGS

A public health approach to drug use prioritizes the physical, social, and mental well-being of people who use drugs. It is concerned primarily with problematic and harmful use, as well as the societal responses—including criminalization—that exacerbate harms. This approach focuses on the structural factors that simultaneously promote drug use and impose the enforcement of drug prohibition, in ways differentially applied to different populations. A public health approach promotes evidence-informed, ethical, and pragmatic approaches to reducing drug-related harms, incompatible with criminalization (CPHA, 2014a; Vienna Declaration, n.d.).

The harms associated with drug use derive from both the use itself, and the contexts and environments surrounding it.

• Problematic drug use can increase risks of blood-borne infections such as hepatitis C and HIV, respiratory and skin problems, overdose, and personal life disruption (for an overview, see Carter & MacPherson, 2013).

• The criminalization of drugs has pushed drug markets underground without quality controls, leading to drugs sold of unknown strength and/or cut with other drugs or adulterants (Cole et al., in GCDP, 2014).

• Without formal regulation, informal economies are regulated largely through violence, exposing people who use drugs to direct, physical harm (Richardson et al., 2015).

• Criminalization encourages overdoses, due to fear of arrest by individuals witnessing medical distress in the context of illegal drug use. This risk has been amplified by the imposition of mandatory minimum sentences for drug-related crimes (Carter & MacPherson, 2013).

• Discrimination against people who use drugs is manifested in health care systems, leading to unmet care needs and outright avoidance of health services (Habib & Adorjany, 2003).

Addressing the determinants of health will both improve the health and well-being of people who use drugs, and prevent and deter problematic substance use in the first place.

- Public health has a role to play in advocating with and on behalf of structurally-disadvantaged populations. This has been affirmed internationally (World Health Organization, 2013, 27), domestically (NCCDH, 2015), and locally (WRHA, 2013, 28). Specifically, Elliott (2012) calls for evidence-informed drug policy advocacy at both the regional and global levels.

- The health, psychological, and social harms of drug use—including criminalization and stigmatization—are not borne equally by all people who use drugs. Harms are exacerbated by structural determinants such as race, housing status, and employment, and by the invisibility of particular groups in policy arenas, for example children and youth who use drugs (Cardoso, 2012).

- Drug-related criminal records can impact a person's ability to gain formal employment, limiting them perpetually to informal and criminalized economies such as sex work and the drug trade (Ditmore, 2013).

- Above and beyond decriminalization, all pillars of a public health approach—including prevention, treatment, and harm reduction—should prioritize environmental interventions rather than simply targeting individuals (Fraser, 2004; Marshall, 2015; McNeil & Small, 2014; Rhodes, 2002).

Local drug-use trends and experiences with criminalization are on par with the rest of the country.

- Thirty-seven percent of Manitobans reported any illicit drug use in their lifetime (Health Canada, 2012, table 2). Likewise, 21% of Winnipeg students (grades 7 to 12) reported using a drug to get high in the previous year (Partners in Planning for Healthy Living, 2012).

- Similar to other Canadian jurisdictions (Carter & MacPherson, 2013), despite an overall crime decline in Winnipeg of 15% between 2005 and 2009 (Statistics Canada, n.d.), the number of drug charges laid increased by 40% in the same time period (CCENDU, 2011).

- People who use safer crack use kits in Winnipeg have reported instances of police smashing or confiscating their harm reduction supplies (Ross, 2015), although this appears to be less common than in both Ottawa (Johnson & Malchy, 2008) and Vancouver (Vancouver Coastal Health, 2013).

Indigenous peoples bear a disproportionate burden of drug-related harms, including those caused or exacerbated by criminalization.

- A scan of people who use injection drugs in Winnipeg found that 70% self-identified as Aboriginal (PHAC, 2006).

- The criminalization of drugs exacerbates inequities by focusing on street-level sellers and users, as opposed to higher-level profiteers (Chu, in Carter & MacPherson, 2013). Due to historical legacies of colonialism, displacement, and residential schools, and present-day factors, including racism and economic marginalization, Indigenous people's drug use is more likely to occur in public spaces (see Marshall, 2015)—and specifically in racialized/Indigenous spaces—which have been heavily policed and surveilled in Canada since colonial times (see Pan et al., 2013).

- In Canada, the criminalization of any act, especially those linked to street economies, disproportionately impacts Indigenous peoples. They are more likely to be sentenced to prison than non-Indigenous people (TRCC, 2015b), and are over-represented in indicators like serving more of their sentence behind bars, parole revocations, and segregation placements (Office of the Correctional Investigator, 2012). Further, the imposition of mandatory minimum penalties limits the ability of judges to consider the backgrounds of Indigenous offenders during sentencing, an allowance that had been affirmed in R. v. Gladue (1999).

Criminalization approaches—i.e., the 'War on Drugs'—do not reduce the harms associated with drug use, but instead exacerbate and create particular kinds of harm.

- The criminalization of drugs has been described as a policy of 'harm maximization,' fueling both the HIV and hepatitis C epidemics (GCDP, 2013; 2014).

- Prohibition in Canada dates back to the Opium Act of 1908, which was rooted primarily in anti-Asian sentiment (Carter & MacPherson, 2013). Since then, the differential application of prohibitionist approaches—allowing for certain drugs to be legalized, and others criminalized—has continued to be influenced by racism; political, economic, and moral agendas; and outdated medical and scientific knowledge (CPHA, 2014a).

- Although directed at a high level by organized crime, the international and domestic drug trades lean heavily on 'drug runners' who are lured by economic marginalization and necessity, and who bear the brunt of policing and criminalization (GCDP, 2014).

- Mandatory minimum penalties for drug-related offences increase the prison population, do not deter crime, and exacerbate inequities due to the differential application of the law. There is no evidence linking stronger drug laws to declines in drug production, supply, or demand (Carter & MacPherson, 2013).

- Criminalization has been called the "state-sanctioned stigmatization of people who use drugs" (Elliott, 2012, 41), driving individuals away from services and discouraging the carrying of safer drug use supplies (McNeil & Small, 2014; Shannon et al., 2008).

- There is an opportunity cost associated with heavily investing in criminalization and enforcement, as this diverts funds from other approaches (CPHA, 2014a). In Canada's National Anti-Drug Strategy, harm reduction was completely absent, and law enforcement initiatives received 70% of all funding (Cavalieri & Riley, 2012). Overall, the combined costs of arrests, convictions, and incarcerations stemming from drug criminalization outweigh its purported cost-benefits (Robinson, 2014).

  Criminalization has imposed a chill on research into the therapeutic and beneficial uses of psychoactive drugs (CPHA, 2014a).

Regulatory models have been studied, developed, and endorsed. These would reduce harm, promote public health, and still meet Canada's international legal commitments.

- Two fundamental pillars of a renewed public health approach to drugs are the establishment of legally regulated drug markets, and the meaningful engagement of individuals who use drugs (GCDP, 2014; Harris, Albers, & Swan, 2015).

- Regulatory approaches can standardize the production, potency, price, advertizing, and accessibility of psychoactive substances, and set restrictions and regulations around the most harmful ones (see GCDP, 2014).

- Jurisdictions have already built productive and positive relationships with local police around (for example) harm reduction initiatives (Jardine, 2013; Strike et al., 2015). This partnership could be expanded, with enforcement activities refocused on the most violent and disruptive elements of a regulated drug trade.

- A regulatory approach would entail the development of measurable and achievable success indicators. Goals would be defined based on evidence and the prioritization of health outcomes, rather than politically-motivated benchmarks (GCDP, 2014).

- Prohibition and criminalization exist in a global context, facilitated by United Nations treaties and sub-organizations that together regulate and influence global health policy (Elliott, 2012). At the same time, the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychoactive Substances does not commit states to any particular sanctions against producers or possessors of drugs for personal consumption (Rolles & Eastwood, 2012), and 25 jurisdictions around the world have deployed some form of drug decriminalization (Rosmarin & Eastwood, in Carter & MacPherson, 2013).

- Portugal, for example, approaches drug use as a public health issue. Pairing decriminalization with other health care and judicial structures and programs, Portugal's reforms have been shown—more than a decade after their implementation—to have decreased problematic drug use (in particular, injection drug-use) and drug-related harms (Gonçalves, Lourenço, & Silva, 2015; Woods, 2011).

- The decriminalization of drugs is supported by numerous human rights and medical groups, including the Canadian Drug Policy Coalition (Carter & MacPherson, 2013), Canadian HIV/AIDS Legal Network (2016b), Canadian Public Health Association (2014a), the Global Commission on Drug Policy (GCDP, 2014), the Global Commission on HIV and the Law (2012), Harm Reduction International (2012), the Health Officers Council of British Columbia (2011), the Lancet (Csete et al., 2016), UNAIDS (2015b), and the signatories to the Vienna Declaration (n.d.), including the BC Centre for Excellence in HIV/AIDS and the International AIDS Society.

A PUBLIC HEALTH APPROACH TO SEX WORK

A public health approach to sex work prioritizes the physical, social, and mental well-being of sex workers. It promotes evidence-informed, ethical, and pragmatic approaches to supporting the health and well-being of sex workers, while addressing the structural factors that may push some individuals into sex work, like poverty, colonialism, and racism (CPHA, 2014b).

These factors are not only ignored by the narrow lens of criminalization, but are worsened by it, due to the inequitable impact of policing and justice systems on poor, Indigenous, and racialized communities.

The harms associated with sex work derive primarily from the contexts and environments surrounding sex work.

• There is no clear evidence that sex workers are at higher risk of STIs because of their work. Sex workers tend to engage in safer sex practices with clients, meaning that their primary exposure to STIs is by intimate (non-paying) partners (Roguski, 2013). Linking sex work and disease transmission has contributed to the stigmatization of sex work.

• The ability to consistently engage in safer sex practices, though, is heavily influenced by environmental factors. Displacement and isolation by police is associated with decreased condom use (Shannon et al., 2009). Conversely, encouraging 'safer environments' facilitates condom use (Krüsi et al., 2012) and may lower STI rates (Cunningham & Shah, 2014; Li et al., 2016).

• Beyond sexual health, the general health of sex workers is impacted by barriers in the health care system. These include negative staff attitudes, refusals of service, inappropriate reporting to child welfare and police, and violence (CPHA, 2014b; Mckinney et al., 2012; Surratt, O'Grady, Kurtz, Buttram, & Levi-Minzi, 2014).

• Sex workers are victimized not only by individuals, but also by groups, agencies, associations, and police (World Health Organization, 2013). This risk is especially pronounced for survival sex workers, who often work outdoors and therefore bear the brunt of criminalization and rescue-based social services (Shaver, Lewis, & Maticka-Tyndale, 2011).

Reducing sex work harms requires addressing the determinants of health.

• Public health has a role to play in advocating with and on behalf of structurally-disadvantaged populations. This has been affirmed both internationally (World Health Organization, 2013, 27), domestically (NCCDH, 2015), and locally (WRHA, 2013, 28).

• Reforms that improve working conditions and maximize autonomy are the most effective way to prevent exploitation (Moen, 2014).

• Survival sex workers are disproportionately members of populations affected by health inequities. These include migrant, queer, gender-variant, and Indigenous peoples (Dennis, 2008; GNSWP, 2014; Roguski, 2013; Ursel, Proulx, Dean, & Costello, 2007), and individuals who use illegal drugs (Ditmore, 2013). While overwhelmingly not desiring to sell or trade sex (Dank et al., 2015), they are often limited to informal 'street economies' such as survival sex work (Iman, Fullwood, Paz, W., & Hassan, 2009).

• Addressing determinants of health will improve the health and well-being of sex workers. Addressing determinants of health also has a greater potential to prevent unwilling entry into sex work than does the criminalization of sex work.

Indigenous peoples are over-represented in survival sex work, and bear an unequal burden of harms.

• The over-representation of Indigenous peoples in survival sex work can be linked to histories of colonialism, displacement, and residential schools, and present-day factors. Indigenous people who migrate to urban centres face racism and economic marginalization (O'Brien-Teengs & Travers, 2006), which can lead to survival sex work (ALST, 2013, 3).

• The stories of Indigenous sex workers are frequently used by others to justify increased state intervention (new laws, more policing) and the expansion of rescue-based social services. But Indigenous sex workers themselves advocate for bodily sovereignty, opposing imposed 'solutions' (Indigenous Sex Sovereignty Collective, 2015).

• In Canada, the criminalization of any act, especially those linked to street economies, disproportionately impacts Indigenous peoples. While alternative measures like Manitoba's 'Prostitution Diversion Program' are available to Indigenous sex workers, these programs neither address the ongoing criminalization of Indigenous peoples, nor their over-representation in the justice system. Indigenous people are more likely to be sentenced to prison than non-Indigenous people (TRCC, 2015b), and are over-represented in indicators like serving more of their sentence behind bars, parole revocations, and segregation placements (Office of the Correctional Investigator, 2012).

Little is known about sex work in Winnipeg, including the perspectives of sex workers themselves.

• Street-based sex work in Winnipeg can be dangerous, with 222 'bad dates' and street hassles recorded between 2002 and 2007 (Comack & Seshia, 2010). These dangers are in part produced by criminalization, for example by making it more difficult to properly screen clients when street-based sex work are displaced to isolated areas (Sex Workers United Against Violence et al., 2014).

- Sex workers in Winnipeg experience violence related to their work, as well as their race, gender, and class (Seshia, 2010).

- Sex workers working outdoors have expressed interest in 'safer work environments' (Seshia, 2010), like those explored in British Columbia (Krüsi et al., 2012).

- Little information exists about indoor sex work in Winnipeg. The most recent discussion was published in 1998 (Selwood & Kohm).

'Asymmetrical' or 'Nordic' approaches criminalize the purchase, but not the sale, of sex. The Canadian government adopted the asymmetrical approach via the Protection of Communities and Exploited Persons Act (PCEPA) in 2014. But this approach has not been shown to reduce the harms associated with sex work.

- Three-hundred academics and researchers agree that criminalizing any element of sex work results in health, social, and human rights harms (CPHA, 2014b).

- The asymmetrical approach makes it almost impossible for sex workers to work in groups or to hire others, such as security staff (Clamen, Claivaz-Loranger, Elliott, Pacey, & Santini, 2014). This has the practical effect of promoting isolation and increasing risks of violence (Krüsi et al., 2014).

- Approaches that criminalize clients can result in unintended consequences. Sex workers may spend more time on the streets seeking clients, sell services they normally would not (including condomless sex), and/or work in isolated areas to avoid police surveillance (Krüsi et al., 2014).

- Under a 'Nordic' model, sex workers report an undiminished police presence in their lives (Krüsi et al., 2014). Sex workers may still be ticketed for impeding traffic, loitering, etc. (Clamen et al., 2014).

- Indigenous (Māori) sex workers report a "radically improved" environment following decriminalization in New Zealand, including the ability to more easily report intimidation and violence to police (New Zealand Prostitutes Collective, 2013, 2).

- Although it is meant to 'protect' marginalized communities, the PCEPA may largely target the friends and families of sex workers, for 'receiving a material benefit' (Clamen et al., 2014). This may in turn increase prosecutions of poor and Indigenous communities.

- The decriminalization of sex work is supported by numerous human rights and medical groups, including the Abortion Rights Coalition of Canada (2015), Amnesty International (2016), the Canadian HIV/AIDS Legal Network (2016a), the Canadian Public Health Association (2014b), the Global Alliance Against Traffic in Women (Ham, 2011), the Global Commission on HIV and the Law (2012), Human Rights Watch (Amon, 2014), the Lancet (2015), the Open Society Foundations (2014), UN Women (2013), and the World Health Organization (2013; 2015).

A PUBLIC HEALTH APPROACH TO HIV NON-DISCLOSURE

A public health approach to HIV non-disclosure prioritizes the physical, social, and mental well-being of people living with HIV. It focuses on the structural factors that contribute to HIV-related harms, as well as the societal responses that exacerbate them. One severe, harm-causing response to HIV transmission is the criminalization of HIV non-disclosure. Under current Canadian criminal law, people living with HIV can be charged, prosecuted, and convicted if they do not tell their partner(s) about their HIV-positive status before having sex, unless their viral load is low and a condom is used (Canadian HIV/AIDS Legal Network, 2013). This is despite evidence and scientific consensus that either condition (i.e., sex with a condom or when the HIV-positive partner has a low viral load) by itself poses a negligible possibility of transmitting HIV (Loutfy et al., 2014). The law therefore criminalizes situations where there is very small or zero risk, and where there is no harmful intent or malice, raising serious public health and human rights concerns (UNAIDS, 2013).

HIV non-disclosure criminalization disproportionally impacts on particular groups.

- HIV-related criminal cases in Canada show evidence of gendered and racialized bias, especially in Ontario, where a large proportion of the charges have been brought against men from Black Caribbean or African communities (Larcher & Symington, 2010; Mykhalovskiy, 2011; Mykhalovskiy & Betteridge, 2012).

Addressing the determinants of health will both improve the health and well-being of people with HIV, and contribute to the prevention of of HIV transmission.

- HIV infection is associated with structural disadvantage and health inequity, and HIV further compounds poverty and social isolation (Global Commission on HIV and the Law, 2012; United Nations, 2001).

- HIV related stigma and discrimination can undermine prevention, care, support, and treatment efforts, thereby worsening the impact of HIV on individuals, families, communities, and populations (Joint United Nations Program on HIV/AIDS, 2009). Realizing fundamental human rights and freedoms for all people with HIV is therefore an essential element of the response to HIV.

- An approach to HIV grounded in education, care, and support contributes to improved prevention by promoting counselling, testing, and treatment approaches (United Nations, 2001). Affordable and equitable access to pharmaceuticals is also a key tenant of this response.

There is no evidence that HIV criminalization prevents HIV transmission.

- Sexual practices and sero-status disclosure among people living with HIV have been found to be no different across different legal contexts (Burris, Cameron, & Clayton, 2008; Horvath, Weinmeyer, & Rosser, 2010).

- HIV transmission in Canada is the result of many people engaging in practices that pose a negligible risk for HIV transmission, rather than a small number of people engaging in practices that pose large risks (O'Byrne, 2011). Criminal sanctions on a small number of people would therefore not contribute to prevention at a population level, nor would sanctions on the larger number of individuals engaging in lower-risk practices be effective or ethical.

- The actions of police authorities, prosecutors, judges, and juries, along with the media, have shaped public policy in the absence of defined legislative parameters on HIV exposure and non-disclosure (Adam, Elliott, Corriveau, & English, 2014). Health organizations have been largely absent in the public discourse around the criminalization of HIV non-disclosure (Adam, Elliott, Corriveau, & English, 2014). Health organizations have a responsibility to promote the use of evidence and ethics, and engage in discussions and decisions that shape public policy regarding HIV and the law.

- Both UNAIDS (2013) and the Global Commission on HIV and the Law (2012) explicitly call for HIV-related criminalization to be limited to instances of intentional, malicious transmission. The criminalization of non-intentional HIV exposure, non-disclosure, and transmission is opposed by the Canadian HIV/AIDS Legal Network (2014), the Canadian Public Health Association (CPHA, 2011), and 72 Canadian experts and doctors (Loufty et al., 2014).

APPENDIX B
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