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# Case 1 : Where are the Sex Workers?

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# CASE 1

## Where are the Sex Workers?

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On August 25, 2014, Sarah Briar, an outreach worker for the Bloom Clinic in Brampton, Ontario, sits at a monthly Peel Harm Reduction meeting, hosted by the Peel Harm Reduction Network. Harm reduction is defined as “a range of practical strategies and ideas focused on reducing the harmful consequences associated with drug use and other risky health behaviours” (Ontario Harm Reduction Distribution Program, 2016). This collaborative-based meeting is supported by a collection of various community support services who discuss key issues and build collective efforts towards harm reduction strategies. Sarah is fairly new to the Bloom Clinic and has previous work experience as a health promoter for refugees transitioning into Canada. Sarah’s work experiences have gained her tremendous knowledge on health behaviour risks with newcomers and on challenges associated with resettlement. In addition, her work experience has built effective partnership collaborations and sustainable stakeholder interests for the Bloom Clinic.

Across from Sarah sits Constable Radishwich, of the Peel Regional Police. Constable Radishwich is involved with the Community Support and Safety division of the Police Department. He has been working for the Peel force for 18 years, and has been awarded many medals for his community based achievements. Furthermore, he speaks regularly at public meetings as an advisor for the Mayor of Mississauga and attends the monthly Harm Reduction meetings to support and speak of harm reduction strategies. In addition, he provides suggestions on how the Peel Regional Police can help other community services in reducing the negative impacts affecting community members.

The meeting consists of a brief recap of last month’s minutes and discussions on various community projects and/or concerns. As this meeting was nearing the end, Constable Radishwich informs the attendees of the potential passing of Bill C-36 (*Protection of Communities and Exploited Persons Act*) and how it is targeted at criminalizing the sex buyers. Most of the committee members know about Bill C-36 and are in agreement that this bill will heavily impact sex workers in Canada. As members are leaving the meeting, they chat amongst themselves on the potential implications the bill will have on the sex industry and, specifically, the sex workers.

Since Sarah is new to the Bloom Clinic and the Peel Harm Reduction meetings, she has not heard of Bill C-36 before and feels apprehensive about asking what it is. She listens to the comments by others around her and thinks of her own team’s current challenges of reaching out to sex workers for Hepatitis C and HIV testing and treatment. Sex workers have a high level of stigma attached to their profession, which creates challenges to Hepatitis C and HIV testing and treatment due to fear of judgment. Presently, sex workers are not specified under the Ministry of Health and Long-Term Care’s (MOHLTC) current mandate for the Hepatitis C Team Program Guidelines. The mandate's goal is to reduce the spread of Hepatitis C and to provide support

and collaborative care for diagnosis and treatment (MOHLTC, 2013). The current MOHLTC mandate targets certain vulnerable groups who face barriers to accessing health care. The six priority populations, listed below, unfortunately do not capture sex workers.

Sarah leaves the meeting and sits in her car, pondering the implications of Bill C-36 for sex workers. She decides to do a quick search on her smartphone on Bill C-36 to find information on this new legislation. One of the first article links she comes across on Google is titled “Canada’s new prostitution laws: Everything you need to know” from the *Globe and Mail*.

Canada's new prostitution laws: Everything you need to know

JOSH WINGROVE
The Globe and Mail
Published Tuesday, Jul. 15, 2014 10:43AM EDT
Last updated Tuesday, Sep. 09, 2014 12:23PM EDT

The article written by Josh Wingrove (2014) provides a brief synopsis of Bill C-36’s focus, the changes to the *Criminal Code* (1985), and a brief historical timeline that led to the formation of Bill C-36. In addition, the article informs Sarah of the potential violation of the *Canadian Charter of Rights and Freedoms* (1982) in regards to Bill C-36.

Sarah emails the article to the Bloom Clinic team and adds Bill C-36 to the discussion topics of the upcoming team meeting.

## BACKGROUND

The Bloom Clinic is a MOHLTC-funded team that facilitates Hepatitis C testing and treatment for the Peel Region (Brampton, Mississauga, and Caledon). In addition, the Bloom Clinic tests for HIV, STIs, and other Hepatitis viruses for care and treatment. This program emerged from a 2009-2014 strategy by the MOHLTC to address Hepatitis C treatment gaps within Ontario (Exhibit 1). Currently, there are 17 Hepatitis C Virus (HCV) teams across Ontario to address the accessibility gaps in screening, care, and treatment. The proposed strategy was based on five components: treatment, prevention, education, support, and research & surveillance (MOHLTC, 2013).

The six priority populations listed below were identified as at-risk peoples due to having barriers “accessing traditional forms of health care” (MOHLTC, 2013):

- Substance users
- People involved with the correctional system
- Homeless people and those with inadequate housing
- Aboriginal Peoples
- Street-involved Youth
- People with tattoos and/or piercings (MOHLTC, 2013)

The specially designed, multidisciplinary Bloom Clinic HCV team consists of a coordinator, outreach worker, nurse, and a psychosocial support worker (MOHLTC, 2013). Additionally, the Bloom Clinic utilizes a peer support worker from the target at risk vulnerable community that provides added support to the team. The peer support worker helps bridge communication and trust between the Bloom Clinic team and the at-risk peoples. The Bloom Clinic’s specialized

team considers the social determinants of health that surround the individual and the stigmatization associated with testing and treatment in their plan of care. Each team member brings unique skill sets to support the needs of the vulnerable Peel Region community members.

Services offered by the Bloom Clinic include confidential testing and treatment of Hepatitis C and HIV, peer-support workshops, and education on treatment/prevention. In addition, the clinic provides a holistic care approach, referrals to primary care services, and collaborative care with community health care providers (Bramalea Community Health Centre, 2016).

## SUPPORTING SEX WORKERS FOR HCV TESTING AND TREATMENT

Sarah Briars' roles and responsibilities outlined by the Hepatitis C Team Program Guidelines are the following:

- Provide education and training for HCV testing, treatment, and prevention.
- Facilitate educational workshops in places easily accessible for the six priority populations.
- Actively outreach in areas where at-risk persons may frequently visit.
- Assist clients with necessary paperwork/documentation (eg. health cards and birth certificates).
- Provide emotional support for clients during medical appointments, if needed.
- Recruit and train peer support workers.
- Report information to the governing agency.
- Design and develop educational materials on HCV and HIV, and distribute this information in various places visited by at-risk persons.

Sarah has been a Bloom Clinic outreach worker for less than a year and has gained valuable experience working with marginalized community members. She works hard to continually reach out to individuals within organizations/places (i.e. shelters, community kitchens, places of worship, and methadone clinics) to attract patients for Hepatitis C and HIV testing and treatment.

The Bloom Clinic's present outreach strategy (Exhibit 2) is based on the following:

- Mapping and exploring community partnerships.
- Responding to and connecting with Peel Region agencies/organizations.
- Identifying target populations who are at risk for HCV and/or HIV.
- Community engagement by identifying barriers to testing and treatment.

However, Sarah wants to expand her outreach beyond the Ministry's current mandate with other vulnerable populations such as sex workers, who are at risk for Hepatitis C and/or HIV infections. Presently, sex workers are not specifically identified in the current MOHLTC mandate; however, some sex workers fit the criteria of an at-risk person under the existing guidelines. Sex workers benefit from a combination of harm reduction strategies and accessibility to health care services for HIV prevention (Lazarus et al., 2012). There is the societal myth that all sex workers are drug users and/or have a history of sexual abuse; thus, this societal myth translates to the assumption that sex workers are captured under the present six specified populations outlined by the MOHLTC (Benoit & Shumka, 2015).

Studies have shown 15% to 30% of individuals who do not seek treatment for Hepatitis C will have their condition progress to cirrhosis of the liver and/or death. It is also challenging for sex workers to obtain health care, as they fear "disrespect from health care providers" (Socías et al., 2015).

Sex workers are a vulnerable population due to their risk of exposure to infectious diseases and violence; therefore, they are sensitive to negative health outcomes. Sex workers are subjected to the stigma and misperception that the nature of their work is illegal (Lazarus et al., 2012). Hence, sex workers are usually not forthcoming with health care practitioners regarding their occupation due to fear of arrest and/or disclosure of practice to authorities (Deering et al., 2015).

According to Benoit and Shumka (2015), a sex worker is a person who exchanges sexual services for money and/or goods. Sex workers vary in demographics such as age, gender, sexual orientation, ethnicity, religion, education, and income level. In Canada, studies have shown sex workers who are migrants/immigrants tend to be tested less often for infectious diseases due to language barriers when accessing testing and treatment (Lazarus et al., 2012).

Sex workers in the Region of Peel provide sexual services in either indoor markets (e.g. massage parlours) or outdoor markets (e.g. on the streets) (Kaminski, 2016). Approximately 20% of sex workers solicit clients on the street, compared to the other 80%, who work in indoor markets (Canadian Public Health Association, 2014). Therefore, there is difficulty in precise data collection on sex worker demographics in Canada. In addition, complexity in locating sex workers builds challenges for Hepatitis C and/or HIV testing and treatment.

### *CANADA (ATTORNEY GENERAL) V. BEDFORD*

On December 20, 2013, the Supreme Court of Canada presided over the *Canada (AG) v. Bedford* case. The plaintiffs, Terri Jean Bedford, Amy Lebovitch, and Valerie Scott, who were current and/or former sex workers, felt the current laws on prostitution violated the *Canadian Charter of Rights and Freedoms* (1982) and created unsafe work environments for sex workers (Lawrence, 2014). This trial was a landmark case as the Supreme Court of Canada ruled in favour of the plaintiffs, declaring sections 210, 212 (1)(j), and 213 1(c) of the *Criminal Code* (1985) unconstitutional and in violation of section 7 of the *Canadian Charter of Rights and Freedoms* (1982): “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice” (Alberta Justice and Solicitor General, 2014).

The provisions of the *Criminal Code* (1982) relevant to *Canada (AG) v. Bedford* are:

(a) s.210, which makes it an offence to keep or be in a bawdy-house;
(b) s.212(1)(j), which prohibits living on the avails of prostitution[1]; and,
(c) s.213(1)(c), which prohibits communicating in public for the purposes of prostitution.

(*Criminal Code*, 1985).

Since the court ruling, which struck down multiple prostitution laws, the courts gave the government one year to implement new legislation. Bill C-36 is a proposed amendment to the *Criminal Code* (1985) resulting from the *Canada (AG) v. Bedford* Supreme Court case. Bill C-36’s objectives are based on the following:

- The majority of those who sell their own sexual services are women and girls. Marginalized groups, such as Aboriginal women and girls, are disproportionately represented.
- Entry into prostitution and remaining in it are both influenced by a variety of socio-economic factors, such as poverty, youth, lack of education, child sexual abuse and other forms of child abuse, and drug addiction.

[1] *Repealed, 2014, c. 25, s. 13.*

- Prostitution is an extremely dangerous activity that poses a risk of violence and psychological harm to those subjected to it, regardless of the venue or legal framework in which it takes place, both from purchasers of sexual services and from third parties.
- Prostitution reinforces gender inequalities in society at large by normalizing the treatment of primarily women's bodies as commodities to be bought and sold. In this regard, prostitution harms everyone in society by sending the message that sexual acts can be bought by those with money and power. Prostitution allows men, who are the primary purchasers of sexual services, paid access to female bodies, thereby demeaning and degrading the human dignity of all women and girls by entrenching a clearly gendered practice in Canadian society.
- Prostitution also negatively impacts the communities in which it takes place through a number of factors, including: related criminality, such as human trafficking and drug-related crime; exposure of children to the sale of sex as a commodity and the risk of being drawn into a life of exploitation; harassment of residents; noise; impeding traffic; unsanitary acts, including leaving behind dangerous refuse such as used condoms or drug paraphernalia; and, unwelcome solicitation of children by purchasers.
- The purchase of sexual services creates the demand for prostitution, which maintains and furthers pre-existing power imbalances, and ensures that vulnerable persons remain subjected to it.
- Third parties promote and capitalize on this demand by facilitating the prostitution of others for their own gain. Such persons may initially pose as benevolent helpers, providers of assistance and protection to those who "work" for them. But the development of economic interests in the prostitution of others creates an incentive for exploitative conduct in order to maximize profits. Commercial enterprises in which prostitution takes place also raise these concerns and create opportunities for human trafficking for sexual exploitation to flourish. (Government of Canada, 2016).

## THE NORDIC MODEL

Bill C-36 is a similar approach to Sweden's 1999 Nordic Model, which criminalizes the purchase of sex. Other countries such as Norway and Iceland have also implemented similar legislation to combat the demand for prostitution. In 2014, the European government advised its member and observer states, which include Canada, to implement the same Nordic-Model approach (Government of Canada, 2016).

Since the inception of the Nordic Model in Sweden, there has been a shift from outdoor prostitution to indoor prostitution. Thus, there are claims that this model has increased the repression of sex workers and built challenges to accessing health care services. Sex workers in Sweden have also faced challenges sustaining housing due to stigmatization (Chu & Glass, 2013).

HIV transmission is a concern among sex workers and using condoms is known as a preventative measure. However, sex workers will not carry condoms in Sweden as law enforcement will link condoms with prostitution (Chu & Glass, 2013).

## EXAMPLES OF OUTREACH STRATEGIES IN CANADA

Rezo, Montreal, Quebec (CATIE, 2016a)

- Provides outreach service for male sex workers in hotels, strip clubs, and bars.
- Evening drop-in centre to access health services.

Orchid, Vancouver, British Columbia (CATIE, 2016b)

- Outreach workers visit primarily massage parlours and develop trust among proprietors by giving cookies (Asian etiquette).
- Rapid HIV and STI (sexual transmitted infection) testing is provided in the massage parlours.

## REFLECT ON CONFLICTING INTERESTS

As Sarah sits in the meeting she knows that she needs to propose an action. But what? She considers which outreach strategies she and her team can implement. Should she and her team take a political stand and advocate for improvements to Bill C-36? What could the implications be if they do enter the political arena? How can she influence policy from her position? Is that within her job description? Does the Oakes test[2] validate her by confirming if Bill C-36 violates the *Canadian Charter of Rights and Freedoms* (1982)?

1) What outreach strategies should Sarah Briar and her team implement to reach Sex Workers in the Peel Region for Hepatitis C and/or HIV testing and treatment?
2) Does Bill C-36 violate the *Canadian Charter of Rights and Freedoms* (1982)? (e.g. is the Oakes test met?)
3) Should the Bloom Clinic team advocate to improve the provisions of Bill C-36? Are there any implications, since they are a Ministry funded team?

## CONCLUSION

At the Bloom Clinic meeting, the team discusses Bill C-36. Sarah briefed the team on the Peel Harm Reduction Meeting she attended, and the feedback regarding upcoming pass of Bill C-36. Each team member read the Globe and Mail article and discussed the implications to their care and outreach. The team was in unison over the complex legal implications of Bill C-36, and their limited resources to advocate and build trust within the sex worker community.

[2] *"This two-part legal test, known as the Oakes test, is applied each time a Charter violation is found in order to determine if a law that infringes a Charter right can be justified under s. 1 of the Charter. The Oakes test is outlined as follows:*

*1. There must a pressing and substantial objective for the law or government action.*

*2. The means chosen to achieve the objective must be proportional to the burden on the rights of the claimant.*

*i. The objective must be rationally connected to the limit on the Charter right.*

*ii. The limit must minimally impair the Charter right.*

*iii. There should be an overall balance or proportionality between the benefits of the limit and its deleterious effects." (Ontario Justice Education Network, 2013).*

**EXHIBIT 1**

## 1 Introduction

The Hepatitis C Secretariat worked with stakeholders across Ontario to conduct a needs assessment, gathering evidence and community input to inform the key recommendations that address the gaps in hepatitis C service delivery.

Community consultations were held in 13 communities across Ontario with stakeholder representation including Aboriginal health and social services, social service agencies, health care providers, correctional facilities and people living with/affected by the hepatitis C virus (HCV).

Subsequent to these meetings, each of the 13 communities were asked to identify a representative to conduct further local consultations with health and social service providers and produce a local community strategy for addressing hepatitis C in their community. The 13 local community strategies were submitted to the Hepatitis C Secretariat and shared with the Ontario Hepatitis C Task Force members. Information acquired through both the local community consultations and the local community strategies were used to inform the Task Force's A Proposed Strategy to Address Hepatitis C in Ontario: 2009 – 2014.

The Task Force's proposed strategy was presented to the Minister of Health and Long-Term Care in September 2009. A Proposed Strategy to Address Hepatitis C in Ontario: 2009 - 2014 focuses on 40 recommendations in 5 priority areas: treatment, prevention, education, support and research & surveillance.

In response, the ministry received cabinet approval in February 2010 to put forward the Ontario Hepatitis C Strategy. The key elements of the Strategy consist of the following:

*Enhanced Services and Supports*
Creation of 16 "HCV Teams" to ensure a coordinated, comprehensive approach to treatment and support of those living with/at risk of acquiring hepatitis C. The HCV teams consist of HCV outreach workers and community coordinators, additional HCV treatment nurses and access to psychosocial supports.

*Education and Outreach*
A targeted education and outreach strategy for at risk communities, and a continuing medical education program for physicians and health professionals.

*Encourage Prevention*
Additional Support for the Ontario Harm Reduction Distribution Program.

Ontario

Source: MOHLTC, 2013.

## EXHIBIT 2

**Bloom Outreach Strategy**

| | Activities | Short-term Outcomes (learning) | Intermediate Outcomes (action) | Long-term Outcomes (change in conditions) |
|---|---|---|---|---|
| | | **PHASE I** | | |
| 1 | **Mapping & Exploring potential Partnerships: Identify allies in the community to partner with** | Identifying which community allies can increase our ability to test, screen & treat those living with HCV | Promotes professional networking to identify new testing sites | Increased accessibility for individuals to be tested in community sites and be connected to treatment |
| | | Identifying mutual interests and goals | Engaging in meaningful conversations that lead to collaborative approaches | Strengthens and supports Bloom Clinic goals for testing and treatment access |
| 2 | **Responding & Connecting: Community engagement with Peel Region partner agencies/organizations** | Identifying commonalities that will increase potential partnerships | Collaboration of programs to increase accessibility of HCV support to current and new clients | Strengthens and supports Bloom Clinic goals for testing and treatment access |
| | | | Increases more effective referral practices between partner agencies for clients living with HCV | More individuals are connected to supports for HCV and intersecting needs |
| 3 | **Identify potential target populations** | Understanding which target populations are at risk for and are living with HCV | Reaching more community members who want to be tested and access HCV treatment | More individuals are connected to treatment, thus decreasing risk and transmission of HCV/HIV in Peel Region |
| | | | | |
| | | **PHASE II** | | |
| 1 | **Community Engagement: Identify intersecting client needs while testing for HCV** | Understanding what barriers are impacting individuals seeking testing | Practical, social and emotional needs are met/addressed thus increasing quality of life | Clients accessing additional Bloom Clinic services are aware of testing & treatment support |
| | | | Increase understanding of HCV in the community through presentations and workshops, and distribution of program resources | Increased education on transmission methods prompts more individuals to be tested, screened and treated |
| | | Raise awareness on HCV risks and vulnerabilities | Individuals access pre-test/post-test counselling to support adaptive & coping behaviours and strategies | Clients feel more supported and increases adherence to treatment for successful outcomes |

Source: WellFort Community Health Services (2016). Bloom clinic strategy. Unpublished internal document.

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# INSTRUCTOR GUIDANCE

## Where are the Sex Workers?

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### BACKGROUND

The Bloom Clinic of the WellFort Community Health Services in Brampton, Ontario is mandated to serve six specific populations for HCV (Hepatitis C Virus) testing. The Bloom Clinic also tests for all Hepatitis viruses, HIV and STIs. The six priority populations listed below were identified as at-risk peoples due to having barriers "accessing traditional forms of health care" (Ministry of Health and Long-Term Care, 2013).

- Substance users
- People involved with the correctional system
- Homeless people and those with inadequate housing
- Aboriginal Peoples
- Street-involved Youth
- People with tattoos and/or piercings

The specially designed, multidisciplinary Bloom Clinic HCV team consists of a coordinator, outreach worker, nurse, and a psychosocial support worker (Ministry of Health and Long-Term Care [MOHLTC], 2013). Currently, the Hepatitis C Team Program Guidelines by the MOHLTC do not include sex workers. However, some sex workers are captured within the six identified specific populations. The mandate's goal is to reduce the spread of HCV by providing accessible support for testing and treatment (MOHLTC, 2013). Statistics show 20% of sex workers work outdoors (e.g. street corners) and the other 80% work indoors (e.g. their own home or client's home, or commercial venues) (Canadian Public Health Association, 2014).

Sarah Briar, the outreach worker for the Bloom Clinic, presently builds partnerships with various organizations, health care providers, and community leaders. Building partnerships is part of the Bloom Clinic Outreach Strategy (Exhibit 1).

Sarah sat at Peel's Harm Reduction meeting and was informed by Constable Radishwich of the potential passing of Bill C-36 legislation. Bill C-36 is intended to criminalize those who purchase sex; this legislation is to resemble the Nordic Model in Sweden. Bill C-36 is the proposed amendment to the *Criminal Code* (1985); however, there is a concern that Bill C-36 will drive more sex workers to work underground and create barriers for health services outreach strategies.

Sarah shares with her team the potential impact of Bill C-36 and how it will affect the outreach strategies for HCV and HIV prevention and treatment. The team is Ministry funded, with limited resources and governance power to improve the provisions of Bill C-36.

## OBJECTIVES

1. Learning the implications of legislation (Bill C-36) on accessibility of services for the vulnerable (outreach strategies).
2. Division of Powers (Federal and Provincial) in reference to Bill C-36.
3. Challenge Bill C-36 by applying the Oakes test – *Canadian Charter of Rights and Freedoms*.
4. Challenges working within a Ministry funded program; in regards to exceeding the Hepatitis C team Program Guidelines and objectives.

## DISCUSSION QUESTIONS

1. Apply the Nordic Model (Sweden) to the Canadian context. What are similarities and differences within the two judicial systems and demographics?
2. Discuss the Oakes test – *Canadian Charter of Rights and Freedoms*; is Bill C-36 proposed provisions connected to its purpose?
3. After developing a concept map of the social determinants of health for sex workers, which outreach strategies would you implement?

## KEYWORDS

Oakes test; Hepatitis C Virus (HCV); harm reduction; accessibility; social determinants of health; *Criminal Code*; health behaviours; *Canadian Charter of Rights and Freedoms*; advocacy.