On the Criminalization of HIV Nondisclosure: HIV Vulnerabilities and Implications for HIV Testing among Survival Sex Workers in a Qualitative Study from Victoria, Canada

by

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BA (Hons), Sociology
University of Victoria, 2013

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We acknowledge with respect the Lekwungen peoples on whose traditional territory the university stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical relationships with the land continue to this day.

Supervisory Committee

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Abstract

Background: In Canada, failure to disclose HIV+ status before sex can result in incarceration and status as a registered sex offender for life. In 2012, the Supreme Court of Canada ruled that there is no legal mandate for HIV disclosure before sex if (i) a condom is used and (ii) HIV viral loads are extremely low. There is very little known about how the legal mandate for HIV disclosure might inequitably affect the health and safety of sex workers.

Purpose: This study critically interrogates the interplay between the legal mandate for HIV disclosure and the routine health-conscious practices (e.g., HIV testing, condom use) of HIV-negative survival sex workers, with particular attention to inequitable health and safety outcomes. This study also qualitatively investigates the structural and social forces that mediate vulnerability to HIV infection and transmission among sex workers, their clients, and their non-commercial, intimate partners.

Method: This study employed an adapted grounded theory approach to conducting and analyzing (n=9) open-ended, in-depth interviews with a convenience sample of currently working and recently exited sex workers who were clients at PEERS, an NGO offering services and support to sex workers in Victoria, Canada.

Findings: The criminalization of HIV nondisclosure had no discernable influence on behavioural HIV risk factors or HIV testing. Participants lacked accurate knowledge of the legal mandate for HIV disclosure. HIV-related health literacy was low. Participants strongly supported HIV disclosure as a legal obligation – but only for exacting justice, and not for reliably offering protective health benefits. The uptake of high-risk sexual practices was driven almost exclusively by (i) extreme needs when servicing clients (e.g., drugs, childcare, money) and (ii) the rich symbolism of condomless sex in non-commercial, intimate partnerships. Participants reported differential degrees of entrenchment in the sex trade at various times in their working lives due to extreme needs. Participants emphasized the importance of ongoing HIV testing as a personal responsibility in order to monitor and maintain their

sexual health. Participants identified increased uptake of HIV-related knowledge as affording the most significant protective health benefits against HIV infection.

Implications: Lower levels of HIV-related health and legal literacies in the sample call for greater scrutiny of the impacts of initiatives such as 'Seek and Treat for Optimal Prevention of HIV/AIDS' (or STOP HIV/AIDS®) which target vulnerable populations across British Columba [BC]. Deeply entrenched sex workers have little recourse to exit the sex trade immediately upon receiving an HIV+ test result, especially in under-resourced social assistance milieux. Targeting this population for HIV testing facilitates the creation of a new caste of HIV+ potential criminals, despite the well-established, beneficial health outcomes at the individual and population levels from early commencement of antiretroviral treatment.

Conclusion: Survival sex workers require special considerations in HIV pre-test counselling. The empowerment of sex workers can come firstly through the enhancement of HIV-related health – and legal – literacies. Full knowledge of the advantages and disadvantages of HIV testing will allow the consent for HIV testing to be truly informed. New HIV testing guidelines make BC the first province to recommend regular HIV screening for all adults. These guidelines also recommend exclusion of discussions of the criminalization of HIV nondisclosure in pre-test counselling for all patients (BCCDC 2016). Re-thinking the consent for HIV testing among sex workers is crucially important for their immediate health and safety.

Keywords: HIV/AIDS; HIV non-disclosure; HIV testing; sex work; vulnerable populations; grounded theory; criminology.

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Lastly, I would like to acknowledge and respect the W̱SÁNEĆ, Lkwungen, and Wyomilth peoples of the Coast Salish Nation on whose traditional territory the University stands, and whose historical relationships with the land continues at present. I am grateful to be a guest in this traditional territory.

Dedication

I dedicate this thesis to the sex workers of Victoria, Canada, who made possible the shared knowledge in what follows.

Introduction[1]

Background: Positioning the Problem

In Canada, persons living with HIV have been legally obligated to reveal their HIV status to their sexual partners since *R v. Cuerrier* in 1998. Failure to disclose their HIV status could result in incarceration and lifetime recognition in Canada's *National Sex Offender Registry.* The crime stems from 'nondisclosure' rather than transmission of the virus. The criminal codes applied to HIV nondisclosure were updated in October of 2012. The Supreme Court of Canada ruled in two high-profile cases that there is no legal mandate for HIV disclosure if the following two criteria are met: (i) a condom is used and (ii) blood concentrations of the virus are extremely low. Legal scholars and HIV advocates have noted that these most recent Court rulings are deeply problematic given the difficulties in providing evidence that these two criteria were met during subsequent criminal investigation (Canadian HIV/AIDS Legal Society 2014). For context, Canada has the second highest absolute number of convictions related to HIV nondisclosure, exposure, and transmission among all global nations, second only to the United States (Bernard and Bennett-Carlson 2012).

There is emerging evidence that the criminalization of HIV nondisclosure is affecting the health-seeking behaviours of populations vulnerable to HIV infection in adverse ways. Some HIV-negative gay and bisexual men express aversion to seeking HIV testing because they fear criminal prosecution for merely knowing their HIV status in Canada (Kesler et al. 2013; O'Byrne, Bryan and Woodyatt 2013; O'Byrne et al. 2013) and other global regions (Harsono et al. 2016; Arreola et al. 2015; Dodds, Bourne, and Weitt 2009). HIV testing is crucially important in the HIV cascade of care in two ways: Early commencement of antiretroviral therapy dramatically improves health outcomes at the individual level while curbing the spread of HIV at the population level (Montaner et al. 2014; Dieffenbach and Fauci 2009).

At present, HIV screening is being scaled up in the province of British Columbia

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[1] On a short lexicographical note, I employ the terms 'vulnerability' and 'entrenchment' throughout this thesis as a matter of convention in the health literature. By no means do I intend to denote 'powerlessness.' I struggle even to use the term 'sex workers' and would rather use, for instance, 'sisters and brothers who happen to be trading sex stuff for other stuff, at some point' to express in this thesis that 'sex worker' denotes a plurality of persons and not a master status. Similarly, I interchange 'persons living with HIV' with 'HIV+ persons' for ease of reading, in some places. The term 'sex worker' emphasizes that this 'work' is recognized as a legal occupational pursuit in Canada.

(BC) through two key initiatives. Firstly, in order to maximize the engagement of vulnerable populations in the HIV cascade of care, the provincial initiative, 'Seek and Treat for Optimal Prevention of HIV/AIDS' (or STOP HIV/AIDS®), expanded across the Province in April of 2013. Under the rubric of 'Treatment as Prevention®,' STOP® outreach teams have been seeking, testing, and treating vulnerable populations who experience difficulties in accessing health services through traditional channels, for reasons that include homelessness and concurrent substance use and mental health disorders (STOP® 2016). Secondly, the Office of the Provincial Health Officer (2014) released HIV testing guidelines in May of 2014 that make BC the first Canadian region to encourage routine HIV testing for all adults within clinical and hospital settings. The appendix to these guidelines discourages any mention of the criminalization of HIV nondisclosure during pre-test counselling when obtaining patient consent (BC Centre for Disease Control [BCCDC] 2016). Indeed, routine HIV testing is being scaled up in British Columbia. HIV testing remains inextricably linked to the legal mandate for HIV disclosure, because the medical record of a person being informed of his HIV+ status remains the only concrete means by which HIV nondisclosure criminal prosecutions in Canada have proceeded. Being diagnosed as HIV+ is a life-altering moment for many persons, but the knowledge of HIV+ status might have more severe ramifications for persons whose immediate survival and care of dependents requires engagement in the sex trade.

Against this backdrop, there remains an absence of literature published on how HIV-negative sex workers understand the legal mandate for HIV disclosure, and how their understandings might interplay with their uptake of HIV testing as well as their patterns of condom use with clients and non-commercial, intimate partners. There is also an absence of literature with respect to how the legal mandate for HIV disclosure might be interacting with (or amplifying) already existing vulnerabilities among sex workers surrounding intimate partner violence, occupational environments, levels of HIV-related health and legal literacies, relationships with law enforcement officials, patterns of hard drug[2] use, and various factors driving entrenchment in the sex trade. Sex workers are recognized across the literature as a highly stigmatized population group whose members live and work amid various social and structural conditions that drive sexual violence and elevate their risk of HIV infection (Shannon et al. 2015; Benoit and Millar 2001; Shannon et al. 2008; Doherty

[2] I use the term 'hard drugs' in this thesis to denote only crack, cocaine, crystal meth, and opioids that are consumed for non-medical purposes.

2011; Lewis, Maticka-Tyndale, and Shaver 2006). HIV-negative survival[3][4] sex workers constitute the population under study in this thesis.

Research Questions

The following research questions guided this study: Firstly, how do HIV-negative survival sex workers understand HIV disclosure, legally and in other ways, and how might this interrelate with their health-conscious practices such as HIV testing and condom use? Secondly, how could social contexts and structural conditions drive HIV vulnerabilities among HIV-negative survival sex workers when providing services to clients, and how are these vulnerabilities be understood? Thirdly, in what ways could social contexts, conditions drive HIV vulnerabilities in non-commercial, intimate partnerships? And lastly, what are the strategies employed by sex workers to maintain and support their health and well-being, and how are these strategies understood?

Rationale

The extent to which Canada's legislative approach to HIV disclosure might be inequitably affecting the health and safety of sex workers is not well known, particularly in the wake of the most recent rulings by the Supreme Court of Canada in October of 2012. Previous studies on the impacts of legislation related to HIV exposure, HIV nondisclosure, and HIV transmission have been conducted among samples of HIV+ gay, bisexual, and other men who have sex with men outside of the sex trade. Among studies in the international health literature on HIV disclosure, few have specifically addressed the impacts of similar laws related to HIV transmission and HIV exposure. Moreover, the experiences of HIV-negative populations vulnerable to HIV infection are either not the focus of these studies, or HIV-negative persons are altogether excluded. Survival sex workers are important stakeholders in the criminalization of HIV nondisclosure not only

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[3] 'Survival' sex work denotes engagement in the commercial sex trade on account of extreme needs for money, drugs, and/or food. This term is commonly associated with sex workers experiencing homelessness, mental health disorders, substance use disorders, and other factors driving severe socioeconomic disadvantage (Flowers 2010; Kelly and Breslin 2010).

[4] Participants in this study expressed varying degrees of unmet needs at different times in their working lives that drove their engagement in trading sex. I employ the term 'survival' not necessarily to denote that all participants were survival sex workers at precisely the time of the interviews (some were), but all participants were indeed able to speak of a period (or periods) in their lives when their engagement in trading sex was driven exclusively by basic needs for survival. This label reflects the convention in the literature. None of the participants in this study self-identified as 'survival' sex workers.

on account of extreme vulnerabilities to HIV infection within the global health literature (UNAIDS 2017), but also on account of their ongoing need to engage in the sex trade to support themselves as well as children. The criminalization of HIV nondisclosure is an especial concern for female sex workers not only because women are vastly overrepresented in the sex trade, globally (UNAIDS 2015), but also because of the historical structures and social forces which overburden women through gender-based power inequities that extend to control over condom use, stigma and discrimination preventing access to health services and police protection, sexual violence, overburden of childcare responsibilities, and lower wages, globally (PSI 2017; UN Women 2017). I make no claims of national (or provincial) representation with the knowledge co-created for this thesis but, rather, I intend to offer 'voice' to an extremely generous, albeit small, subset of sex workers in Victoria, Canada.

In this thesis, I examine a rich qualitative dataset generated from participant interviews with sex workers. I explore their understandings of the disclosure of HIV status, whether moral, legal, or otherwise, and the perceived potential of their sexual protection afforded by the criminalization of HIV nondisclosure. In addition, I explore how levels of HIV-related health and legal literacies might facilitate deeper vulnerability under HIV nondisclosure legislation, particularly through institutional policies that overlook their welfare within HIV pre-test counselling guidelines. I couple this with a sociological exploration of how sex workers experience vulnerabilities within both the sex trade and their non-commercial, intimate partnerships, with additional attention towards the strategies they employ to maintain their health and safety. A nuanced understanding of these dimensions could help health support providers to offer better care in the forms of tailored programs and participatory educational resources. This knowledge could also provide the backdrop for discussions on social policy aimed at ameliorating the health, safety, and well-being of this vulnerable population.

The protagonists of this thesis are survival sex workers. Their health and safety are of key concern, particularly with respect to HIV prevention and treatment as well as avoidance of HIV-related jurisprudential harms. My intent is to recognize sex workers not as vectors of disease but, rather, as empowered voices at the table who live and work amid various structural and social forces which mediate their optimal health and safety in relation to HIV infection at the micro-, meso-, and macro-levels (Shannon et al. 2015; Benoit and Millar 2001; Shannon et al. 2008; Doherty 2011; Lewis, Maticka-Tyndale, and Shaver 2006). On account of severe stigmatization and discrimination by police (Benoit et al. 2016), a relatively higher number of sexual partners, the extreme rarity of exiting the sex trade on the first attempt (Benoit and Millar 2001), nearly 100% acquiescence to receive onsite Rapid HIV testing at street outreach centres (Shannon et al. 2007), and the decisive fact that HIV+ persons experience vulnerability to coercion through the mere 'threat' of false HIV nondisclosure allegations (Barry et al. 2014b), sex workers are particularly prone

to becoming easy targets of the various legislations used in HIV nondisclosure cases. This vulnerability can also be driven by misunderstandings and inaccurate knowledge of legislations employed in HIV nondisclosure cases. I illuminate these dimensions through the review of the current literature and analysis of participants' narratives in what follows.

Specific Objectives

This study takes the following specific objectives: (1) Explore how HIV-negative survival sex workers understand the practice of HIV disclosure on moral grounds, and as a legal obligation affording protective health benefits. (2) Investigate the extent to which sex workers are knowledgeable of the legal mandate for HIV disclosure, and how this might interact with various health-seeking practices such as HIV testing. (3) Explore the contexts and conditions that drive vulnerabilities to HIV exposure and transmission among sex workers, their clients, and their non-commercial, intimate partners. (4) Examine the strategies used by sex workers to protect, maintain, and improve their health. (5) Use this knowledge to guide the development of participatory educational resources for sex workers, and provide recommendations for future research that could be inclusive of, and responsive to, the needs of sex workers in Victoria and other settings.

Methods

This study is informed by open-ended, in-depth interviews with cis-male (n=2) and female (n=7) sex workers, currently working and exited,[5] from the Capital Regional District of Victoria, BC. Participants had provided services to at least 15 clients in one previous year, were at least 19 years of age, legally entitled to work in Canada, and were HIV-negative or uncertain of their HIV status. Through an adapted grounded theory approach, a convenience sample was recruited for participation with assistance from PEERS, a non-profit NGO dedicated to social justice, advocacy, and the empowerment of sex workers through harm reduction and evidence-based approaches. The interviews took place in July and August of 2015. (See Appendix III for interview schedule and brief notes on participant demographics.) The interviews were guided by themes rather than standardized questions (See Appendix I for interview guide.) Prior to the interviews, participants were not offered any information relevant to the legal mandate for HIV disclosure before sex in Canada. Interview data were audio-recorded, transcribed, anonymized, and imported to qualitative software for analysis and interpretation.

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[5] I discuss in Chapter 4 (4.4 *Sample*) issues surrounding the term 'exited.'

The grounded theory method relies on a set of principles and guidelines rather than formulaic prescriptions, beginning with the collection of data, and continuing in tandem with iterative comparative analysis of initial codes, selective codes, and thematic development (Charmaz 2013, 2014). The constructivist grounded theory approach emphasizes recognition of power inequities between researcher and participants, and it aims to capture reality through shared meanings and the co-construction of knowledge; interpretive grounded theory emphasizes 'understanding' over 'explanation' through relativist epistemology and subjectivist ontology (Charmaz 2013, 2014). The full literature review in the final stage of the research process reduced my biases and preconceived notions during the interview process and iterative analyses. Recording reflexive memos is an integral component of the grounded theory method. In this, I kept rich databanks of ideas, thoughts, and insights, which guided me in constant comparative analysis at all methodological and analytic stages (see Charmaz 2014). I continued interviewing participants until 'theoretical saturation' or, the point at which the collection of additional interview data no longer aided in the refinement of key concepts and themes.

Theoretical sampling indicates that participant selection would be guided under ideal circumstances by evolving criteria that were developed from iterative analysis of previous interviews. The adapted grounded theory approach in this thesis employed convenience sampling rather than theoretical sampling on account of the difficult-to-reach nature of the population under study. In generating a rich qualitative dataset on the topics informing the research questions, I was at no point constrained by lack of refinement (or divergence) of the selection criteria for future participants due to the convenience sample. I complemented the adapted grounded theory method with principles from community-based research (Canadian Institutes of Health Research 2013) that emphasize social justice and empowerment of the population under study as well as the coordination of research design and implementation with frontline workers and community leaders.

After full analysis of the interview data and complete literature review, the following three themes emerged: The meanings of HIV disclosure, with considerations of moral, legal, and other (juricical) dimensions (Chapter 5); Co-constitutive factors driving HIV vulnerability among sex workers, delineated as understandings of vulnerabilities in relation to drug use as well as in relation to intimacy (Chapter 6); and HIV testing and strategies to mitigate HIV-related harms.

Findings

As shared by participants, HIV disclosure before sex was understood as a duty to be carried out by (potentially) themselves, their clients, and their non-commercial, intimate partners. Simply put, participants expressed that HIV disclosure should take place under all circumstances. A minority of participants believed that the legal mandate for HIV disclosure offered them some degree of protective sexual benefits, but at no time was this

sense of protective benefit from the law sufficient to override their decision to use condoms with clients. None of the participants had accurate knowledge surrounding the conditions under which HIV disclosure was not legally mandated, but they generally believed that criminal prosecutions for HIV nondisclosure exacted justice appropriately. Some participants were under the presumption that Canadian HIV prosecutions were tied to the transmission of HIV or the intent to infect a partner purposively. Participants generally recognized non-disclosing, sexually active HIV+ persons as careless, reckless, or malicious.

In all, the criminalization of HIV nondisclosure had no discernable influence on study participants' uptake of HIV testing or condom use, or the importance they attributed to these. Participants lacked accurate knowledge surrounding the legal mandate for HIV disclosure before sex. With one exception, all participants stated they would immediately exit the sex trade upon receiving an HIV+ test result, although the legislation surrounding HIV disclosure was not cited as an impetus for exiting. Participants' engagement in practices known to have an elevated risk of HIV infection and transmission was closely tied to violent encounters and engaging in sex work at specific durations in their lives on account of extreme needs for money, hard drugs, and the financial support of children (the support of children was cited by all women who shared that they had children). For at least 2 participants, methadone maintenance played a dramatic, life-changing role in reducing the ongoing urgency to engage in sex work. Participants emphasized that condom use was important to reduce their risk of infection with STIs and HIV from their clients, but there were conditions under which their ability to negotiate for condom use with clients was compromised, particularly while under the influence of hard drugs and/or alcohol. Male participants emphasized the importance of condoms equally to females, but males acknowledged less consistency in their condom use. All participants used condoms rarely, or never, with their non-commercial, intimate partners, despite acknowledging the potential harms to their own sexual and physical health. Participants linked condomless sex to greater degrees of trust and intimacy, and the imperative to engage in condomless sex outweighed acknowledged risk of infection with HIV and other STIs.

All participants strongly emphasized that HIV testing was a responsible strategy to monitor their health. Testing for HIV and other STIs was however non-regular and taken up most often when offered to them. HIV-related health literacy was extremely low among all participants. The availability (and treatment outcomes) associated with highly active antiretrovirals (HAART or combined ART, cART) medications were unknown to participants. Participants who sought medical attention following unprotected sexual assault were not informed of the option of HIV post-exposure prophylaxis. Participants expressed that the enhancement of their HIV-related competencies was a key strategy for maintaining their health and safety. Throughout the interviews, participants expressed a desire to gain more HIV-related knowledge as an effective strategy to maintain their sexual health and

safety, particularly in areas related to the per-act risk of transmission of HIV and other STIs, including HIV risks that are associated with oral sex.

Implications

These empirical findings contribute to scholarship on the criminalization of HIV nondisclosure and HIV-related vulnerabilities among sex workers in several ways. Firstly, the criminalization of HIV nondisclosure had no discernable influence on study participants' HIV testing patterns or on condom use. Moreover, participants were unaware of the more recent rulings by the Supreme Court of Canada in October of 2012 that offered clarification on the conditions under which HIV disclosure would not be a legal obligation. Participants were not offered comprehensive knowledge surrounding the criminalization of HIV nondisclosure in advance of the interviews in order to mitigate bias in their responses. In Chapter 8.2, I will expand on how the non-interventionist research design and interview process could have influenced participants' responses, especially in the contexts of their levels of HIV-related health and legal literacies.

The findings from this study shed important light on the role of health promotion discourse in shaping study participants' understandings of the practice of safer sex in relation to HIV infection. All participants understood consistent condom use to be an important protective sexual health practice with clients, a paragon to strive for as a personal responsibility albeit not always attainable. However, participants also shared that they continued to engage in condomless sex with non-commercial partners despite admitting they had no assurances of their partners' HIV-negative status. This was even the case for participants who questioned the monogamy of their non-commercial partners. One participant continued with condomless sex in this non-commercial, intimate partnership despite knowing the partner was a carrier of Hepatitis C. In Chapter 6, I will discuss the importance of messaging that is specific to intimate, non-commercial partners within health promotion discourse targeting sex workers, combining analysis of interview data with the substantive literature in this area. I will also discuss how the responsibilization of condom use in health promotion discourse is at odds with messaging in health promotion discourse that condom use is the responsibility of all individuals, and I will consider the implications of this dissonance for sexual citizenship within neoliberal regimes of governance.

This study offers a contribution to the theoretical construct of moral regulation in the governmentality tradition, particularly by framing the expectations of HIV disclosure as moral governance of the self and others. An interesting paradox arose in participants' narratives: Participants strongly supported criminal sanctions for HIV nondisclosure while they also acknowledged their own engagement in unprotected sex with multiple partners (and in some cases sharing injection equipment) with self-shame, self-blame, and a retrospective sense of 'luck' that they had not previously been infected with HIV. In the case of HIV disclosure, HIV testing appears at face value a tenuous technology to

transform study participants instantly from potential victims into latent perpetrators (from moral subjects into moral objects, in the moral regulation framework). I will use interview data to inform discussions in Chapter 5.2 on how moral regulation theory could be advanced in areas related to empathy and empathetic deficit.

Lastly, I will present arguments that the massive expansion of HIV testing in British Columbia since 2014 will inequitably impact the health and safety of survival sex workers – perhaps more so than all other population subgroups vulnerable to HIV infection – as long as HIV disclosure remains legally mandated in Canada. On one hand, the population and public health benefits that can be attributed to early commencement of antiretroviral therapy are now evident (Montaner et al. 2014; Dieffenbach and Fauci 2009). On the other hand, it is extremely rare that sex workers in Victoria can exit the sex trade on their first attempt due to an array of entrenching factors (Benoit and Millar 2001), and it remains unclear how survival sex workers might be expected to accommodate their (and their dependents') extreme needs upon receiving an HIV+ test result. In the current study, participants expressed that they were already receiving (or had applied for) social/disability assistance, childcare subsidies, and NGO food hampers, and it is unclear which additional mechanisms would be in place to support them and their dependents – immediately and longer-term – in the event that they received an HIV+ test result.

In the absence of an immediate, operationalizable strategy to exit the sex trade upon receiving an HIV+ test result, the indiscriminate offering of HIV testing to survival sex workers has the potential to put their health and safety in the balance before enrolment in the cascade of HIV care has been deemed feasible for various reasons (e.g. concurrent substance use and mental health disorders). In addition, the current provincial HIV testing guidelines advise clinicians *against* informing their patients of the criminalization of HIV nondisclosure during pre-test counselling (BCCDC 2016 pp. 40-41). I argue that the empowerment of sex workers will thus coincide with the deployment of strategies to enhance their informed consent for HIV testing through channels found outside of clinical HIV testing encounters. In Chapter 8, I will advance a set of guidelines to inform the development of participatory educational programming and resources that include, but are not limited to, considering the option of delaying HIV testing until a more appropriate time when fuller engagement in the HIV cascade of care is more likely to be achieved, and making use of community-based NGOs for the dissemination of practical knowledge that is tailored towards the enhancement of HIV-related health and legal literacies.

Outline of Chapters

In Chapter 1, I begin by reviewing the criminal laws that govern the disclosure of HIV in Canada, and I review the few empirical studies on the impacts of HIV law. I continue in the next section by reviewing HIV disclosure in other global settings, from legal and non-legal perspectives, and finish by highlighting the few studies that are specific to sex

workers. I then present the theoretical construct of moral regulation that I will employ as an analytic frame during analysis. Next, I review the constructivist sociological perspective on HIV/AIDS. I follow this by exploring HIV testing in Victoria and the Treatment as Prevention® and STOP HIV/AIDS® initiatives that have brought world renown to HIV care in British Columbia. I close with a summary and brief discussion that relates this chapter to my first research question on participants' understandings of HIV disclosure, legally and in other ways, and how this understanding interrelates with their health-conscious practices such as HIV testing and condom use. This chapter also lays a foundation for my core arguments related to HIV testing and the creation of health vulnerabilities from HIV-related health policy and HIV the legal mandate of HIV disclosure.

I review in Chapter 2 the sociological and health literatures on commercial sex work, with a focus on studies conducted in British Columbia. The chapter begins by exploring current Canadian legislation governing sex work in the wake of Bill C-36 in 2014. I continue by highlighting structural, social, environmental, and occupational vulnerabilities in the everyday experiences of sex workers, and the ways these relate to gender and power dynamics. I review the literature on entrenchment and the difficulties inherent in exiting the sex trade, current strategies in sex work research, and I conclude with a summary and brief discussion that relates this chapter to my second research question concerning the social contexts and structural conditions driving HIV vulnerability among sex workers when providing services to clients. This literature offers a foundation for my arguments on inequities in the agency of survival sex workers to protect their sexual health consistently as well as their agency to exit the sex trade immediately upon receiving an HIV+ test result.

In Chapter 3, I examine the nuances of intimacy in sex workers' non-commercial, intimate partnerships, particularly as they relate to HIV vulnerabilities. I begin by offering conceptual definitions of intimacy, and briefly review classic social theory related to dyadic and triadic relational dynamics. I then review the literature on HIV vulnerabilities among sex workers related to intimate, non-commercial partnerships, the symbolism of condom use, and the implications of intimate partner violence for elevating the risk of HIV infection. I close with a summary and brief discussion that relates this chapter to my third research question on the contexts, social conventions, and interpersonal norms that drive HIV vulnerabilities within non-commercial, intimate partnerships. The literature reviewed in the second and third chapters offers additional contexts for my analysis that interweaves (i) vulnerabilities within non-commercial, intimate partnership dynamics with the (ii) structural, environmental, and occupational vulnerabilities in survival sex work. I will use this literature to create an analytic frame to unpack how perceived HIV-related vulnerabilities among sex workers are driven (and amplified) in triadic relational axes with both commercial and non-commercial, intimate partners.

I describe the research design and methods in Chapter 4. Here, I review grounded theory and community-based research approaches. I then describe the setting, sample, participant recruitment, my theoretical sensitivity, data collection, and detailed description of the analytic stages. I close this chapter by reviewing ethical considerations and by offering a reflexive statement. I have structured Chapters 5 through 7 to contain both data and discussion components, sectioned into three broader areas: (i) the meanings of HIV disclosure in Chapter 5, (ii) co-constitutive factors driving HIV vulnerabilities in Chapter 6, and (iii) HIV testing and strategies to reduce HIV-related harms in Chapter 7. In the conclusion, Chapter 8, I summarize key findings, arguments, and discuss limitations. I finish by offering several guiding tenets for participatory education among sex workers related to literacies in HIV risks, HIV testing, the legal mandate for HIV disclosure, and current HIV antiviral treatment outcomes. Lastly, I offer considerations for future research in this substantive area.

Chapter 1: The Criminalization of HIV Nondisclosure

This chapter offers a foundation for answering my first research question regarding participants' understandings of HIV disclosure, on legal grounds or otherwise, and how this might interrelate with their health-conscious practices such as HIV testing and condom use. My overall aim with the five sections in Chapter 1 is to provide an overview of the empirical evidence collected to date in scholarly publications, and I offer contexts for the legal and health care discussions related to HIV in Chapters 5 through 7. I begin in the first section (1.1) by examining the laws governing HIV disclosure in Canada. I highlight key historical rulings by the Supreme Court of Canada, and the existing empirical Canadian research on the effects of the legal mandate for HIV disclosure. I follow this in second section (1.2) with a review of the global literature on HIV disclosure, criminal and non-criminal, and I review the available studies on HIV disclosure that are specific to sex workers. My aim with the culmination of these two sections is to establish the diversity of attitudes, behaviours, and beliefs surrounding HIV disclosure, and to highlight complexities in the practice, process, and legal obligation of HIV disclosure, specific to context and region.

The next section (1.3) presents the theoretical construct of moral regulation in the works of legal sociologist Alan Hunt (1993, 1999). Moral regulation will serve this thesis as an analytic frame for understanding participants' perspectives and expectations on HIV disclosure, and the perceived harms of HIV infection through the paradigm of the 'governance of the self and others.' I continue in section 1.4 by reviewing the constructivist sociological perspective on HIV/AIDS that gives agentic dimensions to the virus. In section 1.5, I highlight the HIV testing services available in Victoria, BC, as well as advancements in antiretroviral therapy and evidence-based approaches to HIV treatment and prevention in British Columbia, and two key programs currently underway that aim to greatly expand HIV testing in the Province. The criminalization of HIV nondisclosure is inextricably linked to knowledge of HIV status and, thus, to HIV testing and health policies which delineate protocols for HIV pre-test counselling. I close this chapter with a summary and discussion in brief. This chapter will ultimately frame HIV disclosure, HIV testing, and HIV treatment as phenomena mediated by cultural, moral, legal, and historical understandings of the virus. HIV has social agency beyond the biomedical domain.

1.1 HIV Nondisclosure in Canadian Legislative Contexts

Understanding the issue: The legal mandate for HIV disclosure in Canada

In Canada, the criminalization of HIV nondisclosure is not as old as the virus. Since the precedent set by the Supreme Court of Canada in *R v. Cuerrier* (1998), persons living with HIV have been legally obligated to disclose their HIV status before engaging in sexual activities which posed 'significant risk of serious bodily harm' through viral

transmission, regardless of any intent to harm others. In this particular case, the Court convicted Mr Henry Cuerrier of two counts of aggravated assault, ruling he had obtained sexual consent by 'fraud' in not revealing his HIV status to his partners. Neither of the two women in this case became HIV+, and HIV nondisclosure before consensual sex subsequently became an 'aggravated assault' in Canada. The Court believed this ruling had clear public health benefits and would not have an impact on testing for HIV:

> The criminal law has a role to play both in deterring those infected with HIV from putting the lives of others at risk and in protecting the public from irresponsible individuals who refuse to comply with public health orders to abstain from high-risk activities [...] It is unlikely that individuals would be deterred from seeking testing because of the possibility of criminal sanctions arising later. (*R v. Cuerrier* 1998 pp. 52, 61)

Elaboration of the sexual acts and the conditions that posed 'significant risk' were established in subsequent Court rulings: In October of 2012, the Supreme Court of Canada rendered a decision in two high-profile cases. The Court found that HIV disclosure was a legal obligation before engaging in activities which pose a 'realistic possibility of HIV transmission,' and that vaginal penetrative sex with a condom *and* with an extremely low viral load (below 1,500 copies/mL) are conditions under which transmission is not realistically possible (*R. v. Mabior* 2012; *R. v. D.C.* 2012). However, it remains unclear how these rulings could apply to other sexual practices (for instance, unprotected anal sex between men), and the Court did not explain how one might operationalize 'proof' that these two criteria were met in future cases. For instance, in the absence of a signed contract, witnesses, or video recording that indicates disclosure and condom use occurred, and in the absence of scrupulous records of viral loads leading up to the time of engaging in sex, persons living with HIV are vulnerable to prosecution after engaging in any sexually intimate acts.

Between 1989 and 2015, there were over 180 prosecutions related to HIV nondisclosure in Canada, and this tally does not include nondisclosure cases that may have been pleaded out or investigated (Patterson et al. 2016). As of late 2010, nearly 80% of cases had resulted in conviction (HIV/AIDS Legal Network of Canada 2014). Social justice advocates have noted an overrepresentation of ethno-racialized and marginalized persons in HIV nondisclosure prosecutions. For instance, between 2004 and 2010, over 50% of heterosexual men charged with HIV nondisclosure were Black men (Mykhalovskiy and Betteridge 2012). While African, Caribbean, and Black men constitute 20% of all HIV-nondisclosure defendants between 1989 and 2015, these men have been identified in 62% of Canadian newspaper articles; these media (re)produce the representation of Black men as dangerous, hypersexual foreigners across Canada (Mykhalovskiy et al. 2016). Interestingly, heterosexual men are over-represented in Canadian HIV nondisclosure

criminal cases (Mykhalovskiv and Betteridge 2012) despite the much higher prevalence of HIV among gay and bisexual men in Canada since HIV emerged (Health Canada 2016).

In other global regions, some states have enacted new laws that are specific to HIV exposure, HIV transmission, and HIV nondisclosure. In Canada, however, persons living with HIV continue to be prosecuted under existing legislation. The majority of HIV nondisclosure prosecutions have been undertaken with the charge of 'aggravated sexual assault,' while others prosecutions have included 'administering a noxious substance,' 'sexual assault,' 'attempted murder,' and in one particularly controversial case, a conviction was successful under the charge of 'first-degree murder' (Canadian HIV/AIDS Legal Network 2014). The *Joint United Nations Program on HIV/AIDS* has been highly critical of Canada's legislative approach to HIV nondisclosure. This program seeks to end the overly broad criminalization of HIV nondisclosure, exposure, and transmission in all global regions, limiting criminal prosecutions exclusively to 'blameworthy' cases of HIV transmission (UNAIDS 2013). To these ends, Canada is a disappointment: In absolute terms, Canada has the second highest number of HIV exposure convictions of all global nations, second only to the United States (Bernard and Bennett-Carlson 2012).

Indeed, the legal mandate for HIV nondisclosure should ultimately serve as a protective measure to deter the transmission of HIV and to facilitate informed consent prior to engaging in sex. However, the Canadian HIV/AIDS Legal Society (2014) has noted that the protective public health benefits from this legislative approach to HIV disclosure is illusory given the prevalence of undiagnosed HIV cases. The Public Health Agency of Canada (2014) estimates that approximately 21% of Canadians living with HIV were unaware of their positive HIV status at the end of 2014. Undiagnosed persons living with HIV are unable to disclose their status in any contexts. Instead of improving public health, Jürgens et al. (2009) have noted that the legal disclosure mandate could lead some sexual partners to assume incorrectly that they are at very little risk of HIV infection due to the *absence* of HIV disclosure, thereby reducing their uptake of protective sexual practices.

The criminalization of HIV nondisclosure has further effects on HIV-related clinical health practices in Canada. In the last two decades, there has been a dramatic increase in the number of civil suits filed by both HIV+ and HIV-negative persons against Canadian health care providers and governmental agencies for not informing them of exposure to HIV by their partners (Symington 2009). This has created a problematic milieu in medical settings among clinicians who report they are uncertain how to delineate HIV-related health counselling from HIV legal disclosure obligations (O'Byrne and Gagnon 2012), a finding also confirmed in interviews with clinicians by Mykhalovskiy (2011). I continue with a review of the available evidence on the impacts of the criminalization of HIV nondisclosure among sexually active Canadians, and I follow this by exploring HIV disclosure in Canada from a non-legal perspective, including issues specific to women and Aboriginal populations.

Empirical research on the criminalization of HIV nondisclosure in Canada

Empirical studies on the effects of the legal obligation for HIV disclosure in Canada are scarce. Most available studies to date have drawn from samples of HIV+ gay and bisexual men, while only a small portion of studies have included HIV+ women or HIV-negative men and women. For instance, in two survey studies from Ontario on self-identified gay and bisexual men, 17% of HIV-negative (or uncertain of their HIV status) respondents reported that prosecutions for HIV nondisclosure had negatively impacted their uptake of HIV testing; these men also reported greater engagement in unprotected sex and greater use of anonymous HIV testing services (O'Byrne, Bryan, and Woodcraft 2013; O'Bryan, Bryan, and Roy 2013). In another mixed-methods study on (both HIV+ and HIV-negative) gay and bisexual men from Ontario, O'Byrne et al. (2013) found that HIV+ men had believed the public health department openly shared HIV information with law enforcement officials, and this rendered them unwilling to seek public health services that might otherwise help stop the onwards transmission of HIV, despite their desire to maintain safer sex practices. Both HIV+ and HIV- men in this study felt that HIV+ men were already labelled as promiscuous criminals; in particular, HIV+ men felt linked to the justice system before any illicit action had taken place, and they also felt that the public health focus was to track down their previous partners, with little concern for their own mental health and well-being (O'Byrne et al. 2013). Conversely, several HIV-negative men likened unprotected sex with a non-disclosing HIV+ man to 'having sex with a criminal' (O'Byrne et al. 2013).

In a qualitative study of 122 men and women living with HIV from Ontario, Adam et al. (2014a) found that disclosure was extremely complex due to unfavourable HIV disclosure experiences in the past, feelings of betrayal surrounding their own infection with HIV, and coping with HIV stigma when disclosing to new persons. The demands of universal adherence to HIV disclosure mandates placed participants in a complicated situation wherein they feared rejection, stigma, and prosecution, all before the public health concerns of HIV transmission could even be addressed (Adam et al. 2014a). In addition, participants in this study felt the legislated mandate for disclosure created a 'guilty until proven innocent' climate, and participants lived amid fears that disgruntled partners could use the law against them at any point (Adam et al. 2014b).

HIV laws in Canada are applied not only to disclosure before sex, but can be used on breastfeeding women living with HIV. In a qualitative study of women living with HIV in Ontario, Kapiriri et al. (2016) reported that their participants held some knowledge of the laws surrounding HIV nondisclosure for adults, but most had no knowledge of laws surrounding vertical (mother-to-child) HIV transmission; some women in this study shared that their children had been removed from their custody on account of breastfeeding.

A Toronto survey of 442 men who have sex with other men found that 7% were less willing to seek HIV testing under HIV disclosure law, a proportion which rose to 15%

among men who had unprotected sex with casual partners (Kesler et al. 2013). Other Canadian studies have included HIV nondisclosure at the periphery, but not as a primary focus. For instance, from data gathered in a 2011 cross-sectional national survey (n = 2139), 31% of respondents reported their belief that the criminalization of HIV nondisclosure was negatively affecting the willingness of Canadians to seek HIV testing (Calzavara et al. 2012). At the time of publication, there have not been any larger-scale, national studies to assess the potential impacts of the criminalization of HIV nondisclosure on HIV testing.

Empirical research on HIV disclosure in Canada within non-legally mandated contexts

In Canadian studies of HIV disclosure undertaken from a *non-legal* perspective, the process of disclosure is nearly as complex. For a backdrop on HIV disclosure in British Columbia, one recent province-wide study of 657 HIV+ men and women with previous antiretroviral experience found that only 74% of respondents disclosed their HIV+ status to all sexual partners (Allen et al. 2014). Not disclosing HIV status was found to be more common among respondents who reported having sex with strangers (including sex workers), identifying as a woman or gay/bisexual man, and not being on antiretrovirals (Allen et al. 2014). As this study drew from a sample of persons already engaged in the HIV cascade of care, these findings cannot be understood to be representative of HIV disclosure among the entire provincial population of persons living with HIV.

The literature on HIV disclosure in Canada indicates that there are issues specific to cis-gender and trans women. Firstly, in broader terms, there is overrepresentation of women living with HIV among Aboriginal populations, injection drug users, new Canadians and refugees, sex workers, and the LGBTQ community (Public Health Agency of Canada 2014). Canadian women in all contexts and settings receive more HIV testing when compared to men by way of pre-natal HIV screening, and this increases their chances of being aware of their HIV status. HIV screening among pregnant women has raised ethical issues in HIV-related health care related to opt-in versus opt-out HIV testing protocols (Walmsley 2003), and ethical discussions of HIV pregnant women often defer to weighing the risks and rights of children being born with HIV over health concerns for expectant mothers (Knight et al. 2014). Prenatal screening and improved access to antiretrovirals has resulted in less than 1 in 1000 reported vertical transmission of HIV (mother-to-child) in Canada between 1997 and 2012 (Bitnun et al. 2014). In contrast to men, women in British Columbia receive poorer overall quality in HIV-related health care, and quality of care is even lower among Aboriginal women, women living in rural areas, and women living on Vancouver Island (Carter et al. 2014), home to the current study setting. In contrast with men, studies indicate that meeting the current legally mandated criterion of having extremely low blood concentrations of HIV is less common among women on account of greater antiretroviral treatment interruption (Samji et al. 2015), less viral suppression (Cescon et al. 2011; Loueren et al. 2014), and lower adherence to

antiretroviral medications (Puskas et al. 2011; Tapp et al. 2011) Additional literature on women from studies in other global regions will be reviewed in the following section.

1.2 HIV Disclosure across Diverse Global Settings

Global perspectives: HIV disclosure within non-legally mandated contexts

While empirical studies on HIV disclosure in the Canadian context remain scarce, research on this topic has been advanced in other global regions, albeit rarely through a legal framework. Contrary to assumptions on the protective benefits of HIV disclosure before sex, health scholars have consistently found that HIV disclosure does not necessarily lead to the uptake of safer sex practices (Simoni and Pantalone 2004; Crepaz and Marks 2003; Marks et al. 1994; Serovich and Mosack 2003; Marks and Crepaz 2001; Millett et al. 2005; Poppen et al. 2005). Drawing from the results of a systematic review of 231 articles on HIV disclosure, Obermeyer et al. (2011) have reported that the processes that influence HIV disclosure are entirely contingent on localized settings and contexts. For instance, HIV disclosure patterns are reported to vary according to whether individuals live in developing nations, post-industrial nations, rural areas, urban settings, gender, and socioeconomic status, among other things (Obermeyer et al. 2011). Considerations of confidentiality and HIV-related stigma are of particular significance within smaller rural communities, ethno-racial minority groups, and within intimate and work relationships (Obermeyer et al. 2011). Some studies in the global literature indicate that HIV disclosure is more common among women (Olley, Seedat, and Stein 2004; Stein 1998) while others do not (Obermeyer et al. 2011). Sullivan's (2005) systematic review of 17 scholarly articles about HIV disclosure experiences among men found that, in nearly every setting, differential disclosure rates were explained by whether males were in longer-term partnerships (versus one-night stands) and their number of sexual partners; disclosure rates were higher in longer-term partnerships and lower as the number of sexual partners increased. HIV disclosure and HIV nondisclosure patterns are difficult to generalize.

Closer to Victoria, in a qualitative study of 55 HIV+ men who have sex with other men in Seattle and Los Angeles, study participants expressed reticence to disclose if they were in denial of their HIV status, had a low viral load, and feared rejection (Gorbach et al. 2004). Conversely, the men in the study who were most likely to disclose had intimate feelings for their partners, felt responsible for their partner's health, or feared arrest; interestingly, some men assumed that their partners were HIV+ if they did not ask them their HIV status (Gorbach et al. 2004).

There are inconsistent patterns in HIV disclosure among women across the international literature due to localized factors and contexts; there remain however barriers specific to women in HIV disclosure which resonate globally (Obermeyer et al. 2011). In contrast with men, women sometimes face amplified pressures to delay disclosure on

account of HIV-related stigma, fears of rejection, and fears of abandonment (WHO 2004; Rouleau, Cote, and Cara 2012). Power inequities driven by gender limit the agency for HIV+ women to negotiate the use of condoms before sex and refuse sexual advances from heterosexual men (Siegel, Lekas, and Shrimshaw 2005; Mackinnon and Crompton 2012). Specific to women, there are indications in the some studies that the disclosure of bisexual behavior to female partners is associated with increased condom use (Wolitski et al. 1998), while other research has not identified bisexual disclosure as having similar effect (Kalichman et al. 1998). In all, across the global literature on HIV disclosure from a *non-legally mandated* perspective, the contexts and meanings of sex appear to be the most important factors influencing how, or whether, to disclose HIV status.

Global perspectives: HIV-related criminalization

Only a few empirical studies from other global regions specifically examine HIV disclosure through a criminal framework. These studies rarely include HIV+ and HIV- women. From a quantitative perspective, risk behaviours among persons vulnerable to HIV show no difference in American states that have enacted HIV-specific laws in comparison with states without them (Burris et al. 2007). Qualitative research has largely focused on the experiences of HIV+ persons and the added complexities of HIV disclosure under the law. For instance, HIV+ men and women in Michigan expressed that the HIV laws increased their perceived sense of responsibility for HIV infection, worries about their partners' sharing their HIV status to others, and fears of false accusations from former partners (Galletly et al. 2009). Another multi-site American study on HIV-related laws found HIV+ persons mistrusted the government with nominal HIV reporting, and they believed that HIV prevention should be a personal and not governmental responsibility (Kiltzman et al. 2004).

Beyond North America, the only locatable English language publications on HIV criminalization are from the United Kingdom. Surveys collected from over 6000 sexually active gay and bisexual men revealed that most were supportive of imprisonment for HIV transmission; among these men, the majority felt imprisonment was appropriate for the harm caused by HIV while only 4% felt that imprisonment was appropriate as a preventative measure (Dodds et al 2009). A qualitative study of HIV+ gay men in England and Wales found that prosecutions for 'recklessly causing bodily harm by HIV transmission' had directly prompted some men in the study to take up safer sex practices (Dodds, Bourne, and Weait 2009). Other men in this study reported that criminal prosecutions had not prompted any changes to their sexual practices or, indeed, they had taken up practices that adversely affected the health of their partners such as maximizing their anonymity and decreasing transparency surrounding their HIV status (Dodds, Bourne, and Weait 2009). In addition, inaccurate understandings of the law led some men

to believe incorrectly that certain acts and statements offered them protection from prosecution (Dodds, Bourne, and Weait 2009).

There is a lack of international literature on the criminalization of HIV nondisclosure, exposure, and transmission beyond the United States and the United Kingdom. While even less has been published on sex workers and HIV disclosure, I briefly review three available studies in the following section.

Global perspectives: Sex workers and HIV disclosure

HIV disclosure by sex workers and their clients is not commonly studied. The few extant studies suggest that HIV disclosure is uncommon, but these studies cannot be readily compared with Canadian contexts due to regional laws surrounding sex work, regional laws surrounding sodomy among males in particular, and diverse socioeconomic statuses. Saggurti et al. (2012) found that HIV+ female sex workers in India disclosed their HIV status before roughly three-fifths of their sexual encounters, while only two-fifths of HIV+ male clients disclosed their status. Factors that decreased nondisclosure to male clients included lacking accurate information about HIV transmission, not knowing the HIV status of their partners, and having a higher number of partners (Saggurti et al. 2012). Among female sex workers, alcohol consumption led to the lower likelihood of disclosure (Saggurti et al. 2012).

In an ethnographic study of 72 male sex workers in the Dominican Republic, Padilla et al. (2008) found that when these men partnered with male clients, they harboured intense fears related to possible infection and subsequent infection of their wives and girlfriends. The authors also found that the absence of condom use was found to be highly symbolic of mutual trust with all partners, and 9 out of 10 fathers in the sample used sex work income to support their children (Padilla et al. 2008). Complicating this picture was rampant cultural homophobia as well as stigma related to both sex work and sodomy that prevented men from sharing their health anxieties with their family networks and non-commercial partners (Padilla et al. 2008). In another study of 32 male street-based and internet-based sex workers in Massachusetts, Mimiaga et al. (2009) found that most HIV+ interview subjects usually disclosed their HIV status to clients but felt that safer sex was a personal responsibility and that it was not their own obligation to initiate discussions on HIV and other STIs; 25% of the entire sample of sex workers had never been tested for STIs, 2 men reported becoming HIV+ from client interactions, and nearly one third of internet escorts were full- or part-time students. One HIV-negative man reported examining the medicine cabinets of his clients, looking for evidence of antiretrovirals, while all respondents reported engaging in higher-risk sexual practices more often with their non-commercial partners than with their clients (Mimiga et al. 2009). Aside from the few HIV-negative men in the studies by Mimiga et al. (2009) and Padilla et al. (2008), there remains

no locatable literature on HIV disclosure among samples of HIV-negative sex workers in any region.

Summary

Scholars contributing to the literature on HIV disclosure have established that this practice has implications not only for sexual and physical health, but also psychological health through stigma, discrimination, isolation, and fears surrounding these elements. In addition, women have are special stakeholders in the impacts of HIV disclosure, and this effect is graver when adding dimensions such as 'race,' hard drug use, and living in rural areas. In any case, HIV disclosure does not occur in a vacuum; it is rather a practice mediated by trust, use of protection, the length of relationship, gender, and fears of rejection and retaliation, among other factors. While many of the social forces identified in HIV disclosure that have been reported as complicating disclosure among women may also apply men, the key take-away is that women are subject to these forces to a greater extent on account of global patriarchal structures rooted in divisions of labour, childcare, and gender power dynamics. The core moral dimensions of HIV disclosure will be unpacked in this thesis through the theoretical framework of moral regulation, which I review in the following section.

1.3 Governance of the Self and Others through Moral Regulation

The criminalization of HIV disclosure is in many senses situated at the intersecting axes of HIV-related health literacy, law, and morality. This thesis uses moral regulation as an analytic frame to aid in understanding participants' characterization of the 'others,' the sexually active HIV+ persons who could potentially harm them with HIV by not disclosing their HIV status. Moral regulation also frames the mutual moral expectations of sexually active persons in the moral governance of the self and others. Systems of knowledge and differential levels of HIV-related health literacy are implicated in the moral project of HIV disclosure.

According to Hunt (1999), moral regulation maps a common social process wherein practices and behaviours considered harmful to individuals – and society as a whole – become rallied against, often leading to the enactment of policy and legislative changes. Moral regulation entered the sociological canon with the publication of *The Great Arch*, by Corrigan and Sayer (1985). Building upon the works of Durkheim, Weber, and Marx, the authors Corrigan and Sawyer (1985) explored culture and politics in the formation of the State apparatus in England, beginning with the Norman Conquest. Moral regulation for these authors was 'a project of normalizing, rendering natural, taken for granted, in a word, 'obvious,' what are in fact ontological and epistemological premises of a particular and historical form of social order [...] State forms are always animated and legitimized by a particular moral ethos' (Corrigan and Sayer 1985:4).

Advancing this theoretical construct, Hunt (1997; 1999) examined moral regulation as a form of governance and a system of moralization wherein the values, culture, and the conduct of others have been problematized and, consequently, the larger population demands regulation in response. In short, nothing is intrinsically 'moral' in our world but, rather, through an historically contingent process of moralization, various moral discourses, moral subjects (victims), moral objects (targets), moral strategies, and moral techniques become linked (Hunt 1999). 'Moralization' is the process that links these aforementioned items. Poor moral conduct, then, requires a normative judgment that the conduct of the 'other' is bad or wrong; moral judgments thus rely on systems of moralized knowledge in both expert and informal forms (Hunt 1999). Moral regulation in this formulation is situated within the governmentality tradition inspired by the works of Michel Foucault, and it draws on the concept of the 'governance of the self and other' (Hunt 1999) in a quid pro quo moral arrangement.

Moral projects, in Hunt's (1999) conceptualization, share several common elements: They involve agents of reformation, that is, the 'moral subjects' (or 'victims') who target specific groups of people who share common, salient characteristics. Through specific moral strategies and techniques, moral projects persecute the morally corrupt 'other,' and they systematically produce and disseminate 'moral discourses' as they forge oppositional groups at all societal strata (Hunt 1999). Drawing on Foucault's 'dividing practices,' Hunt (1999:8) suggests we create moral categories which delineate 'good' from 'bad,' yielding differential treatment of, for instance, the 'deserving poor' and the 'undeserving poor' (Hunt 1999:8).

Among his works before developing the theoretical construct of moral regulation, Hunt (1987) proposed a 'relational theory of law' in which legal regulation is tacitly interwoven within all other forms of social relations. Moreover, the relational theory of law illuminates how various legislations penetrate the full gamut of social interaction, including not only institutional interventions through legislation, but also the presence of ideas surrounding these legislations in society that are often understood as separate from the law (Hunt 1993:225). In short, this functional and critical perspective holds that the law is not externally autonomous and exogenous of society, and that law as an object to be interrogated must be understood through its interaction within all other forms of social relations. To illustrate this, Hunt (1987) offers the example of the institution of marriage:

> [T]he social institution of marriage involves a number of different forms of social relations (legal, economic, gender, sexual relations, etc.); such a conceptualization makes it possible to explore questions about the role which law plays in the development and change of this and other social institutions and practices. (p. 17)

Scholars have used the construct of moral regulation to tear apart various social phenomena in Canadian population and public health. For instance, Lucas (2009) employed the frame of moral regulation to unpack the presumption by Health Canada's

Marijuana Medical Access Division that medical cannabis was frequently being used *illicitly* rather than *therapeutically*, consequently reducing access to this relatively safe herbal drug. In the wake of the evidence-based failures of the 'war on drugs,' Canadian policy makers resorted to moral imperatives to divide the licit and the illicit, alcohol/tobacco versus cannabis, socially acceptable versus harmful, resulting in an over-regulation of many therapeutic marijuana users who indeed benefitted from using cannabis as prescribed (Lucas 2009). Other scholars have framed the moral discourses concerning the human papillomavirus and cervical cancer prevention as a moral project led by the pharmaceutical industry in Canada (Connell and Hunt 2010). These discourses targeted mothers and young women through responsibilization and the moralization of health through risk management strategies (Connell and Hunt 2010). It is clear that moral regulation is an adaptable analytic frame.

Within the social processes that have led to the criminalization of HIV nondisclosure, I will consider the practice of HIV disclosure as mediated by morality, cultural understandings of HIV/AIDS, HIV-related health and legal literacies, and the discourses of HIV risk aversion. Governing these elements are formal and informal systems of knowledge. I attempt to review these systems in the following section through the constructivist sociological perspective of HIV/AIDS.

1.4 Constructivist Perspectives on HIV/AIDS

There is a deeply rooted cultural component through which the uptake of HIV-related risk knowledges is filtered. Across the literature, stigma and irrational fear continue to influence popular understandings of the virus, despite significant advancements in biomedical research and pharmaceutical interventions. Popular discourse identified HIV/AIDS in its early days as a problem for the 4-H Club, that is, for homosexuals, Haitians, hemophiliacs, and heroin users (Dolgin 2010; Fouron 2013). The virus, currently a global pandemic, has since had a devastating effect on the lives of persons outside of these subgroups, in all strata of society. HIV, at a level far greater than other STIs, has achieved 'agency' in the public discourse of fears, health risks, and uncertainties related to sexual health during intimate sexual practices. A constructivist perspective can best capture the social processes that have assigned agency to the virus in the cultural consciousness.

Following their analysis of global language, discourse, and interaction, Goldstein et al. (2003) suggested that HIV/AIDS is 'divine retribution' for the sexual sins of groups and individuals, similar to the symbolic plague of syphilis in terms historically stigmatized infections. The agency of HIV even has enough power to reshape human interaction surrounding sex, from negotiations of sex to abstinence, and even 'serosorting,' that is, partner selection based on HIV status (van Dyk 2001).

Cultural understandings of HIV/AIDS have shifted in harmony with developments in antiretrovirals that render HIV a chronic, manageable condition in most advanced

industrial nations. Highly active antiretroviral therapy (HAART) erased the AIDS death sentence, thereby improving cultural perceptions of the virus and reducing HIV-related stigma worldwide (Preston-Whyte 2003; Zuch and Lurie 2012). Scaling up HAART in the 2000s created new dialectic frames of HIV: Persons dying from AIDS, and persons living with HIV-related challenges (Conroy et al. 2013). Advancements in HIV therapies complicate 'social' diagnoses of HIV because people no longer exhibit the signs and symptoms outwardly and may no longer be infectious, and at least three frames currently remain: AIDS fatalism, the uncertainty of treatment, and HIV-related optimism (Conroy et al. 2013).

With respect to the criminalization of HIV nondisclosure, we might consider that transformative public understandings of HIV follow the paradigm of the historically specific and culturally contingent nature of risk discourses (Hallgrímsdóttir and Benner 2014) that are informed by media, advancements in biotechnology, and both formal and informal systems of knowledge which operate through power and exclusion. Of course, HIV treatment relies on HIV diagnostic testing, the topic of the following section.

1.5 HIV Testing and HIV Treatment as Prevention in British Columbia

Pathways to HIV testing in British Columbia

At present, the legal obligation for HIV disclosure could only begin with HIV testing. While there are many complexities surrounding anticipated privacy following HIV disclosure, it remains difficult to keep the results of an HIV test a personal secret in British Columbia. There are various reasons for which persons may prefer complete HIV testing anonymity that extend beyond the risk of prosecution (for instance, persons who work in healthcare; 'closeted' men who have sex with other men; persons living in small rural communities). Unlike in almost every other province,[6] British Columbia did not offer the option of 'anonymous' testing in health clinics in Victoria at the time of this study's interviews (*British Columbia Centre for Disease Control* [BCCDC] 2013). Some, but not all, clinics in British Columbia did offer (and continue to offer) non-nominal testing wherein blood samples are sent to labs with a code or initials attached; however, in order to receive non-nominal results, an in-person clinical follow-up is mandated. Indeed, clinicians and health practitioners could be, and have been, summoned to testify against their HIV+

[6] At the time of participant interviews, the only provinces/territories which did not offer anonymous HIV testing were BC, Yukon, Northwest Territories, Nunavut, Manitoba, and Prince Edward Island (Health Canada 2013).

clients in nondisclosure prosecutions, an approach that challenges clients' presumed medical confidentiality (HIV/AIDS Legal Network 2014).

At the time of publication of this thesis, a Pilot Project from the BCCDC offers the first anonymous testing in British Columbia. Beginning at a few sites in the Lower Mainland in March of 2013, the Pilot Project has since extended to 19 sites at the time of publication, now including one location on Vancouver Island near the downtown core of Victoria (Smart Sex Resource 2017).

'Rapid HIV Testing,' also known as 'Point of Care' (or POC) testing, is regularly available at two locations in Victoria (Smart Sex Resource 2017). This testing method offers HIV status results within minutes of testing. There is not, however, any promise of anonymity and this is not a reliable option for detecting infections that may have occurred within the previous six months (Smart Sex Resource 2017). In all, the key takeaway is that anonymous HIV testing was almost impossible for study participants at any time during, and prior to, the interviews informing this thesis. I continue by examining the HIV antiretroviral therapy health care approach that has made British Columbia a global leader in HIV treatment and prevention.

British Columbia: A world leader in HIV treatment and prevention

HIV treatment as prevention and HIV testing guidelines

British Columbia is an exceptional Canadian province that serves as a global model for the reduction of new cases of HIV transmissions. In 1996, when antiretroviral therapy first became subsidized in the Province, 241 out of 252 (96%) annual deaths were reported among persons living with HIV; this number declined to 44 out of 218 (20%) in 2013 due in large part to the increased uptake of highly active antiretroviral therapy, or HAART (Lima et al. 2015). British Columbia is also the launching ground for the HIV public health strategy 'Treatment as Prevention,' or TasP®, which has been adopted by a growing number of countries globally (Montaner et al. 2014).

In British Columbia, highly active antiretroviral therapy (HAART) medications are available at no cost to persons with an HIV+ confirmation. The expansion of HAART between 1996 and 2012 has led to a sustainable decrease in HIV/AIDS-related deaths, sickness, and transmission, under the TasP® program: For every 100 persons using HAART, HIV incidence has decreased by an estimated 1.2% (Montaner et al. 2014). Since April of 2013, the provincial initiative, 'Seek and Treat for Optimal Prevention of HIV/AIDS' (STOP HIV/AIDS) has been seeking, testing, and treating vulnerable populations across the province; this program was designed to engage with persons experiencing difficulty in accessing HIV health care in more traditional settings.

Most recently, in May of 2014, the Office of the Provincial Health Officer (2014) released new HIV testing guidelines that made BC the first Canadian region to encourage

routine HIV testing for adults. Health care providers are recommended to test their patients routinely every year (aged 18 – 70) if they belong to a population with a 'higher burdens' of HIV infection, every five years for all patients (aged 18 – 70), and once at (age 70 or older) if HIV status of the patient is unknown. Sex workers, gay and bisexual men, Aboriginals, Caribbean and Sub-Sahara Africans, and injection drug users are clarified as having higher burden of infection according to these HIV testing guidelines. Specific guidelines for HIV pre-test counselling among sex workers are not given, but the HIV testing guidelines across BC offer directives for obtaining consent as follows:

> The purpose of a pre-test discussion is to establish informed consent. For HIV testing, obtaining informed consent is the same as for any other diagnostic test or treatment. *As with other diagnostic tests, if the pretest probability of a positive result is high, more extensive discussion may be warranted* (see *BCCDC* Sexually Transmitted Infections Guidelines for Testing, Follow-up and Prevention of HIV). If a patient declines an HIV test, the reason for refusing the test should be explored to ensure it is not due to false information about HIV infection or the consequences of testing. (Office of the Provincial Health Officer 2014:6, my emphasis)

The directed citation (BCCDC 2016 October) states the following:

> [I]nforming patients of the possibility of criminal prosecution is not required at the testing encounter, but should be discussed with individuals who test positive for HIV (p. 39)... Discussing criminalization is a discussion aimed at informing an individual of the limits to his or her rights and freedoms... [Since] holding a discussion on criminalization has little to do with HIV testing (but rather ought to be a part of post-test counselling for those who actually test positive), we remove the specter of any conflict that may arise between individuals and society. *In fact we can see that removing the necessity of routine conversations on criminalization at the time of testing actually serves the needs of both individuals and society: individuals will be more likely to get tested and their health will be improved, but at the same time the needs of society are served by the enhanced identification of HIV positive individuals and thus limiting the unintentional spread of the virus... We do not believe it should be a part of the conversation prior to testing as there is no chance of prosecution at the time of testing.* Criminalization is only a factor after a positive test is obtained, and even then *it will only be an issue for very few people* because most people will go on to practice safer sex and treat their HIV infection. *Requiring a conversation about criminalization before testing is, at best, out of place, and, at worst, a barrier to accomplishing enhanced HIV testing.* (pp. 40-41, my emphasis)

Knowledge of the legal obligation for HIV disclosure is recommended to be offered in post-test discussions according to guidelines from the British Columbia Centres for Disease Control (2016). There is no available health literature evaluating the effect of these

guidelines among sex workers in British Columbia, or the effects of similar HIV testing guidelines for vulnerable populations in other global regions.

HIV pre-exposure prophylaxis

An interesting approach emerging in HIV prevention efforts among high-risk population subgroups in recent years has been pre-exposure prophylaxis, or PrEP, by which high-risk HIV-negative persons take daily antiretroviral medication as a strategy to protect themselves against HIV infection (Escudero et al. 2014). In one study of couples wherein one partner was HIV- and the other HIV+ (Baeton et al. 2012) and in another study of men who have sex with men (Grant et al. 2010), PrEP was demonstrated to reduce the risk of HIV infection by over 90% and as high as 99%.

In February of 2016, Truvada was approved by Health Canada for prophylactic use in the prevention of HIV. Pills can be taken once daily, or on-demand, that is 2 pills prior to engaging in sex, then 1 pill at 24-hours, and a final pill at 48-hours. However, at the time of participant interviews in this study, Truvada® was only available in Canada through off-label prescriptions. PrEP costs between $800 and $1,100 per month, in Canadian dollars, and is not subsidized by public medical insurance for most Canadians (CATIE 2016; ACT 2016; Betteridge 2016), with the notable exceptions of universal prescription coverage in Québec and persons with 'Indian' status under the federal Non-Insured Health Benefits Program.. From a pharmacological perspective, PrEP favourably compares to Aspirin in terms of user safety (Kojima and Kloausner 2016). From a social perspective, however, persons using this medication are often subject to stigma and discrimination by medical professionals, friends, and family (Lui et al. 2014; Fallon 2014). While PrEP may not be a panacea by itself, PrEP is indeed an effective complementary technology in the reduction of HIV transmission and new infections when accessible and used as prescribed.

Pharmaceutical approaches versus structural changes to curb the spread of HIV

Pharmaceutical interventions and the uptake of safer sex practices are poised to tackle HIV through increased access to, and compliance with, antiretroviral drug regimens and through individual-level behavioural changes. However, moving above individual-level interventions, Shannon et al. (2015) reviewed 204 articles from the international literature on female sex workers and HIV, finding that increased condom use and increased access to antiretrovirals had much less influence on new HIV infections than various structural factors. The authors concluded that the decriminalization of sex work would have the greatest potential to reduce new infections in all settings by as much as 46% (Shannon et al. 2015). The main takeaway from this large-scale review is that behavioural interventions such as HIV disclosure and biomedical interventions, alone, are not nearly as effective as macrostructural transformations for curbing the spread of the virus.

1.6 Summary

The core purpose of this chapter was to review the literature that gave contexts to the first research question regarding the sexually protective practices and health-seeking behaviours of survival sex workers against the backdrop of the legal obligation for HIV disclosure. This review shows firstly that, at the very least, HIV disclosure is complex, varying according to regional laws, socioeconomic status, life experiences, and levels of HIV-related health and legal literacies, among other things. Generalizations are difficult to render. Criminalizing the socially complex process of HIV disclosure adds further vulnerability to the deeply personal and symbolic process of HIV disclosure, and the literature offers very little knowledge about how this process applies to the health and safety of HIV+ and HIV-negative sex workers. It is noteworthy that HIV testing is being scaled up across the Province in hospitals and clinical health settings for virtually all adults engaged in health care, and that current HIV pre-test counselling policy explicitly advises against discussions of the criminalization of HIV nondisclosure (BCCDC 2016), irrespective of their levels of vulnerability. Scholars have reported that available literature report that persons diagnosed with HIV have ongoing concerns that disgruntled partners will use HIV laws against them. Moreover, the mere 'threat' of going to police under HIV laws could be used for coercive means, for instance, to sustain a relationship marked by intimate partner violence among already vulnerable sex workers. Indeed, the legal mandate for HIV disclosure is further complicated by factors which drive entrenchment in the sex trade and thus render immediate exit unlikely. I will examine various factors driving entrenchment in the sex trade in Chapter 2.

I began this chapter by offering an historical overview of the legislation related to HIV nondisclosure in Canada. At present, there is no available evidence to suggest that HIV nondisclosure legislation offers protective health benefits; conversely, the limited evidence suggests that some gay and bisexual men who are vulnerable to HIV infection are disinclined to seek HIV testing under HIV law or have taken actions to promote anonymity and otherwise conceal their HIV status. In Canada, the available data on HIV nondisclosure prosecutions moreover may reflect institutional racism, targeting visible minorities in much greater proportion than non-visible minorities in the Canadian population.

I reviewed the theoretical construct of moral regulation that serves as an analytic frame for HIV disclosure in this thesis, and the constructivist perspective of HIV/AIDS. I highlighted the impossibility of anonymous HIV testing in Victoria at the time of participant interviews, and I reviewed advancements in pharmaceutical technologies that continue to shape HIV treatment, HIV prevention, and the public consciousness surrounding HIV outcomes. British Columbia is a province for exceptional HIV health care, particularly through the 'Treatment as Prevention' (or TasP) strategy that has demonstrated efficacy in improving population and public health. The British Columbia

HIV testing guidelines updated in October of 2016 recommend that clinicians avoid pre-test discussions of the criminalization of HIV nondisclosure. Their rationale may underscore utilitarian and consequentialist directives in population and public health initiatives, and I will return to the ethics surrounding informed consent for HIV testing among sex workers in the discussion section of Chapter 7.

The evidence on the importance of structural changes in HIV/AIDS should not be overlooked. As in the study by Shannon et al. (2015), the collective analysis of swaths of global studies has shown that macrostructural shifts, such as the *de*-criminalization of sex work, is by far a more effective strategy in curbing the global spread of HIV than the promotion of individual-level behavioural changes, such as increasing condom use.

I will continue in the following chapter by reviewing the sociological and health literature specific to sex work and HIV in Canada. To be clear, sex work is legal in Canada. However, practices that could maintain the safety of sex workers, such as the negotiation for sexual services in safer occupational contexts, continue to be criminalized. The criminalization of HIV nondisclosure may dovetail with the criminalization of core elements at the periphery of sex work to exacerbate the health and safety of sex workers and, among other things, sustain a distrust of law enforcement officials. The following chapter will couple with Chapter 1 to offer a backdrop for my arguments related to the problems inherent in screening deeply entrenched sex workers for HIV when nondisclosure remains a criminal offense. Ultimately, there is an array of social and structural factors driving extreme vulnerabilities to HIV when working in the survival sex trade (Chapter 2), and there are unique individual-level and relational vulnerabilities among sex workers in non-commercial, intimate partnerships (Chapter 3). This thesis will show how these vulnerabilities interplay with HIV laws to put the health and safety of sex workers in the balance in much more extreme ways.

Chapter 2: The Sociology of Sex Work in the Canadian Context

'One of the women who have faced prosecution in Canada was a 17 year-old girl, living on the streets, who was charged for not disclosing her HIV status before having sex with two teenage boys. It was the community centre where she had found shelter that contacted the police.[7] Her name, picture and HIV-positive status were published and distributed in the media prior to a publication ban being issued.'[8] (Canadian HIV/AIDS Legal Network 2014:4)

This chapter offers a backdrop for answering my second research question with respect to the social contexts and conditions that drive vulnerabilities to HIV acquisition and transmission among survival sex workers and their commercial sexual partners. I have delimited the literature reviewed in this chapter to only that which includes HIV vulnerabilities affecting sex workers when trading services with commercial clients. The distinct vulnerabilities to HIV among sex workers with their non-commercial, intimate partners will be the focus of Chapter 3.

I begin the first section (2.1) by reviewing the laws governing sex work in Canada. I follow this the second section (2.2) by examining empirical contributions to the literature on the contexts and conditions that drive HIV-related vulnerabilities among sex workers, with a focus on studies from British Columbia. In the final section (2.3), I review previous and current research strategies in the sociological study of sex workers, and I conclude the chapter with a discussion and summary in brief. The culmination of the literature reviewed in this chapter will lay a foundation for my discussion and key arguments related to the compromised agency of survival sex workers to protect their sexual health consistently in their commercial client transactions, and to exit the sex trade immediately, if desired, upon receiving an HIV+ test result.

2.1 Sex Work in Canadian Law and Society

Selling (or trading) sexual services is legal in Canada. However, core occupational features that could otherwise enhance the health and safety of sex workers have been criminalized. This brief summary of legislation surrounding sex work in Canada begins

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[7] Elliot, R. (2011, August 15). 'Teen's trust was broken.' *Edmonton Journal*, Opinion.

[8] Simmons, P. (2012, February 25). 'Was HIV-infected girl harmed or helped by the state?' *Calgary Herald*.

with the ruling in *Canada v. Bedford* by the Supreme Court of Canada in December of 2013. In this case, the Court ruled that key provisions of the criminal code were in violation of sex workers' constitutional rights to occupational safety and security that are guaranteed in the Charter of Rights and Freedoms (*Canada v. Bedford* 3SRC 1101, SCC 78). The Court delayed the enactment of their ruling by one year in order to give the government an opportunity to create new legislation. In June of 2014, the Canadian Minister of Justice, Peter MacKay, introduced Bill C-36, the *Protection of Communities and Exploited Persons Act*. The Bill received Royal Assent and became law in November of 2014 (S.C. 2014, c.25). Bill C-36 had restored many of the provisions declared unconstitutional by the Supreme Court only a year prior.

According to Bill C-36, it is illegal to obtain (or communicate for) sexual services, receive financial or material benefit from sexual services, and communicate for sexual services anywhere persons under 18 could be present (S.C. 2014, c.25). Interestingly, 'sexual services' is never defined. While sex workers may legally self-advertise their services, it remains unclear whether websites and print publications constitute third parties, subject to criminal prosecution. Ultimately, selling sex in Canada remains legal for sex workers, but the purchase of sexual services is illegal. This approach mirrors the Nordic model wherein the 'demand' side of the sex trade (mostly heterosexual men) trade is criminally targeted while the supply side (mostly heterosexual women) is encouraged to exit, in theory at least (Johnson and Matthews 2016).

Health scholars have not identified any improvements to the health and safety of sex workers in British Columbia in the wake of drafting Bill C-36. In Vancouver, BC, the sexual violence, distrust of law enforcement, and displacement to unsafe neighbourhoods that limit sex workers' agency in safer sex negotiation and client screening have been much the same both before (Shannon et al. 2008) and after (Krüsi et al. 2014, 2016) the 'demand' side of the sex trade became the official target of law enforcement.

2.2 Structural, Social, and Occupational Factors Driving HIV Vulnerabilities

In general terms the criminalization of sex work in Canada reduces control over working conditions, scales up violence and discrimination, marginalizes sex workers from health care and social services, and drives sex work to unsafe spaces or, indeed, underground (Shannon et al. 2008; Shannon et al. 2009a; Shannon and Cste 2010; O'Doherty 2009; Canadian HIV/AIDS Legal Network 2014). A growing body of literature from British Columbia has empirically mapped how these nuances might drive vulnerability to HIV infection, which I review in the following section.

Police patrolling and spatial displacement

Unsafe working environments are powerful factors driving HIV infection among sex workers (Shannon et al. 2008; Krüsi et al. 2016; Benoit and Millar 2001), and a

growing body of literature has examined how spatial displacement and the strained relationship between law enforcement and sex workers increases occupational vulnerability to HIV infection and transmission. According to Krüsi et al. (2016), the violence, theft, and fraud that is committed against survival sex workers is often responsibilized and normalized by police as part and parcel with working in the sex trade, and sex workers are consequently reluctant to report crimes (Krüsi et al. 2016). On the other hand, police swiftly displace sex workers from areas after receiving complaints from neighbourhood residents (Krüsi et al. 2016). Widespread stigma and the framing of sex workers by police as both 'victims' and 'victimizers' drive adverse interactions between survival sex workers and law enforcement officials, increasing HIV vulnerabilities for sex workers in this province (Krüsi et al. 2016) and in other global regions (Rhodes et al. 2008; Shannon and Csete 2010). There are indications from interviews with sex workers, nationwide in Canada, that the principal causes of distrust of police are perceived stigma and discrimination (Benoit et al. 2016). In short, official zoning policies, distrust of police, and displacement to unsafe neighbourhoods, among other things, are structural factors driving vulnerability to HIV infection among street-based sex workers, by compromising the negotiation of condom use (Shannon et al. 2009a) and scaling up sexual violence (Shannon et al. 2009b).

Gentrification can have a significant impact on the working environments of sex workers, leading to a rise in the use of online technology to facilitate sex transactions. For instance, in the Yaletown area of Vancouver, the former 'Boystown' was largely shut down due to urban planning prior to the 2010 Winter Olympics and, consequently, online sex transactions among male sex workers increased substantially (Argento et al. 2016). As a favourable consequence, these online sex transactions have decreased stigma and reduced harassment from law enforcement officials. while the online platform has also facilitated increased security and screening of clients by using of webcams prior to meeting (Argento et al. 2016). On the other hand, the shift to online platforms has ruptured longstanding social networks among male street-based sex workers, increased their perceived isolation, scaled up competition, and brought new risks in the form of 'fake' online profiles created by clients (Argento et al. 2016). Neighbourhood renewal can also increase the presence of private security and police, which continues to compromise the ability of sex workers to remain in safer public spaces (Shannon et al. 2016; Hubbard 1998) in a greater structural project of spatial containment, exclusion, and surveillance of sex workers in the city (Hubbard 2016; Laing and Cook 2014).

Entrenchment in the sex trade

Exiting the survival sex trade is an extremely difficult, complex process that is rarely successful on the first attempt in Victoria (Benoit and Millar 2001) and elsewhere (Rand 2015). In Benoit and Millar's (2001) study of 200 sex workers in Victoria, key factors

driving entrenchment included drug and alcohol dependence, lack of social supports, and constraints to employment opportunities outside the sex trade such as having a criminal record and lacking the necessary skills, training, and previous experience. Conversely, re-entry to the sex trade was motivated not only by economic necessity, but also by the need for immediate, easy funds that did not require waiting until the issue of a paycheque, particularly during times of crisis (Benoit and Millar 2001). Among all study participants, 70.6% had attempted to exit the sex trade at least once, and the average number of attempts before having exited for at least two years was 6 (Benoit and Millar 2001). A non-exhaustive list of reasons given for exiting the sex trade, in order of descending frequency, is the following: burn out and stress (21%); external pressure from friends and family (18%); quitting drugs and alcohol (16%); and sickness and poor health (8%) (Benoit and Millar 2001).

Studies from other global regions have identified a variety of factors driving entrenchment in the sex trade at all levels of analysis. For instance, in a qualitative study that included 19 sex workers and 12 social service providers in Kansas, Rand (2015) found that substance use disorders, shame and guilt, lower self-worth, normalization of the lifestyle, and lack of support networks were factors driving entrenchment at the individual and relational levels. At the meso-level, stigma and a previous criminal record with limited work history made other employment extremely difficult to secure (Rand 2015). Structural barriers to exiting the sex trade include limited resources, inadequate social service supports, and insecure housing (Rand 2015). In a multinational study of prostitution and human trafficking, analysis of 854 interviews with sex workers in nine countries, including Canada, revealed that 89% remained in the sex trade on account of their lack of alternative employment opportunities and having no exit strategy (Farley et al. 2004). In all, it seems reasonable to reduce the fundamental factor driving entrenchment in the sex trade appears to be poverty.

Vulnerabilities driven by drug and alcohol use

Globally, hard drug use is more common among sex worker than the greater population (World Health Organization 2012). Hard drug use is not uncommon among sex workers in Victoria. In Benoit and Millar's (2001) study, roughly 1 in 5 sex workers reported that their initial entry in the sex trade was motivated by the need to support their drug and alcohol use; in the previous six months, current sex workers reported using crack and cocaine (48.2%), opioids (36.6%), and crystal meth (9.0%). Crack and cocaine use was more common among females, while crystal meth was more common among males; drug use was more common among street-based street based workers (Benoit and Millar 2001).

Several functional effects of drug use in the sex trade have been reported in Victoria (Benoit and Millar 2001) and globally (de Graaf et al. 1995). Drug use while working long shifts can provide additional energy and facilitate an escape from the negative

aspects of reality (Benoit and Millar 2001) while allowing some workers to overcome their aversion to their clients (de Graaf et al. 1995). Only a relatively small number of sex workers in Victoria self-report to having used hard drugs while working in the sex trade (Benoit and Millar 2001). However, direct sex-for-drugs exchanges can drive extreme risks of infection with HIV and other STIs. Sex workers most often attempt to avoid sex-for-drugs transactions, but the extreme need for drugs can often outweigh the intense shame and stigma of sex-for-drugs transactions (Duff et al. 2012; Maher 1997). In Vancouver, sex-for-crack exchanges were more common among sex workers who shared crack pipes with their clients, smoked crack in alleys and crack houses, and serviced more than 10 clients per week (Duff et al. 2013).

Participation in the sex trade does not appear to amplify HIV vulnerabilities among injection drug users. In Montreal and Vancouver, women who inject drugs and participate in the sex trade more commonly share injection supplies and use more crack and heroin than injection drug users outside the sex trade, but the prevalence of HIV infection in both groups is roughly equal (Spittal et al. 2003). Injection with cocaine and environmental factors are stronger predictors of HIV infection than participation in the sex trade among injection drug users (Kerr et al. 2016). Injection drug users in all contexts are however at greater risk of HIV infection.

Hard drug use and substance use disorders offer a structural constraint to the negotiation of safer sex and the acts that will be performed. Indeed, HIV vulnerabilities due to drug use vary by needs, and there is a plurality of drug use patterns among sex workers in all settings. The following section examines the dichotomous indoor/outdoor division in the sex trade and the vulnerabilities inherent in each. Ultimately, this division is not cleanly cut.

Vulnerabilities that are driven by occupational environments

Indoor sex workers face disparate vulnerabilities and working conditions in comparison with their street-based counterparts. For instance, indoor sex workers in Victoria often express having less occupational control over the services they provide, the clients they service, their wages, and their pace of work; however, they experience less everyday harassment than their independent and street-based counterparts (Benoit and Millar 2001). However, other studies have found that indoor workers have greater ability to screen clients, fewer anonymous clients, greater safety from check-ins with agencies, greater agency to negotiate the services they offer (Weitzer 2009), and are move likely to accept additional payment for unprotected sex (Deering et al. 2013) than outdoor sex workers.

Street-based, or outdoor, sex workers in Victoria often have greater access to safer sex supplies, but less secure housing, less control over their occupational safety, and experience greater harassment than their indoor counterparts (Benoit and Millar 2001). Other studies have shown that outdoor sex workers are more likely to be HIV+, entered

the sex trade at an early age, have a history of incarceration (Goldenberg et al. 1999; Goldenberg et al. 2014), and their incomes are often stratified by race, drug dependence, and third-party involvement from pimps and managers (Weitzer 2009).

As noted by Benoit and Millar (2001), delineating indoor from outdoor sex workers is not a simple task on account of the commonly reported oscillations between indoor/outdoor sex work over time. Sex work, unlike many other occupations, rarely offers vertical ascension over time. Put another way, sex workers in all venues do not work their way up the ladder to safer settings, employment stability, and higher remuneration. Benoit and Millar (2001) report that home-based sex workers have the greatest control over their wages, the services they perform, and their pace of work. Ultimately, occupational environments can drive significant vulnerabilities to HIV and, based on their level of needs, sex workers might place themselves in riskier contexts.

Sex work and HIV in Victoria

Aside from Benoit and Millar's (2001) study of 200 sex workers, there is an absence of literature on HIV among sex workers in Victoria. HIV is only covered in brief in this study, but it is nonetheless important to review. Benoit and Millar (2001) found that roughly half of the study participants reported having been infected with an STI while engaged in the sex trade. Of particular interest to this thesis, 7 participants in Benoit and Millar's (2001) study self-reported that they were HIV+ and 5 of these participants were currently engaged in sex work at the time of the study. 1 participant attributed her HIV status to engagement in the sex trade and 1 attributed her infection to sex with her non-commercial, intimate partner's injection drug use. The others attributed their HIV infection to shared needles. As interviews for this study began in 1999, only recently following *R v. Cuerrier* (1998), the effects of the criminalization of HIV nondisclosure may not yet have been important for sex workers balancing their work in the sex trade with their legal obligation for HIV disclosure.

2.3 Perspectives for Sex Work Research: Looking Back and Moving Forwards

A history of sociological approaches to the study of sex work

Before discussing the most current perspectives in the sociological study of sex work, it is important to give historical contexts to research in this substantive area. The twentieth century began with the study of 'prostitution' as a problem in need of a solution; by the 1970s, victimization and sexual trauma were dominant perspectives, and scholars scrambled to figure out why prostitutes entered the commercial sex trade (Vanwesenbeeck 2011). Scholastic attention in the 1990s turned to condom use, STI prevention, vulnerabilities and risks, and the inclusion of male and trans sex workers, although sex work itself was too often framed as the problem and not the attached stigmatization (Vanwesenbeeck 2001).

Weitzer (2009) has identified two dominant models in current sex work scholarship. Firstly, the 'oppression' model features male dominance, assumptions of early physical and sexual abuse, poor working conditions, 'paid rape,' and 'survivors,' and abysmal anecdotes used as representative of the entire trade (Weitzer 2009). Conversely, the 'empowerment' model emphasizes the agency of sex workers, harms reduction, and is more often coupled with a critical stance on the criminalization of sex work, and the normalization of sex work as only one legal bartering transaction among others (Kerrigan et al. 2015; Weitzer 2009). Harm-reduction strategies have included improving education on occupational health and safety, decriminalizing sex work, implementing self-help groups, the distribution of safer sex and injection supplies, and drug and alcohol interventions (Rekart 2006).

Current thinking in sex work research: Empowering the community

The current approach to sex work research emphasizes the meaningful involvement of sex workers in projects aimed at ameliorating their well-being, and living conditions, in alignment with social justice principles; this approach can facilitate the creation of new social and legal networks while reducing vulnerabilities to HIV and other STIs (Bekker et al. 2015; Jones et al. 2014). Community leadership adds cohesion to sex work research and improves access to this population (Kerrigan et al. 2015).

Paiva et al. (2015) have argued that HIV-related health interventions must account for structural and cultural contexts in order to be effective; these interventions require tailoring to specific locations and historical contexts, ideally through participatory and community-based empowerment approaches. This approach has had some empirical success, for instance, in Vancouver, where community empowerment through social cohesion, connectedness, and mutual supports has a major influence on decreasing client condom refusal, thus reducing the risk of HIV infection among sex workers (Ardento et al. 2016).

Adding new dimensions to sex work research are digital technologies that enhance outreach service support networks and promote sexual health through social media; indeed, support service providers have effectively used smartphones to engage with sex workers and other isolated members of vulnerable populations (Allison et al. 2014; Pedrana et al. 2013). Sex work and sex work scholarship have clearly changed in form dramatically over the last century.

Improving and empowering sex workers in Victoria, BC

Upon completion of their study of sex workers in Victoria, Benoit and Millar (2001) offered several recommendations that are worth mentioning. Key to this thesis are recommendations for readily available, stable, affordable housing; better sensitivity training for police and other law enforcement officials; the availability of a cascade of care in social services to be accessed as needed (Benoit and Millar 2001). For currently working sex

workers, Benoit and Millar (2001) recommended educating sex workers on laws governing sex work as well as the development of 24-hour outreach services and childcare for dependent children; for sex workers wanting to exit, recommendations were given to increase the availability of outreach support workers, access to second-stage housing, high school education and meaningful vocational training, and access to services for mental health and substance use disorders upon exit. It is reasonable to suggest that the necessity to implement these recommendations persists at present. The empowerment model is guiding the current study, and full engagement with the community will be the final stage of the project.

2.4 Summary

In this chapter, I offered a review of literature relevant to my second research question with respect to the social contexts and conditions that drive vulnerabilities to HIV infection and transmission among sex workers when providing services to their clients. I began by highlighting the current legislation governing sex work in Canada, and I followed this with a review of other structural, social, and environmental factors that adversely constrain the agency of sex workers to operate safely in their trade, seek protection from law enforcement officials, and protect themselves from sexual violence and HIV infection. Given that sex workers can be indoors and servicing elite clients, outdoors and serving clients in their vehicles, home-based, teenage runaways, mothers needing a rare and immediate cash payment, or with an ongoing need to support their hard drug use, the diversity of continually changing characteristics and motivations within this population is evident. Lastly, I reviewed current research strategies in sex work, identifying the empowerment model and the recommendations for policy and programming offered by Benoit and Millar (2001) fifteen years prior to the current study.

Interestingly, the criminalization of sex work has been resisted in Canada most recently not only as a human right in the Supreme Court of Canada, but a constitutional right to occupational safety. The evidence-based research documenting the adverse occupational conditions faced by sex workers offers an important foundation for my arguments on the constrained agency of sex workers to live and work safely under the law. Their vulnerability to HIV in their occupational environments is evident. Deep entrenchment renders some sex workers particularly prone to not only the consequence of prosecution under HIV laws, but also the 'threat' of prosecution from clients as well as non-commercial, intimate partners. Many of the arguments in the literature on the effects of the criminalization of HIV nondisclosure follow legal and ethical frameworks which have not yet been substantiated with empirical evidence. This is not a shortcoming; rather, this is a point of departure for scholars to build upon in this substantive area of importance for the health and safety of sex workers in Canada and other global regions.

In the following chapter, I will review the unique vulnerabilities to HIV that pertain to non-commercial, intimate partner dynamics among sex workers. Non-commercial, intimate partnerships have been implicated in a wide array of factors that ameliorate sex workers' mental and sexual health, safety, and support networks; conversely, intimacy can drive HIV vulnerabilities through differential patterns of condom use and the propensity to share drug supplies. Chapter 3 will ultimately combine with the literature reviewed in the current chapter to build a foundation for my discussion on the compounding of risk factors from non-commercial, intimate partners alongside the structurally and environmentally driven occupational risk factors to realize a synergistic vulnerability effect to the health and safety of sex workers under the legal mandate for HIV nondisclosure.

Chapter 3: Sex Work, Intimacy, and HIV: Complex Intersections

This chapter offers a foundation for answering my third research question with respect to the social contexts, conditions, and interpersonal norms that drive vulnerabilities to HIV infection and transmission among sex workers with their non-commercial, intimate partners. I begin in section 3.1 by elaborating on conceptual definitions of intimacy in the literature and in this thesis, and I briefly review classical social theory related to dyadic and triadic relational dynamics. In the following two sections, I review the literature on vulnerabilities among sex workers in their intimate, non-commercial partnerships, and the symbolism of condom use, and I review the specific implications of intimate partner violence for HIV transmission in dyadic relational dynamics. I follow this with a review of sociological theory on intimacy in late modernity and close the chapter with a summary and discussion in brief. The culmination of literature reviewed in this chapter offers contexts for considering the interweaving of (i) vulnerabilities from non-commercial, intimate partnership dynamics with the (ii) structural, environmental, and occupational vulnerabilities identified in the previous chapter. I will use the literature in these two chapters to create a working analytic frame to unpack how HIV-related vulnerabilities among sex workers are driven (and amplified) in triadic relational axes with both commercial and non-commercial, intimate partners.

3.1 Understanding the concept of intimacy in social geometry

Clarity on non-commercial, intimate partnership in this chapter

Intimacy, as a conceptual framework, is difficult to pin down. In the most general sense, intimacy is tantamount to trust, bonding, and mutual nurturing while 'intimate partner' will often connote non-commercial sexual partnerships for one night or possibly for decades. I use the term 'intimate, non-commercial partner' to denote the heightened trust, connectedness, and vulnerabilities due to disparate power relations that are not necessarily present in all non-commercial sexual partnerships. Non-commercial, intimate partners can be husbands, girlfriends, or lovers, so long as the sense of connectedness could be described loosely as 'higher,' for the purposes of this thesis.

There are indications in the literature outside the sex trade that intimacy has disparate functions according to the ideal types of emotional intimacy (Joseph and Black 2012), instrumental intimacy (Kerfoot 1999; Alfred 1995), economic intimacy (Lands 2000), physical intimacy (Moss and Schwebel 1993), and sexual intimacy (You et al. 2014). These subsets of intimacy in the material world exist in a zone of irreducible distinction, yet instrumental intimacy has been recognized as distinct from other forms of intimacy for its implications in control and power disparities within dyad pairing dynamics (Kerfoot 1999). In the literature review specific to the sex trade that follows, I indicate the specific forms of intimacy described by the authors, where possible.

Implications of intimacy for social geometry

In the classical conceptual framework of sociological geometries pioneered by Georg Simmel, the term 'dyad' denotes the smallest possible social group, that is, a pairing of two people, and 'dyadic' refers to their interactions. Social geometry is unusually simple to understand and straightforward, lending itself to diverse empirical analyses. Common to dyad dynamics are discernable patterns of personality interactions, divisions of participant functions, and clearly defined power statuses; greater dyadic intimacy also coincides with greater opportunities for conflict (Becker and Useem 1942). Sociocultural environments influence the rise and function of dyads while, at the same time, the function of dyads maintains and (re)produces social structures and social orderings (Becker and Useem 1942).

The concepts 'triad' and 'triadic' refer to groups consisting of three and their dynamic interplay. The competitive triad model presupposes power disparities among agents, the propensity to control others in the triad, and the added strengths of coalitions, that is, two-against-one in the triad (Caplow 1956). For the purposes of this thesis, I consider a group of people, for instance, 'all commercial clients' and 'all non-commercial, intimate partners,' to be participating agents in the triadic model, although I focus on the health and safety concerns of sex workers above the other groups, throughout.

3.2 Non-commercial, intimate partnerships among sex workers

Female sex workers and the function of intimacy

Intimacy has a substantial influence on benefits to the health and safety of sex workers, globally, but it can often function as a double-edged sword. For instance, intimate, non-commercial relationships between female sex workers and their male partners in Kiberia, Kenya, are commonly associated with increased emotional support, improved access to medications, encouragement to live healthier lifestyles, and additional supports related to childcare (Benoit et al. 2013). Greater emotional intimacy also strongly predicts relationship satisfaction among sex workers and their non-commercial partners in the United States – Mexican borderlands (Syvertsen et al. 2013). On the other hand, increased intimacy and trust in these partnerships can commonly predict the sharing of injection drug equipment and engagement in practices known to carry an elevated risk of HIV infection (Feldman et al. 2008; Duff et al. 2016; Syvertsen et al. 2016; Syvertsen et al. 2013). Consistent condom use with all partners is important for curbing the spread of HIV at the individual and population levels, but there is evidence that patterns of condom use with non-commercial, intimate partners has important social meanings for sex workers.

Female sex workers and condom use patterns with intimate partners

The consistent uptake of condom use by female sex workers varies within and across contexts and settings. However, as an almost universal observation, scholars have found that sex workers more often have condomless sex with their non-commercial, intimate partners than clients (Vanwesenbeeck 2001; de Graaf et al. 1995; UNAIDS 2002; Murray et al. 2007; Deering et al. 2011; Spina et al. 1998), and there are several explanations for this. For instance, Varga (1997) found that female sex workers use condoms with their clients more often than their non-commercial partners in order to compartmentalize working life from pleasure activities; condoms can also violate a sense of trust, bringing an element of disorder to the equilibrium of sexual relationships (Varga 1997). Condoms can signify barriers to intimacy and trust with commercial partners (Deering et al. 2011; Murray et al. 2007), and they can also be used as instruments of control and resistance when working (Wokcicki and Malala 2001; Sanders 2002). On the other hand, using a condom can be seen by an intimate partner to represent infidelity, and condom use thus severs perceived trust (Varga 1997). 'Regulars,' or male clients who are well known to female sex workers over extended periods of time, can often occupy a middle-ground between client and intimate partner. Many of the patterns of non-commercial condom use are prevalent with 'regulars,' and because these clients provide a steady source of income, failure to accommodate their demands could jeopardize sex work partnerships in the future (Wokcicki and Malala 2001).

The literature indicates that all forms of intimacy intersect with power disparities to drive vulnerability to violence and HIV infection. Outside the sex trade, Edwards, Barber, and Dziurawiec (2013) have reported that relationships with greater degrees of emotional investment can reduce power and control during sexual encounters, resulting in the commodification of sex and condom use. More equitable distributions of power with non-commercial partners has the potential to give women greater control in the negotiation of condom use, if desired (Edwards, Barber and Dziurawiec 2013).

Close to Victoria, in a study of 369 female sex workers in Vancouver, BC, 70.1% of respondents indicated that condom use was inconsistent with their non-commercial, intimate partners, and this inconsistency was more common in longer relationships, regardless of cohabitation living arrangements (Argento et al. 2015). Inconsistent condom use was also associated with providing financial support and drugs to intimate partners, receiving physical safety, intimate partner violence, and non-injection drug use (Argento et al. 2015).

Economic dependence on intimate partners and condom use

There are indications in the literature that the economic dependence on non-commercial, intimate partners can decrease condom use and increases risks of HIV infection (Deering et al. 2011; Luke 2006). Economic support is more than simply

monetary support as it can often take non-monetary forms such as gifts and drugs, and these can compel female sex workers to take up sexual practices known to carry a greater risk of HIV infection (Deering et al. 2011), including unprotected anal sex (Luke 2006). Adding to these vulnerabilities related to dependence, intimate male partners who begin relationships in the role of a conventional boyfriend can evolve in their role over time to become exploitative managers or 'pimps' (Shannon et al. 2008; Benoit and Millar 2001).

Male sex workers and intimacy

There is a trend in the literature on male sex workers and intimacy, in both high- and low-income nations, towards studying gay and bisexual men, typically younger servicing older, and these men are often grouped in studies with non-gender conforming biological males, or trans women; this oversight has been noted by Baral et al. (2015). There is nonetheless a body of literature concerning male sex workers and intimacy. For instance, in Australia, male sex workers have reported a greater number of non-commercial partners than female sex workers, but they also report less unprotected sex with non-commercial partners than gay and bisexual men outside of the sex trade (Escourt et al. 2000). In a national Australian survey, almost 1 in 5 gay, bisexual, and other men who have sex with men reported having been paid for sex with another man (Prestage et al. 2009). Unprotected sex among gay males with non-commercial, intimate partners can foster mutual trust and stabilize intimate relationships for the future (Blaize 2006), while the essence of masculinity can be tied to 'flesh to flesh' sex for some men (Webb 1997). In studies of heterosexual male sex workers, Missildine et al. (2006) have reported that HIV+ men often invoke masculinity as a strategy to sever the longstanding joinder between sexual encounters and the investment of emotional intimacy with their partners. In a general sense, hegemonic masculinity can generate not only a fear of intimacy, but also the denial of male dependence on emotional intimacy from others (Missildine et al. 2006).

3.3 Intimate Partner Violence against Sex Workers

Female sex workers and sexual violence from non-commercial, intimate partners

Physical, emotional, and sexual violence against sex workers by their non-commercial intimate partners is commonplace, globally (George et al. 2016; Panchanadeswaran et al. 2008; Argento et al. 2014). In Vancouver, recent violence against female sex workers from their non-commercial partners was found to lower their

likelihood of experiencing power in their relationship by a factor of roughly 4,[9] even after controlling for confounding factors such as age, non-injection drug use, and migrant status (Muldoon et al. 2014). Intimate partner violence against sex workers has also been associated with childhood abuse, non-monogamous partners (Ulibarri et al. 2010), depressive symptoms in male partners, and unprotected sex in the United States-Mexico borderlands region (Ulibarri et al. 2015).

In Vancouver, a study of 387 female sex workers revealed that recent physical/sexual violence was linked to greater inconsistent condom use, prescription opioid use, financially supporting an intimate partner, and receiving drugs from an intimate partner (Argento et al. 2014). Over one fifth of sex workers in the study had experienced intimate partner violence in the previous six months (Argento et al. 2014). In the international literature, a South African study found that 1 out of 7 new HIV infections in female sex workers was attributable to lack of power in intimate partnerships which led to inability to negotiate for condoms during sex.

Exposure to sexual violence from non-commercial partners among female Cambodian sex workers has been associated with inconsistent condom use with non-commercial partners (Moret et al. 2016). Sexual violence aside, only a history of physical violence has been associated with sexual practices known to have an elevated risk of HIV infection, amphetamine use, greater number of sexual partners, and greater likelihood of having sex while high on drugs (Moret et al. 2016).

Male, trans, and Aboriginal sex workers facing intimate partner violence

Male sex workers and violence

Sex workers with ethno-racial visibility often experience greater intimate partner violence than the greater population of sex workers. Among gay and bisexual male sex workers in Peru, unprotected anal sex was more common among men who were victims of violence and men who were perpetrators of violence, but HIV infection is more common only among victims of violence (George et al. 2016). In a study of gay and bisexual Latino men in three United States, male sex workers' experiences of physical, sexual, and emotional violence were commonly associated with the likelihood of engaging in unprotected receptive anal sex with non-monogamous, intimate partners (Feldman et al. 2016).

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[9] Using Pulweritz's Sexual Relationship Power Scale and The World Health Organization Intimate Partner Violence Against Women scale.

Aboriginal women sex workers and intimate partner violence

Among Aboriginal women in Canada, there are elevated levels of reported intimate partner violence. In Vancouver and Prince George, BC, the likelihood of experiencing sexual violence was higher for Aboriginal women who were involved in the sex trade, had at least one parent who attended a residential school, had experienced childhood sexual abuse, and had used injection drugs (Pearce et al. 2016). On account of influences related to colonialism and institutional racism, Aboriginal women are over-represented in the Vancouver sex trade (Shannon et al. 2008) and three times more likely to experience generational sex work than non-Aboriginal sex workers (Bingham et al. 2014).

Implications of intimate partner violence for sex workers

In all, intimate partner violence against sex workers is a key predictor for conditions and practices known to elevate the risk of HIV infection. Ultimately, female sex workers, in particular, are often in situations where their agency to take up safer sex practices is compromised by violence and hegemonic power relations with their non-commercial partners on account of dependence, emotional or otherwise. The literature has established a strong link between violence and increased transmission of HIV among sex workers and their non-commercial, intimate partners. Sex workers, no doubt, have historically been poised to receive the worst of the stigma related to HIV and other sexually transmitted infections in all relationships.

3.4 Summary

In this chapter, I reviewed literature that offers a foundation for answering my third research question regarding the social contexts, conditions, and interpersonal norms that drive HIV vulnerabilities among sex workers in non-commercial, intimate partnerships. In contrast with the vulnerabilities and risk factors presented in Chapter 2, this chapter highlighted vulnerabilities that are associated with intimacy in partnerships with (usually) one person outside the sex trade. Indeed, there are disparate concerns, values, and normative exchanges among sex workers in these intimate, non-commercial, relationships. The literature highlighted the dynamic interplay of gender and power, particularly for women and trans women.

I began by reviewing the conceptual definition of intimacy used in this thesis, and I continued by highlighting the frame from social geometry theory that will be used to unpack the additive vulnerabilities among sex workers with their clients and in their non-commercial, intimate partnerships. I followed this by reviewing the function of intimacy in the literature on sex workers in non-commercial partnerships, and the blurred lines of normative rules for condom use when engaging with clients who are 'regulars.' I continued by identifying the literature on the symbolism of condom use, and I described the literature on intimate partner violence and some of its nuances among female sex workers, male sex

workers, and trans sex workers. As the literature shows, 'good' intimate partnerships are immeasurable beneficial for the health, safety, and security of sex workers. Intimate partner violence in all relationships is disturbing; among sex workers, the everyday stigma, discrimination, and emotional dependence on non-commercial, intimate partners renders violence somewhat worse, particularly among female sex workers. Figure II illustrates the various factors mediating HIV risk, drawn from participant interviews, and this includes intimate partner violence among the breadth of environmental, occupation, and client-based risks. The map in Figure III isolates clients and non-commercial, intimate partners in the triad/double-dyad relationships using interview data and the literature in order to illustrate how that the risk of HIV is more than additive from both clients in the sex trade and non-commercial partnerships. I will discuss in Chapter 6 the importance of HIV-related health promotion discourse targeting sex workers that is inclusive of non-commercial, intimate partnerships in addition to commercial client transactions.

Ultimately, there is an array of social and structural factors driving extreme vulnerabilities to HIV when working in the survival sex trade (Chapter 2), and this chapter reviewed studies which uncovered unique individual-level and relational vulnerabilities among sex workers in non-commercial, intimate partnerships. This thesis will show how these vulnerabilities interplay with HIV laws to put the health and safety of sex workers in the balance in much more extreme ways. I continue in the following chapter by outlining the design and grounded theory methodological approach of this study.

Chapter 4: Research Design and Methods

This study adopts an exploratory, qualitative approach to investigate the social processes and personal histories of sex workers with respect to HIV disclosure and vulnerabilities related to intimacy, HIV testing (policy), and health and legal literacies. In addition, I use moral regulation theory as an analytic frame to unpack the processes surrounding HIV disclosure, and I tease out the factors that amplify vulnerability to HIV among sex workers, their clients, and their non-commercial partners through an analytic frame drawn from social geometry theory. The purpose of this chapter is to explain my design, interviews, and the decisions I rendered when conducting the study.

I begin the chapter with a methodological overview of constructivist grounded theory, including the epistemological and ontological perspectives of this approach (Charmaz 2013, 2014), and I follow this with a review of principles from community-based research (Canadian Institutes of Health Research 2013). Then, I describe the research design, setting, sample, and recruitment of participants, and I follow this by highlighting my theoretical sensitivity in the grounded theory method and interview data collection. I describe the data analysis through initial coding, selective coding, categorical development and refinement, and the practice of keeping memos throughout. I close with a review of ethics for this research with human participants, and I offer a reflexive statement.

4.1 Grounded theory method in the constructivist tradition

The study in this thesis was methodologically guided by the constructivist approach to grounded theory that has been advanced by Kathy Charmaz. The constructivist approach rejects objectivity, focusing instead on power, privilege, reflexivity, and the standpoints of researcher and study participants (Charmaz 2013). This interpretive, inductive approach views co-constructed knowledge as historically and culturally contingent, prioritizing giving 'voice' to participants (Guba and Lincoln 1994; Charmaz 2013). In this tradition, I adopt a relativist ontology and subjectivist epistemology to understand the HIV-related health and safety among survival sex workers in the contexts of the criminalization of HIV nondisclosure. This approach assumes that these elements interact with various other structural, systemic, and environmental forces, unfixed across time and settings (Kawachi et al. 2004; Denzin and Lincoln 2013; Charmaz 2014).

On one hand, objectivist approaches assume a singular reality and a passive, neutral, value-free observer, and the collection of self-evident data to inform generalizations and theory with predictive power (Charmaz 2008). On the other hand, Charmaz (2006, 2008) assumes the existence of multiple, constructed realities of an obdurate, real world, and a research process which emerges from various social interactions that can account for the positionality of the researcher and participants (Charmaz 2008:402). Data are co-

constructed as part of the research process, that is, data are produced within the research process and they are not objects that are external from it (Charmaz 2008:402).

This grounded approach relies on a set of principles and guidelines rather than formulaic prescriptions, beginning with the collection of data, and continuing in tandem with iterative comparative analysis to develop codes into key concepts, group them into categories, and finally produce themes; the complete literature review is the final stage of grounded theory studies (Charmaz 2013, 2014). Recording memos is an integral component of the grounded theory method. In this, the researcher keeps rich data banks of ideas, thoughts, and insights, which guide the researcher in constant comparative analysis at all methodological stages (Charmaz 2014).

4.2 Community-Based Research Principles

This research combines the grounded theoretical approach with principles from community-based research. The Canadian Institutes of Health Research (2013) offers a definition of this approach in the following:

> Community-based research is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. Community-based research begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health, and eliminate health disparities. Community-based research brings researchers together with members of the community in order to identify issues, collect, analyze and interpret the data, and decide how to use the results to inform policy, change practice, and improve conditions in the community. (Para. 2).

This approach aligns well with features from constructivist grounded theory, particularly in the co-construction of knowledge with the aims of informing discussions on social policy and improving the health, safety, and lived experiences of survival sex workers. The negotiation of a 'safer space' for participants is a necessary feature of community-based research involving marginalized, vulnerable populations, as participants must feel confident that the information they share will not cause them harm, especially when expressing critical or dissenting opinions (Bergold and Thomas 2012). Within this safer space, researchers can seek to identify and subsequently mitigate power imbalances between researcher and participant (Bernier et al. 2006).

Unlike traditional studies that are undertaken by 'outside' scholars who seek confirmation of previous research, community-based grounded theory research can open a space for new dialogues and new modes of thought across intersecting disciplines (Bernier et al. 2006). The current study roughly combines sociology, criminology, and the social dimensions of vulnerable population health. Participants in community-based research can be empowered through the research process, and the results can lead to discussions of

progressive social policies that are tailored to the needs of the population under study (Teram, Schachter, and Stalker 2005).

4.3 Research Design

I began this study by writing a project proposal for funding from the Canadian Institutes of Health Research for my Master of Arts degree in Sociology. I expanded the proposal and received approval from the Supervisor and Committee Member in early 2015. The study began with a brief literature review that covered topics related to the criminalization of HIV nondisclosure as well as structural and social vulnerabilities that drive HIV-risks among sex worker. I shared the project proposal, ethics application, proposed methods for data collection, and participant recruitment with partners from PEERS, at every stage of the project's development. I recruited participants, conducted interviews, transcribed, and iteratively analyzed and interpreted the data, and produced the first draft for feedback. I expanded the literature review in response to emergent concepts and themes that had been developed through the constant, comparative analysis approach. I made multiple visits to the principal field site, PEERS, with the aim of normalizing my presence as an outsider within the safer space of participants; these visits may have tacitly fostered a sense of trust between community members and me, with the additional benefit of broadening my understandings of the culture and community at PEERS.

The study adapted grounded theory for pragmatic reasons. There was very little available literature on the criminalization of HIV nondisclosure. Literature from other global regions is localized, subject to regionally specific HIV exposure/transmission laws, and cannot adequately account for British Columbia's exceptional HIV care as a background for context, meaning, and the scaling up of HIV testing, province-wide. In the absence of previous theory, the grounded theory method allowed for the development of new theory. In qualitative studies, however, the 'theory' emphasizes the development of understandings rather than explanations. The most significant deviation from methodological purism in the current study was in the sampling procedure. Theoretical sampling is a staple of most grounded theory studies, a sampling procedure by which additional participants are included in the study who meet dynamic inclusion criteria based on emergent findings and constant comparative analysis (Charmaz 2014). However, the convenience sampling procedure is this study was taken up due to the difficult-to-reach nature of the participants and the potentially lengthy process of resubmitting modifications of the shifting participant selection criteria and interview guide to the Human Research Ethics Board for approval. As in most action research, methodological and technical rigour can be sacrificed in favour of generating evidence to be used and developed in a timely fashion (Kemmis and McTaggart 2001:591).

I made certain to avoid an interventionist bent throughout the gathering of interview data. By this, I mean that I aimed to capture the rich narratives of participants'

understandings of HIV disclosure without influencing their answers by informing them prior to the interviews of the specific conditions under which they (or their partners) had a legal mandate to disclose their HIV status. At no point was it my intention to have participants avoid HIV testing because of the criminalization of HIV nondisclosure. I was very careful not to give health advice to participants when asked. In some instances, I offered some clarity on some basic HIV questions, but otherwise I suggested participants contact the BC Nurses' Hotline or AIDS Vancouver Island, and I offered them contact information for these resources and other resources on an informational sheet at the close of the interviews.

I intend to offer a participatory educational activity on site at PEERS that is tailored to the needs of sex workers in the community. This participatory activity will be informed by the knowledge created in this thesis, and it will follow rigourous consultation with the staff at PEERS. The specific goals and content of this educational activity are not published in this thesis. I will however offer tentative guidelines for this activity in Chapter 6.

4.4 Setting, Sampling, and Recruitment

Setting

Interviews took place in the Greater Victoria Regional District on Vancouver Island, BC. Greater Victoria has a population of approximately 345,000 and is the 15th largest metropolitan area in Canada (Statistics Canada 2011). The staff at PEERS offered a private room that featured comfortable chairs and a sofa. 8 interviews took place on site at PEERS, and 1 took place on a public bench near the downtown core of Victoria. The location of the street-based interview was selected by the participant. This participant was given other optional settings. I conducted interviews in July and August of 2015 (see Appendix III for interview schedule).

Sample and sampling

The sample population in this study was 9 sex workers located in Greater Victoria who were clients at PEERS, 2 cisgender male/men and 7 cisgender female/women participants. The number of participants in the study was not preconceived. Sampling continued until 'theoretical saturation' was reached. Theoretical saturation in grounded theory studies denotes the point at which the inclusion of additional interview data yields no new categories or the development of themes (Morse 1995).

For inclusion in the study, participants were either currently working in the sex trade or had exited. 'Exited' was only loosely defined due to the reported oscillations between exiting and entry in the population; Benoit and Millar (2001) define 'exited' as over 2 years away from trading sex (to achieve this, the average number of exit attempts was 6). By this definition, it is not clear if the participants in this study who self-identified as exited were indeed 'exited.' In any case, participants who identified as 'exited' were asked

to speak of the time in their life when they were active in the sex trade. Participants were selected because they had serviced clients on at least 15 occasions in one year, they were at least 19 years of age, and they were legally entitled to work in Canada at the time of the interviews.

Being a 'survival' sex worker was not preconceived in the criteria for participant selection. Survival sex work in this study denotes engagement in the commercial sex trade on account of extreme needs for money, drugs, and/or food, and this term is commonly associated with sex workers experiencing homelessness, mental health disorders, substance use disorders, and other factors driving severe socioeconomic disadvantage (see Flowers 2010; Kelly and Breslin 2010). Participants in this study expressed varying degrees of unmet needs at different times in their working lives that drove their engagement in trading sex. I employ the term 'survival' not necessarily to denote that all participants were survival sex workers at precisely the time of the interviews (some were), but all participants were indeed able to speak of a period (or periods) in their lives when their engagement in trading sex was driven exclusively by basic needs for survival.

Participants were recruited through convenience sampling due to the difficult-to-reach nature of the population under study. Service workers and client outreach support workers at PEERS aided in the recruitment of participants, in some cases through direct referral. In other cases, participants learned of the study through word-of-mouth and one participant was recruited and interviewed during an evening ride-along in the PEERS street-outreach van. I gave service workers and client outreach workers a participant recruitment letter in which the objectives of the project were described. In the recruitment letter, I provided my contact information and the contact information of my Supervisor, and I explained the purpose of the study and the expectations of participants (see Appendix II). Following interviews, I offered participants the letter of recruitment letter to share with other potential participants who met the inclusion criteria. Each participant was offered a $10 honorarium for their time. While the staff from PEERS was encouraged to refer potential participants to me for the study, the precise identities of final participants were neither explicitly nor implicitly shared with the staff at PEERS, and none of the information from the interview transcripts was shared prior to anonymizing the data. One potential participant was excluded prior to the interview because he identified as HIV+.

4.5 Theoretical Sensitivity

The interpretive approach to grounded theory required me to be sensitive to the subtleties of the data. Theoretical sensitivity in grounded theory denotes acknowledgment of my own research background and my (i) ability to give meaning to the collected data, (ii) capacity to understand the data, and (iii) ability to separate relevant information from non-relevant information (see Dey 1999). The sources of theoretical sensitivity can include the

literature, professional experience, personal experience, and the process of analysis (Dey 1999).

In the study informing this thesis, I identify as belonging to the academic community with both public and private concerns regarding social inequity. The sources for theoretical sensitivity were the academic literature, advocacy websites for sex workers and persons living with HIV, and my personal experience volunteering at AIDS Vancouver Island. I began this research with a strong biological understanding of HIV/AIDS and a social understanding of HIV/AIDS among self-identified gay men, particularly those who were born within and after the 1980s. I remained informed of advancements in HIV/AIDS health care through my coursework in my undergraduate studies and private readings of the social health literature on HIV/AIDS, including the criminalization of HIV exposure, transmission, and nondisclosure. The culmination of my understanding of the criminalization of HIV nondisclosure among sex workers, including HIV testing, came during the full literature review for this thesis and coinciding writing process. I was surprised that some of my original thoughts were, in fact, already existing in the literature. The significance of HIV testing was not at the foreground during the interview process, but it became more significant during the writing process. The process of analysis continued to shape my worldview, my politics, and my norms, as I progressed.

4.6 Interview data collection

Interviews lasted for durations of roughly 30 to 60 minutes. I recorded the interview data using the digital recording feature on a password-protected smartphone with no network data capabilities. I anonymized interview data during transcription, omitting all names. In some cases, I made minor alterations to, for instance, specific locations or the ages and number of participants' children, in order that the identities of participants could not be inferred from interview data. In anonymizing the data, I ensured that the substance and contexts of statements remained unaltered. The inclusion of more detailed demographic information would have been helpful to give contexts and history to the participants' narratives. However, given the small, tightly knit community at PEERS, a more detailed review of participants' key demographic information and life history would no doubt render participants vulnerable to identification by others.

The guide for open-ended, in-depth interviews (see Appendix 1) covers 'themes' rather than standardized questions. This approach allowed for greater latitude in the exploration of substantive areas for this study and did not require modifications to an overly specific interview guide to be submitted to the Human Research Ethics Board for approval. In addition, this exploratory latitude was important due to the extreme paucity of extant literature on HIV-negative sex workers and the criminalization of HIV exposure, nondisclosure, and/or transmission, globally.

During the interviews, I did not push 'scare tactics' or read sample 'case studies' to participants to force answers on how the criminalization of HIV nondisclosure might inequitably affect 'them' under different circumstances (i.e., if they were HIV+), and I did not describe HIV testing as a life-changing technology that could affect not only their mental health, but also their occupational health and safety. I would have made the error of generating results from the study that reflected *my* anticipations and not the worldview of the participants. To reiterate, the interview process itself was not intended to be an (occupational) intervention for the health and safety of participants.

4.7 Data Analysis

I analyzed the interview data with the assistance of the qualitative analysis software platform, *DeDoose*. From the constructivist grounded theory methods (Charmaz 2014; Charmaz and Belgrave 2002), I chose to employ open coding and selective coding for the purposes of my analysis. Open codes are simple and precise, and they represent ideas and insights gleaned from *inside* the interview data themselves, line-by-line. In this sense, I made an effort to allow codes to emerge in the absence of preconceived categories or coding guidelines. The coding was complemented at every stage with intensive memo-writing, which I will return to, later in this section. Many phrases and sentences were assigned more than one code. In a non-exhaustive list, initial codes included the following:

- HIV risk
- HIV knowledge, change over time
- Risk at work, environment
- Risk at work, client selection
- Understanding HIV law
- Having good experience with non-commercial partner
- Having bad experience with non-commercial partner
- Anxiety and fear
- Sex work to support others
- Extreme needs

Next came the iterative analytic phase of selective coding. In this, the categories from open coding are fused to build theory and develop core categories to which all other themes and categories are interrelated (Charmaz 2006). The selective codes specified the properties and dimensions of groups of initial codes, and they were linked to other selective codes through common interactions, conditions, and consequences; this coding reassembled the data coherently to answer questions such as 'why,' 'under what conditions,' and, 'how' (Charmaz 2006). As an example of categorical development, the code, 'understanding HIV risks,' reflected action, and had the selective code properties of 'navigating and understanding adverse/unknown HIV-related situation, with an outcome

generated by chance.' I associated this code with the phrase, 'I've been lucky enough not to get HIV or become an AIDS victim through sharing needles. By the grace of God, I never got it.' In a non-exhaustive list, other selective coding categories included the following:

- Understanding legal dimensions of HIV disclosure
- Understanding HIV risks
- Working while under the influence of drugs
- Understanding HIV disclosure through non-legal, moral dimensions
- Interacting with law enforcement officials
- Working under averse occupational environments
- Understanding HIV testing

I oscillated between open coding and selective coding to develop and refine categories and draw interconnections. Eventually, selective codes were grouped under themes. For instance, the codes, 'working while under the influence of drugs' was associated with 'interacting with law enforcement officials' under the broader umbrella thematic of 'HIV risks and vulnerabilities: Co-constitutive driving factors,' which became Chapter 6. It was difficult to isolate categories, as separations were not always clear-cut. For instance, poor interactions with law enforcement officials in the past were also related to potential vulnerabilities in the future under the criminalization of HIV nondisclosure. This was noted in the memo-writing process.

Recording memos is an integral component of the grounded theory method (Charmaz 2006). In this, I kept rich databanks of ideas, thoughts, and insights, which guided me in constant comparative analysis at all methodological and analytic stages. I made a few rough sketches to map concepts by hand, but most of the memos I kept in a separate WORD file that grew longer, and longer, during the writing process and iterative analysis.

In order to offer a visual representation of findings, I created three concept maps (see Figures I, II, and III). The first illustrates the moral and legal dimensions of HIV disclosure, as shared by participants; this includes quotes in an easy-to-read format. The second illustrates the contexts and conditions that drive the risk of HIV infection among sex workers, taken from interview data; this map illustrates the multitude of social, structural, and interpersonal factors which drive the risk of HIV infection. Lastly, the third illustrates the V-shaped triad (or double-dyad, but not a fully connected triangle) of additive vulnerabilities to HIV among sex workers, linked to clients and non-commercial, intimate partners, using both the literature and interview data. Although this is not a sophisticated quantitative model, it allows for consideration of synergetic effects of vulnerability to HIV from clients as well as non-commercial, intimate partners. On a final note, I presented results in larger block quotations in Chapters 5, 6, and 7,, where appropriate, in order to capture participants thoughts in their own words, free of mediating interpretations.

4.8 Ethical Considerations

I obtained verbal consent for participation in this study in the form of audio-recordings at the beginning of the interview. The Letter for Verbal Participant Consent (see Appendix III) highlights the objectives of the study, the expectations of the interview participants, and the measures that were in place to ensure their anonymity and confidentiality. The Letter also explained that participants could cease the interview at any time and withdraw their data from the study at any point prior to publication, without negative consequences to them. Participants were assured that their relationship with PEERS would not be affected in any way if they were to withdraw.

In the conduct of research involving vulnerable populations such as sex workers, and in studies that take as their foci sensitive issues such as criminal acts and HIV, attempting to obtain signed consent could have created barriers to trust and anonymity. The Human Research Ethics Board at the University did not approve the original ethics application that included HIV+ participants in the sample, noting that the RCMP could seize my data to pursue future or current criminal investigations. In the interests of timely ethics approval, I modified the original participant selection criteria to include only persons who were HIV-negative or uncertain of their HIV status. This not only solved the problems associated with the extreme likelihood of HIV+ participants' revealing the 'crime' of HIV nondisclosure, but it also opened a space for the 'voices' among (to my knowledge) not yet studied HIV-negative sex workers within the substantive literature on HIV disclosure.

Following the completion of each interview, the consent for participation was briefly reviewed one final time. I offered an informational sheet to participants that included a 24-hour crisis line, contact information for AIDS Vancouver Island for any HIV-specific concerns, the BC Nurses Hotline for general health information, and other resources for securing longer-term, in-person counselling, if desired. Because all participants in this study were already clients at PEERS, they would have had the opportunity to be linked with similar resources in the past.

4.9 Reflexive Statement

My interest in HIV and sex work stems from curiosity about these highly stigmatized social phenomena that predates my entrance to sociological studies I always thought it dehumanizing to be affixed, for life, with a master status and discrimination related to these. Perhaps this was because HIV and sex work were a far distance from my life in my childhood and adolescent years.

I became a volunteer at AIDS Vancouver Island upon moving to Victoria in 2011. I met many clients and other volunteers, and I was able to observe first-hand the challenges in the lives of the 'vulnerable population' served at AVI. These challenges spanned areas related to generational poverty, working in the sex trade, mental health and substance use,

access to safer injection supplies, housing insecurity, and discrimination when attempting to access health and social services. Interfacing one-on-one with clients and frontline service workers evolved and informed my own norms and politics.

As I was in the planning phase of my Master of Arts degree in late 2012, the news media had announced that the Supreme Court of Canada ruled in two high-profile cases nondisclosure cases on the new conditions under which disclosure was no longer a legal obligation. The new rules seemed non-progressive to me, and persons living with HIV seemed subject to arbitrary conviction for sexual assault. Indeed, the Courts were continuing to convict HIV+ persons of sexual assault despite expert medical testimony in many concerning cases where the risk of HIV transmission approximated 'zero.' And how does one consistently offer proof that HIV disclosure took place? Can the law not be used and abused by jilted lovers when disclosure cannot be proven to have occurred? Can the law lead to coercion and sustained violence by partners who threaten persons living with HIV with (false) accusations? I was deeply curious as to how HIV disclosure legislation would play out among sex workers, a population already impacted by social, structural, occupational, and environmental forces that mediate their optimal HIV-related health and safety in inequitable ways.[10] I struggled with language in writing this thesis. 'Vulnerable' and 'marginalized' are blanket labels, and these fail to capture the plurality of persons, personages, histories, and brilliance among the participants whom I met. It pains me to think participants from this study might one day read this thesis and believe I thought they were all the same, all vulnerable sex workers. This was not the case.

I ultimately departed on the assumptions that (i) participants were concerned about HIV infection, (ii) participants were no more 'responsible' for the uptake of harm reduction practices than others outside of the sex trade, by virtue of working in the sex trade, and (iii) participants were no more 'responsible' than others outside of the sex trade for the spread of disease, by virtue of working in the sex trade. I also assumed this research was more or less documenting 'the criminalization of poverty and extreme needs' among a highly stigmatized, local group of legal workers who are subject to ongoing discrimination, debasement, and abasement, in everyday life. Here, I restate from the introduction that the protagonists of this thesis are survival sex workers, and their health and safety are my key concerns. The embedded paternalism in the above statement aside, it is nonetheless guiding this thesis, albeit through an empowerment approach.

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[10] This approximates my personal definition of the term, 'vulnerable population.'

Despite appearing as an able-bodied, Caucasian male who was conducting an academic study, I was surprised how friendly and open the clients at PEERS had been in their interactions with me. In addition, I was deeply moved by the accommodation that the PEERS staff and service workers had granted to me. It was an unspoken truth that there were power inequities between the participants whose narratives inform this thesis and me. There was no escaping my relatively more privileged background; it was best to recognize this and to attempt, as much as possible, an hermeneutic reading of the narratives that were presented to me, giving emphasis to capturing the 'voice' of participants.

I attempt to present this study, and the arguments contained within, through the empowerment model of sex work research. I have not attempted to conceal this ideological paradigm in identifying issues related to social inequities that form the cornerstone of this thesis. I recognize that this thesis adds to a 'sociology of the underdog,' ultimately begging the question, 'Whose side are we on?' in this academic discipline. I further recognize that I sediment HIV disclosure and HIV vulnerabilities as issues for persons traditionally recognized as marginalized, while their wealthier and better-resourced counterparts remain largely undocumented in the academic literature. This is the disciplinary situation that I arrived in, but this is not the disciplinary impetus that I wish to propagate.

I look forwards to continuing in my engagement with community-based organizations and returning the co-constructed knowledge in this thesis to the community. The publication of this thesis is the midway point of this project rather than the endpoint. The sharing of the knowledge contained within this thesis, in meaningful ways, is the ultimate goal.

Chapter 5: The Meanings of HIV Disclosure

The purpose of this chapter is to reveal, and then discuss, interview findings related to the first research question, 'How do survival sex workers understand HIV disclosure, legal and in other ways, and how might this interrelate with health-conscious practices such as HIV testing and condom use?' I have separated the findings into the two broader areas of (5.1) moral understandings and (5.2) legal understandings of HIV disclosure. Moral understandings highlight the key themes of conditions and contexts that drive the practice of HIV disclosure, and the self-responsibilization of future HIV infection. Legal understandings underscore participants' perceived protective benefits of HIV disclosure, anticipated consequences of receiving an HIV+ test result, and participants' relationships with law enforcement officials.

In the discussion section of this chapter (5.3), I review the findings through an analytic frame developed from moral regulation theory, and I consider both empathy and HIV testing to be moral technologies that play a key role in informing participants' understandings of the criminalization of HIV nondisclosure. It is interesting that some participants' understandings of the 'legal' mandate for HIV disclosure were indeed interpreted and justified through 'legal' frameworks and language,[11] which I will also discuss in the second section. I have provided a visual map of participants' responses from this chapter in *Figure I.*

5.1 Findings: Moral Understandings of HIV Disclosure

Universal and contextual imperatives for HIV disclosure

Among almost all participants who were able to delineate their understandings of HIV disclosure outside of the legislative frameworks, there was general consensus that HIV disclosure before sex was a 'good' or correct practice on moral grounds. However, most responses were terse, universal declarations, even when participants were prompted to expand. For instance, H.B. *(female, 30, currently working)* shared, 'Anyone should disclose their status, anyone. You should never, ever 'not' tell your partner that. It's just criminal as far as I'm concerned.' K.D. *(female 40 currently working)* echoed this: 'Disclosure is a big 'must.'' The responses of other participants were similar to these.

[11] I am reminded of the term, 'différance,' central to Jacques Derrida's deconstruction theory. This term denotes difference and the deferral of meaning. In the case of HIV disclosure, the legal 'wrongs' associated with nondisclosure were deferred or postponed to a cascade of legal signifiers. Put another way, HIV nondisclosure was described by some participants as 'wrong' because it was against the law.

One participant deviated significantly from the others on account of his higher degree of reflexivity – using himself as an example – when explaining the contexts and conditions that should prompt HIV disclosure, or reticence to disclose. A.B. *(gay, male, mid-20s, currently working)* shared that there were even contexts in which he felt the moral obligation to disclose that he was *uncertain* of his HIV status, particularly when engaging with new partners after previous high-risk sexual encounters. The quality of the partner, that is, 'nice guys versus johns,' was a significant determinant of his decision to disclose *any* STI, while stigma and rejection were factors that might drive his reticence to disclose to a casual, non-commercial partner. A.B. explained this in the following:

> If I'm fooling around with another person, sometimes I'm thinking whether I should tell him that I don't know my HIV status and that there've been some unprotected stuff in my past, and I don't know if I should tell them because then they might not want to sleep with me. If he's really hot looking, I'd probably do it for free and tell myself that it's just oral sex and you can't even catch anything from oral sex. But I have tooth decay, and I'm sure that if my tooth is rotten, then something could go into my tooth... *Can you get infected that way?* There's both a lot of fear and unconcern around this. And disregard for the health and safety of others...
>
> *If a john asked me my status, I'd probably lie. I would imagine that they wouldn't tell me their status, either.*
>
> If I'm with a john, I'm not thinking about my well-being. I'm self-sabotaging so I don't ask them their status... But for a nice guy who I was romantically interested in, I'd probably definitely tell them. But johns... I hate johns. I despise them. I can't stand them. They make me sick... They take advantage of my need for money and they exploit my desperation for drugs, money, or something.

Self-responsibilizing future HIV infection: Not blaming partners' nondisclosure

For R.G. *(bisexual male, 30, HCV+, not currently working)*, potential HIV infection from a client was understood to reflect his shortcomings as a responsible actor during commercial sex transactions. R.G. directed the blame of potential infection towards himself rather than his partners' reticence to disclose HIV status. This was also tied to his understandings of health outcomes for persons living with HIV:

> If my john had HIV and I put myself in that situation, would I blame him for it?... I think deeper, beyond and into the aspect of it, thinking that I couldn't blame him because *I put myself there*. Whether or not he decided to disclose, I know what kind of bagger I am, and I couldn't blame him. I can't speak for everybody. I don't think I could hate him for it. I couldn't. In the end, I'm the one who has to live with myself and feel comfortable that I just collected a deadly virus that will never

> leave me and will never be cured. In the end, I would carry a virus that is going to kill someone.

5.2 Findings: Legal dimensions of HIV disclosure

Perceived protective benefits of the legal mandate for HIV disclosure

There was consensus among interview participants that HIV disclosure could, and should, be legislated. There were however many nuances among the rationales offered by participants, not least of which their general skepticism that all persons would necessarily disclose, on every occasion. Participants had neither specific nor accurate knowledge of conditions under which HIV disclosure was legally mandated. Participants also lacked knowledge about the prosecutorial and punitive consequences for the charge of HIV nondisclosure, and several participants had confused HIV transmission as necessarily complementing the criminalization of HIV nondisclosure.

V.R. *(female 40 not currently working)* stated she felt more secure engaging in sexual activities with her clients knowing that HIV disclosure was a legal obligation. She shared that she had her first child at 21 and entered the sex trade as a single mother to support her child. She likened nondisclosure to a capital crime: 'I do feel safer because of the law. But I don't know whether disclosure is necessarily being done, but it's like murder, almost, in a way…' Y.A. *(female, 50, currently working)* similarly believed the laws 'should be harsher,' although she was uncertain what the laws surrounding HIV were. H.B. *(female, 30, currently working)* felt that there were indeed protective benefits afforded by the law: 'People say, 'I have HIV,' or they don't right? They should be truthful. Some people would not otherwise disclose if there was no law. You should never, ever, 'not' tell someone that you have HIV.'

K.D. *(female, 40, on methadone, currently working)* also felt that the legislative approach to HIV disclosure afforded some protective benefits, although this belief was balanced with her skepticism about the effectiveness of the law: 'I feel safer big time. Disclosure is a big 'must.' But I don't think there is a big fear of the law. Wouldn't you get charged with attempted murder if you didn't disclose?' K.D. went further to share a personal story about a friend who had warned her about a man who had been exposing female sex workers to HIV out of disregard for their health:

> I mean, there was a case where one of my [heterosexual] girlfriends was around Vancouver and she had an encounter with a Black man who was potentially infecting girls with HIV. She actually warned me about him, and thank God she didn't get HIV, but she let me know who the person was. He ended up getting charged.

Some participants explicitly felt that legally mandated HIV disclosure afforded very little protective health benefit. For instance, L.J. *(female, 30, not currently working)* stated that

she had never heard of anyone going to jail for 'passing it on after sleeping with someone,' and she believed that the criminal charge was currently manslaughter. During the interview, I clarified that the crime in Canada was anchored within only HIV nondisclosure, and she asked, 'What about transferring? That's pretty bad. Don't you get charged for that?' L.J. ultimately believed that the law would provide little protection from her male clients, 'I don't believe that people will disclose their status. I do know females who have disclosed because they wanted to, for really no reason. But men, I think more so that men *won't* disclose than women so there is a law.' This was the only participant to add a gender-related dimension to her perceptions of HIV+ persons' reticence to disclose to their sexual partners.

While participant R.G. *(male, 30)* was in favour of the legislative mandate for HIV disclosure, he felt that the legislative approach was ineffective and unenforceable, and there were clear moral-legal overlaps related to concerns for partners' well-being that encompassed intimacy:

> To legally state that if you don't disclose, have you committed a murder? That is what that section of the law is trying to say. If I sleep with you and you have HIV and you catch the HIV, does that make me a murderer, because I didn't state I had HIV?
>
> You can force anything upon people but it doesn't mean they're going to listen to it. In the end they're either going to decide to disclose or not to. You can't legally force it... the only person who can force it is the person who cares. Either they're going to care for the person or they're not. And if to me, intimacy says something about someone who cares for themselves enough to be open and honest with the other person. That is being intimate. You know, I care about you enough, but I can't 'not' disclose my HIV status. (R.G. *male, 30*)

Understandings of the consequences of a positive HIV test result

Participants were asked to share their thoughts and understandings of the outcomes of receiving a test result indicating they were HIV+. Because HIV+ sex workers were excluded from the sample, the findings remain speculative projections of a future condition. Most participants were in consensus that they would exit the sex trade, although no participant specified that the *criminalization* of HIV nondisclosure had any bearing in this decision. Some participants focused on the emotive elements surrounding an HIV diagnosis. For instance, K.D. *(40, on methadone, currently working)* shared, 'I would just have a flood of emotions. It would be like someone telling me that I had cancer... I would automatically think that it means death. First, I would think of my kids. I don't even know what the lifespan is. I couldn't keep on working.' K.D. continued by identifying herself in relation to other HIV+ sex workers:

> I would be too angry, honestly. I wouldn't go out to work... If I did go out to work then I am not that kind of person... as I say I am 100% safe when I go out... but I wouldn't meet someone and not use protection out of spite or anger. There have been cases that I have known personally, my friends, who found out that they were HIV+ and were all like, 'Fuck the world, I am going to die anyway, so I might as well go and...' Well, I am not that person. (K.D.)

Similarly, V.R. *(female, 40, not currently working)* could not consider the possibility of working in the sex trade while living with HIV, 'I don't think I could live with myself and, you know, continue, as it just wouldn't... feel right. I would leave immediately.' Similarly, L.J. *(female, 30, not currently working)* felt that an HIV+ test would alter her working life: 'If I told a client, and I would have to tell them, I think that being HIV+ would limit my work because people wouldn't want to be with someone who was HIV+, like if the condom breaks or something... it would be hard to find a partner.'

There were 2 notable exceptions. H.B. *(female, 30, with children, currently working)* suggested that she would begin serosorting her commercial partners, that is, finding other people who were HIV+ as clients: 'I would find other people who had HIV and spread it with them, you know, people with the same sort of thing. I'd probably find people like my friends and go on an HIV date.'

A.B. *(male, mid-20s)* insisted that receiving a positive result on an HIV test would not affect his ability to work. However, this was on account of his desire to exit the sex trade forever at the time of the interview. Despite his intentions, his management of hard drug use was a recurring barrier to exiting the sex trade. His response highlights entrenchment due to hard drug use:

> *Me*: How do you think that having an HIV+ test come back tomorrow might impact your working life? Would it affect it?
>
> *A.B.*: No. I'm trying not to work anyway, so I don't see how I could answer that question because I don't want to end up working, hopefully ever.
>
> *Me*: When was the last time you worked?
>
> *A.B.*: Just like a weekend ago. Because I had a really bad drug relapse. It was crystal meth for four days.

Distrust of law enforcement and despondence in reporting crime

On the topic of the legal obligation to disclose, several participants spoke directly to their dissatisfaction with police and law enforcement officials in their past. By this, these participants were skeptical as to the possibility of effective legal recourse in the event that they approached law enforcement officials with a report that their partner had not disclosed their HIV status. For instance, R.G. *(male, 30)* adopted an attitude of 'why bother reporting' nondisclosure: 'I mean are the cops going to be there when I need them? When

a dude's stabbing me up in the back alley?... Cops can't be everywhere at the same time. They just can't be there.' Similarly, A.B. *(male, mid-20s)* shared this pessimism in reporting crime: 'We have prostitutes that are criminals now, anyway. I'd probably already be a criminal myself.'

H.B. *(female, 30)* shared that her interactions with police in Victoria were poor on account of how they related to her previous drug use and drug selling to clients:

> There's are a whole lot of cops in this city and they don't like you using drugs outside. And I know that for sure. The dealers all tell me, 'Hey, go suck some dick.' Go suck dick and get me money means that I'm not really worth anything. They give me bad, dirty drugs. The cops caught me before and they stole my drugs. They told me that I had to make a choice, because the cops are either against drugs or they could be using drugs themselves. Another time I was raped – and they took my drugs. I told the cops once, 'I'm going to quit drugs and you can have all the dealers.' I mostly quit drugs.

This chapter subsection on the moral, legal, and juridical understandings of HIV disclosure highlights the widely varying diversity in attitudes, behaviours, and beliefs in this substantive area. The key take-away is that participants had strong feelings related to HIV disclosure and HIV nondisclosure, but these feelings were not informed by accurate information on the macrostructural laws surrounding the criminalization of HIV nondisclosure.

5.3 Discussion: Understanding the Criminalization of HIV Nondisclosure

5.3.1 Moral regulation: HIV disclosure as moral practice

It was difficult to delineate participants' specific understandings of the necessity or obligation for HIV disclosure outside the legislative domain. However, participants' understandings of HIV disclosure within non-legal frameworks fit within the domain of morality. To be clear, the 'moral' which I identify is an analytic terminological choice, as the word 'moral' was not used by participants. The indistinctness between moral understandings and legal understandings could be explained through a third, interrelated 'juridical' dimension that denotes an arrangement of ideas beyond the system of directives created by law-makers; indeed, laws come to permeate the consciousness individuals with in the population, playing a role beyond merely preventing certain actions by the enactment of legislation (Tadros 1998). This is similar to the relational theory of law (Hunt 1998) that finds legal frameworks tacitly distilled within all forms of social interactions and relations.

Moral regulation theory is well-suited as an explanatory framework to unpack participants' discursive framing of the criminalization of HIV nondisclosure at individual and collective levels, particularly given participants' tacit understandings of HIV disclosure as a reciprocal, moralized process that dovetails with the 'governance of the self and others' analytic paradigm. I draw this theoretical construct to explain the criminalization of HIV

nondisclosure as follows: Moralization in this context is a process, an historical and cultural linkage between moral objects (targets, the non-disclosers), moral subjects (victims, the sex workers in the study), and the proliferation of moral discourses (practise safer sex!), all acted upon by moral strategies (get tested!), practices, and techniques (disclose your HIV status!). The sex workers in this study imputed personal and collective harms to the conduct of reckless or malicious clients who, knowingly, did not disclose their HIV+ status. As voiced by participants, there was consensus that HIV disclosure was a practice of equal importance both for their sexual partners and (potentially in the future) for themselves. This understanding reflects the reciprocal nature of governing the self and others in accordance with the moralization of HIV disclosure that is (re)produced through channels of both formal and informal knowledge of various moralized elements, and these include HIV testing, HIV treatment, HIV-related exposure/transmission legislation, and HIV-related health outcomes.

Participants did not mention their expectation of HIV disclosure from non-commercial, intimate partners specifically. This could most likely be explained by the higher levels of perceived intimacy and trust with non-commercial partners that was most saliently reflected in their use of condoms rarely or never with these partners. I will return to the topic of intimacy as an HIV risk factor, specific to sex workers and selective condom use in Chapter 6.3.2.

Moral regulation and empathy for the non-disclosing 'other'

There was an absent 'empathetic' dimension in participants' understandings of potential sexual partners who knew their HIV+ status and chose not to disclose. Putting aside the extremely rare instances of HIV+ persons who are actively seeking to transmit the virus to HIV-negative partners, the exigent literature on the complexities of HIV disclosure reveals many contexts and conditions that could contribute to reticence in HIV status disclosure.

On one hand, the HIV-negative sex workers in this study highlighted their paragon of minimizing their risk of HIV infection in all circumstances, while various structural, social, and occupational factors drove vulnerabilities to HIV infection, compromising their agency to take up safer sex practices. Participants stressed that there were occasions in their past when they were at extremely high risk of HIV infection. On the other hand, even among participants who acknowledged that their non-commercial, intimate partners were non-monogamous or carriers of blood borne pathogens, there was little reported deviation from engaging in condomless sex with non-commercial partners. Given the higher vulnerability to HIV infection acknowledged by participants, presently and in the past, it is curious that they expressed little empathy for others (e.g., survival sex workers) who had also at one time embodied the role of 'potential victim.'

From this, I argue that moral regulation theory could be advanced in substantive areas related to empathy, or the lack thereof. Put another way, living amid extreme vulnerability to HIV and 'living with HIV' could be tenuous distinctions over an extended period working in the sex trade. Participants' characterization of abysmal, non-disclosing HIV+ clients who do not disclose their HIV+ status, acting maliciously or recklessly, may have obscured the materiality of their own deep entrenchment in the sex trade as well as the structural, social, and interpersonal conditions driving their vulnerabilities to HIV infection. It might be reasonable to infer that participants' understandings of non-disclosing HIV+ persons are denied a personage, a history, and the structural and social factors that drive him or her to continue to engage in sex – or the sex trade. In short, empathy and considerations of mitigating contexts and conditions of the non-disclosing 'other' were absent. It remains unclear how HIV stigma and

Moral regulation and HIV testing as a moral technology

The ability to disclose HIV status is contingent upon HIV diagnosis following an HIV+ test result, increasingly available across British Columbia. It follows that HIV testing appears at face value a tenuous technology to galvanize the trading of roles, in some cases within 5-minutes through Rapid Testing, from moral subjects (victims) to moral objects (targets). From this, I argue that moral regulation theory can be advanced by considering that, in some cases, the targets of moral projects are not longstanding 'villains,' but can be instantaneously transformed from being the subjects to the objects of moral regulation by technology, that is, HIV testing. Moral regulation in this context is somewhat novel.

Unlike other morally regulated targets whose threat to society requires significantly longer culturally understood histories and practices such as medical marijuana users (Lucas 2009), parents who do not vaccinate their children (Connell and Hunt 2010), or even non-users of 'Green' products (Mazar and Zhong 2010), the targets of HIV nondisclosure can only be created through HIV testing. Most interestingly, these moral targets decisively create themselves, of their own volition. For participants in this study, HIV testing had been previously taken up of their own volition under the implicit assumption of informed consent. I will return to the issue of obtaining informed consent for HIV testing from survival sex workers in Chapter 7.5.

5.3.2 Legal Understandings of HIV Nondisclosure

Participants' understandings of the criminalization of HIV nondisclosure often deferred to legal terminology of what is lawful and what is not. This highlights the juridical aspect of understandings of this topic, that is, the law shaped participants' understandings of that which can be considered legitimate behaviour. Legal literacies related to the criminalization of HIV nondisclosure were low among all participants. It is not fair to state that almost all participants were in favour of the criminalization of HIV nondisclosure;

rather, participants supported laws related to HIV nondisclosure, HIV exposure, or HIV transmission, whichever way the laws were understood. The key takeaway is that all participants were aware of an existing legal recourse related to sex with HIV+ persons who did not share their HIV status. Among participants who reported that the legal mandate for HIV disclosure offered them some degree of sexual protection, this protective benefit was insufficient to affect their insistence on taking up condom use with all clients under ideal conditions and within ideal contexts. The legal mandate for HIV nondisclosure had no discernable influence on participants' patterns of condom use with clients or non-commercial, intimate partners. In all, participants viewed HIV-related law as retributive and punitive, but negligible as a protective mechanism.

The criminalization of HIV nondisclosure had not created any discernable barrier to HIV testing practices among participants. Instead, almost all participants stated they would immediately leave the sex trade upon learning of their positive HIV status. The reasons for immediate exit from the sex trade centred on emotional distress and projections of difficulties in finding clients in the future as an HIV+ sex worker. For one participant, she stated she would go on 'HIV dates,' that is, adopt the practice of serosorting of among her clients. Only one participant, who had not engaged in sex work for several years, cited the legal mandate for HIV disclosure as a motivating force for exiting the sex trade upon becoming HIV+. Put another way, the fear of prosecution for HIV nondisclosure was not a significant factor driving their anticipated exit from the sex trade, succinctly summed by one participant with the statement, 'We have prostitutes that are criminals now, anyway. I'd probably already be a criminal myself.'

The criminalization of HIV nondisclosure runs paradoxically against the messages proliferating in official health promotion discourses from Health Canada that emphasize the uptake of safer sex practices to reduce the risk of STIs as a personal responsibility under all circumstances. These dissonant HIV-related legal and health messages from the State apparatus are at best unhelpful and confuse sense of responsibility that can be convergent on a single person in a dyad sexual partnership. At worst, the criminalization of HIV nondisclosure could keep health-conscious sex workers (outside of those sampled in this study) from otherwise seeking HIV testing and treatment, even when practising safer sex.

The following chapter reveals, and then discusses, findings related to the contexts and conditions that create HIV vulnerabilities in the commercial sex trade with clients, and the role of intimacy as factor that can reduce as well as enhance the health and safety of sex workers.

Chapter 6: Co-Constitutive Factors Driving Vulnerabilities to HIV

This chapter addresses the second and third research questions with respect to how structural conditions, social contexts, and interpersonal norms could drive HIV vulnerabilities among sex workers, their clients, and their non-commercial, intimate partners. In the first data section (6.1), I reveal co-constitutive factors in HIV vulnerability related to hard drug use. The findings in this section did not arise from a centralization of interview questions specific to hard drug use but, rather, they arose from participants' own emphasis on responses related to this substantive area. Categories include engaging with clients while using hard drugs, entrenchment driven by the need for hard drugs, and client violence in relation to hard drugs. The sum total of this data section suggests that (the extreme need for) hard drugs has a significant impact on sex workers' HIV vulnerability.

The second data section (6.2) reveals participants' understandings of HIV vulnerability as it relates to intimacy. Categories in this section include the symbolism of condomless sex, trust formation with longstanding clients or 'regulars,' and broader conceptualizations of intimacy in relation to non-commercial, intimate partners. This section ultimately reveals the dynamic interplay of intimacy and other factors that result in both increased and decreased HIV-related vulnerability to the health and safety of sex workers. The findings are visually represented in Figure II.

In the discussion section of this chapter (6.3), I review interview data against the backdrop of findings from previous scholarship. Indeed, the HIV risk factors that are commonly associated with substance use among sex workers were present in this small sample. These findings invigorate a discussion on how the symbolism of condomless sex could be the most consistently reliable factor driving HIV vulnerability among sex workers. While levels of extreme needs and hard drug use patterns may fluctuate over time and drive differential HIV risks with clients according to context and settings, patterns of condomless sex in non-commercial partnerships remained constant.

6.1 Findings: Understanding HIV vulnerabilities related to substance use

Entrenchment co-driven by the need for hard drugs

All but one participant shared that they had engaged in sex work while using, or to fulfill the need for, hard drugs. For these participants, at some points and to varying degrees, sex work was co-driven by one or more of the following factors: a need for drugs in exchange for sex, a need for money to purchase drugs from non-clients, a need for drugs/money to alleviate 'dope-sickness,' and a need for drugs to numb the experience of having sex to support the most basic survival needs, including the needs of their children.

Prior to commencing methadone therapy, K.D. *(female, 40)* explained that her dependence on opioid pills was a key driving factor her engagement in the sex trade. She

took up sex work at times with the express aim of alleviating her excruciating opioid withdrawal symptoms. At the time of the interview, she had been stable on methadone for two years but still 'dabbled' in cocaine on occasion. Hard drug use had an anesthetizing effect when engaging in the sex trade. She further clarified that she was a 'normal' person whose engagement in the sex trade was motivated by extreme needs beyond what disability assistance from the State could cover:

> Being a sex worker is just not me. I use drugs to make me feel like I am somebody else because I'm so proud of being a single mother and I have that persona. But the nightlife is different, so it's like I have to have something in my system to be able to do the things I do, working-wise. *I'm not addicted to sex work but I still have to go out and consistently work. I'm on disability that does not cover enough food and stuff like that. (K.D. female, 40)*

For all women in the sample who had children, sex work was taken up at times partially or wholly in support of their children. V.R. *(female, 40)* had a personal history similar to K.D.'s wherein her engagement in the sex trade was co-driven by drug use and the financial support of her children. In retrospect, she felt that luck or divine intervention had kept her from being infected with HIV.

> I first started sex work when I was 21, and I did it because I was the single mum of a three-year-old and a one-year-old. And I was on social assistance and I needed the money... sometimes we would share needles and you don't know if the person has HIV or not, and we'd clean the needles with bleach but there's no proof, no safeguard. I've been lucky enough not to get HIV or become an AIDS victim through sharing needles. By the grace of God, I never got it.

Engaging with clients under the influence of hard drugs and alcohol

For R.G. *(male, 30, not currently using drugs)*, sex in exchange for drugs had led to extreme violence and rape on several occasions. Sex, hard drug use while working, and hard drug dealing were part and parcel:

> A lot of my drug trade involved sex. I would sell myself to men, to the dealers, or to the people around who see my intoxication or my stoned-ness, or whatever you want to call it... I would get drunk and make money out of a deal. I didn't know what to expect, or what I was going into, but there was no talk about HIV at all. (R.G.)

A.B. *(male, mid-20s)* admitted to going to wooded public areas to find clients in Victoria when he was 'all f**ked up and dangerously lustful.' He continued, 'And then when I want more money to get more fucked up, that's when I mostly do work stuff.' For A.B., hard drug use was not understood as a co-driver, but rather as *the* singular driver:

> *I think that drugs are the only component to my continuing in sex work.* I only do it when I am desperate for drugs. I used to think I could drink alcohol and quit everything else but I realize I am totally powerless over alcohol. I start with two drinks one day… and three drinks a week later… and then twenty drinks and I am out looking for drugs. When I stop going to AA, that's when I have my relapse.

K.D. *(female, 40)* recounted her younger days when alcohol and hard drug use were closely tied to high-risk sexual encounters and elevated risks for STI. She recalled this with regret:

> When I would drink when I was younger, I was not aware of the risks, which was bad on my part. There were a couple of occasions when I could have easily been infected with HIV. I was also using cocaine as well, and just alcohol and drugs. I ended up suffering from getting sexually transmitted diseases. Gonorrhea was at the top of the worst that I could get but that kind of opened my eyes. I was very promiscuous and I didn't use protection when I would drink. (K.D.)

L.J. *(female, 30)* believed that the drug γ-hydroxybutyric acid (GHB or 'G') had created significant vulnerabilities for other female sex workers in Victoria who sought this drug from male clients:

> From what I have known in Victoria and the people I have hung around with, GHB makes for a high-risk encounter. Guys give it to girls who are young, and give them more than they should, and *it's not rape because the girls went looking for it.* This one guy I know, he wouldn't be with the different girls, every day, all the time, if it weren't for GHB. I even asked him once, 'Don't you worry you'll get a disease?' And he said, 'No. Every time I go to jail I get tested, so I'm not worried.' His GHB operation seems to work out for him in getting girls. And he is putting other people at risk.

Ongoing hard drug use was described as the most significant factor driving entrenchment for A.S. *(female, 40, exited for over 2 years)*. She had a co-habitation arrangement with an intimate partner who would 'pimp' her out to friends in the Lower Mainland in a home-based operation. Sex work was used to 'survive,' in her words, and afford her extreme need for crack for roughly 6 years. Treatment for crack use and support of family members facilitated her exiting the sex trade which, in turn, allowed her to evaluate her 'distorted mindset' in retrospect during her peak engagement trading sex for survival.

Understanding HIV risks from 'other' sex workers in relation to hard drugs

H.B. *(female, 30)* had been compelled in the past to engage in sex work in need of an urgent 'fix.' Interestingly, she felt that her vulnerabilities to HIV infection came not only from her clients, but also from other injection drug using female sex workers. She expressed deep concerns surrounding HIV infection and anticipated physical deterioration

upon acquiring HIV, while her self-understandings were defined in comparison to other sex workers:

> I know that other hookers mostly have diseases by using IV heroin. I have to use protection when I go on dates so that I don't get HIV... it's the sickest thing. Other girls do rigs. But hookers like me, I don't do rigs. Other hookers positive their johns, and they can positive me by sleeping with me without a condom. So now when a guy picks up a girl and she has diseases, now he could give them to me because he's mad at her. And it's not fair because I didn't do anything. But the other girl did, by putting a rig in her arm and sharing dirty rigs. And then he gets mad at me and says to me, 'You're the one who made it like this.' And I say, 'No, it was somebody else.' So he's infected and now he wants to give it to me. And all I know is that hooking is a waste of time because he could have HIV. And there are lots of girls at PEERS who are HIV+ and they get picked up. And they don't use condoms, and they get HIV disease, and they could spread it to me – or you – through unprotected sex. Why would I want to get paid for HIV disease? It's not really worth it. That could affect my looks, my beauty, make me sore. (H.B.)

Experiencing entrenchment, recruitment from an early age, and the role of hard drugs

For L.J. *(female, 30)*, sex in exchange for crystal methamphetamine was a significant part of growing up in group housing run by the State, between the ages of 13 and 16, in the interior of British Columbia. She described drug use and sex in exchange for both drugs and money as the cyclical norm for the girls living with her in the group home:

> I was addicted to crystal meth, and then I went into a delusional psychosis, because it was bad, and because I lost my oldest child for two months. So then I just quit drugs after that. Meth was a bad drug. I was so young, in a group home when it was introduced to me by the older working girls. They were like, 'You should try this drug,' and I didn't even know what it was. I tried it, and of course I liked it. I did more, and the older girls would teach us, and bring us to johns' houses and teach us how to make money. This was the cycle in the Interior place I was from. All the younger girls were introduced to it by the older girls... It's really bad for recruitment, like into gang operations and stuff, too. That is what mostly happens in group homes.
>
> STIs were not really discussed. The staff would occasionally get us to do an annual checkup. They did encourage it, but we didn't have to do it. That almost gave the impression to me that being a sex worker was okay, to a 13-year-old. We shouldn't have been having sex. We were just little girls, but we were tested once a year. I thought it was weird that they would do that. It was like the staff didn't care or they encouraged it. I know but I wouldn't want my child at 13 to be doing that. I would to whatever it would take to prevent it.

Understanding HIV risk from non-commercial, intimate partner's hard drug use

Drug use by non-commercial, intimate partners presented contexts driving vulnerability to HIV infection. This was exemplified by H.B *(female, 30)*:

> I had an HIV boyfriend ten years ago. And he would share pipes with other people, and if you share them, your slobber can give you HIV. I think it's in your slobber and the slobber can't kill the bacteria. He told me he had HIV, and I said, 'I'm not going out with you,' and he said, 'Too bad, you're going out with me right now.' He put a condom on himself, but I still don't have diseases though I still had the risk of getting HIV. *(H.B.)*

Understanding occupational risk from client's hard drug use

The use of hard drugs *by clients* presented additional risks to the health and safety of some participants. For instance, J.P. *(female, 40, no hard drug use, sex work to support children)* explained, 'Most risky was taking on somebody I really, really didn't know.' She shared that she was frightened of meeting with clients who were high on drugs, not knowing what condition or shape they would be in, upon meeting. She understood the risk factor, here, as rooted in the discretion of the person who referred her to a client. She finished by clarifying the necessity of her sex work, 'I had no partner at home. *This was all for my kids, to survive. That's what it was.*'

Experiencing client violence in relation to hard drugs – street-based vulnerabilities

For H.B. *(female, 30)*, most of her clients were met on the streets during a 'stroll.' She had previously been working in the sex trade under men who acted in the dual role of manager and dealer, although she worked more independently at the time of the interview. H.B. recalled an extremely violent encounter with a client, and she described the lack of investment in her health and safety from her dealers/managers:

> When I was young and I looked like a model, I was prostituted by male dealers because I was young and pretty. One time, this guy grabbed a rock and said, 'Let's go to a field.' And I thought, 'This doesn't sound right.' I went anyway. I should have followed my instincts. It was just forty dollars. Then, I said, 'I am not doing this.' He takes me down, spreads my legs, fucks me, picks up a rock and hits me five times over the head, fucks up my model face. I had swollen beats all over my face.
>
> He tried to dig me underground, and he beat me more to bury me more, and he left me there. He raped me, and took my money, and I went back to the drug dealers, and they looked at my face and said, 'Who the fuck did this to you?' I said, 'Some guy raped me and beat me tonight.' They said, 'Oh we're going to find him right now.' I said 'Whatever. You don't give a shit about girls like me that would get

> raped and almost killed.' They didn't even care. They just stood there. There's no protection for me.

This narrative excerpt from H.B. also highlights the occupational environments which drive vulnerabilities to violence, rape, and HIV infection among street-based sex workers.

6.2 Findings: Understanding HIV vulnerability in relation to intimacy

In all, participants made a clear distinction between patterns of condom use with their clients and their non-commercial, intimate partners. This dichotomy held that participants were nearly always consistent in condom use with their clients but equally insistent on 'not' using condoms with their non-commercial, intimate partners. The decision-making process in condom use with non-commercial, intimate partners was 'active' and not subject to mitigating factors such as unfavourable circumstances, access to condoms, or decisions which were made under the influence of hard drugs. As reviewed in the literature in Chapter 3, intimacy has been typified by scholars in discreet terms (for instance, instrumental versus emotional). Across the interviews, however, participants understood intimacy in more general terms as a signifier of emotional connection, trust, and sexual pairing with (one at a time) steady, non-commercial partners.

Symbolism of unprotected sex, despite acknowledging HIV risk

Participants offered various reasons for not using condoms with their non-commercial partners. These distinctions were made in most cases by comparing and contrasting their intimate partner experiences with their client experiences. In all, participants expressed that intimacy was the 'norm' during lifetime sexual encounters, and their experiences with clients were discursively framed as a deviation from this norm. **L.J.** *(female, 30)* was concerned that her current intimate partner, and father of her child, had been engaging in sexual relationships with men when out of town for employment contracts. This, as she described, still had no impact on the imperative to use sexual protection with him:

> Even though I'm concerned that he might be with other people, we don't use condoms. Sometimes he tries to use them, but I think it's because we had a child together. I could see him not using a condom with other people. When I was younger, [condom use] was like 70% of the time. Now, it's like 90% of the time... With a stranger, I would use a condom... I think [condom use] depends on who the person is. The father of my son, I think is a little bit bisexual. I saw him looking at shirtless guys at the skate park. I'm thinking I should be more likely to be scared of him than some random guy, and it would be more logical to be worried about a stranger, but I just think of his lifestyle choices. I know that people can be safe and all that, but *homosexuality and HIV scare me the most.*

L.J. later explained that if she had asked to use a condom with her current non-commercial, intimate partner, he might have 'known what [she] was up to,' in reference to providing commercial sexual services to male clients.

K.D. also expressed that unprotected sex was the norm in her non-commercial, intimate partnerships, relating this to the length of her current relationship and sexual health literacy: 'I feel safe enough to feel that he's not doing anything with others. I have been checked for HIV with every pregnancy, and I know the 'ins and outs' of getting HIV and hepatitis and whatnot.'

A.B. *(male, mid-20s)* had rather different views from other participants when engaging in unprotected sex with his intimate, non-commercial partner who he knew to be currently carrying Hepatitis C. The risk of acquiring an STI from his partner was a source of great anxiety, but not a deterrent for unprotected sex.

> My boyfriend has Hep C and I still don't use protection with him. That worries me right now because I slept with him the other day... I've never caught it [HCV] yet. But I think I caught herpes from him. (A.B.)

Trusting 'regulars' and financial incentive – unprotected sex with clients

For H.B. *(female, 30)*, if one of her regular male clients had a wife, she took this as a signifier that this client did not pose a risk to her sexual health. Here, trust as well as financial incentive was a factor in convincing her to avoid condom use:

> I usually use condoms, but if I know the guys and I have been tested through the years and they are my same clients and they have wives, then I am sure that their wife doesn't have disease and he doesn't either, then I would give a blowjob [fellate] without a condom. Sometimes, they will be like, 'Oh, I'll pay you more,' and I've done it like a couple of times. (H.B.)

Condom use as symbol of 'control' with clients

Condom use was not always understood according to frameworks related to HIV-related risks and intimacy. For instance, J.P. *(female, 40, no drug use)* expressly stated that she had never been unable to negotiate for condom use with clients. She was terse: 'I made it quite clear. I was in control of that part. It was like, *Here's a condom*... I never really had a bad date or was in a situation where I didn't feel in control with clients.' Only H.B. and Y.A. had never experienced client perpetuated violence, with Y.A. sharing, 'My worst date was when some guy stole my purse... You always use a condom with johns, but [non-commercial, intimate partnerships] comes with lust and romance, and you don't think about condoms with them.'

Conceptualizing HIV risks with non-commercial, intimate partners

Participants had mixed views on engaging in relationships, both sexual and non-sexual, with persons who were living with HIV. These views were often described as transformative over time, but participants were often inconsistent in their personal 'rules' for engagement in unprotected sex with partners in the context of HIV infection. For instance, R.G. *(male, 30)* expressed that he had a crush on another male in his youth. He continued by sharing that the reason he did not takes steps towards further interactions with this prospective partner was precisely because of his HIV status. HIV infection was moreover understood by him to be a death sentence:

> I have a friend, who I actually really wanted to be with, and he was HIV+. He was from my hometown, a beautiful young guy my age, a Native like me, and everything I could have dreamed of except he was HIV+. And I actually pondered the thought of sleeping with him, although I would practise sex safely. But would I put myself at risk of something going wrong? Especially as an addict who doesn't care half the time who might just say, one day, 'Oh fuck it, I love you I want to spend the rest of my life with you and I want to die together.' So I'm just going to get the disease just so I can be with you.' That's a mental thing. Are we willing to put ourselves at that level, of that person? Because we thought or we feel that we're intimately in love with that person... I couldn't even tell him that I wanted him.

When asked in a follow-up question about concerns that his intimate, non-commercial partner could put him at risk of a sexually transmitted infection, R.G. responded in somewhat contradiction to his earlier statement: 'Of course I am concerned he might have a disease, but that doesn't mean I'm going to stop being with him.' Being with a non-commercial, intimate partner whose HIV status was unknown could facilitate a sexually intimate encounter while, conversely, being with an intimate partner known to be living with HIV was not a risk he was willing to take.

L.J. *(female, 30, not currently working)* was more open to the possibility of having a non-commercial partner who was HIV+. As she explained, her level of aversion to engage with an HIV+ partner was dependent on the relationship they had previously fostered: 'I'd be really upset, but I mean it depends on the person. If I liked him and we were close, I would use protection and stay with him. But if I liked him and we weren't really intimately close, I would stay friends but not sleep with him.'

Psychological burdens from lack of intimacy when engaging with clients

A lack of intimacy, support, and trust was a source of frustration for some participants when describing their relationships with their clients. As a result, these participants expressed that they felt 'used' by their clients. For instance, R.G. *(male, 30)* shared his regrets following a recent paid encounter with a client:

> Deep inside me, I beat myself up and hate myself for destroying my life. I guess for me that the experiences with johns aren't really intimate. It isn't about intimacy. It's about an old man who wants to get pleased, and also me, who is just a distracted mess, who hates myself and doesn't care about myself.

A.B. *(male, mid-20s)* drew a connection between intimacy and romanticism, and these features were notably absent during his client transactions. 'Pretending' to act as an intimate and caring sexual partner during encounters with clients was part and parcel with working in the sex trade, and this left him somewhat emotionally drained:

> I'm not intimate with any of the johns I'm with. *Sometimes I can feign intimacy, if I feel like that is what they want, but even that, I feel I am giving a sacred part of myself away to someone else.* When I was younger I was a total romantic. And I still try to hold on to that notion of romance. Yet I've had all these bad lovers and bad things go on. And I've probably been bad and greedy and selfish, and so I find it harder and harder as the days go by to believe in romance... I still believe that I can get myself back to that point. But I have to be responsible not to put myself in situations where I feel I am demeaning myself. That is how I view prostitution. I view it as a demeaning act.

L.J. *(female, 30)* felt that lack of intimacy was favourable when providing services to clients. Having a non-commercial, intimate partner also created internal tensions when concurrently working in the sex trade:

> It's hard to separate intimacy in sex work and HIV. Like, being with somebody as an intimate partner and then sex work, because being intimate is something you *don't* want to do during your sex work. And then if you're being with a non-work partner there is jealousy and it's not viewed as a job.
>
> Sometimes it's also the men who want the women to work because they bring money back, so they don't really care and they're not jealous. *Personally, I wouldn't want to be doing sex work while I also had an intimate partner... I wouldn't want it because it would feel like I was cheating on him and just feel weird.*

Findings summary: Hard drugs and intimacy

The findings in this chapter were sectioned into the co-constitutive factors driving vulnerabilities to HIV infection under the two broader lenses of substance use and intimacy. HIV vulnerability was a strong theme throughout the interviews precisely because it was the core topic of this research. However, substance use and intimacy were not especially preconceived as distinctive themes during the project planning or interview process but, rather, they emerged through the course of data analysis. In any case, hard drug use was distilled in almost every high-risk client encounter with clients, while the use

of condoms was acknowledged as extremely important with commercial clients but actively avoided with non-commercial, intimate partners.

6.3 Discussion: Factors Driving HIV-Related Vulnerabilities

When I asked participants to speak of risks and vulnerabilities in their working lives with their commercial partners, the majority of responses were tied at the core or periphery to hard drug use, selling hard drugs, or selling sex on account of the extreme need for hard drugs. All participants had worked independently at some point, that is, working in the absence of a pimp or manager. There was no pattern in working under conditions that offered greater safety across time and increased experience with clients. There was however a pattern that illustrated less safe sex practices with clients due to an extreme need for hard drugs due to dope-sickness, money to support children, being offered more money for unprotected sex, trusting 'regular' clients, and being generally 'talked out of it.' Conversely, 2 participants insisted they had never been on 'bad dates' that presented contexts and conditions in which they were not in control of the sex transactional situation with their clients. Participants recalling their street-based sex work had emphasized their history of rape and sexual violence (and attempted rape), most often in the contexts of hard drug-seeking or hard drug-selling to clients.

6.3.1 Hard drug and alcohol use

For all participants with a history of difficulties in the management of hard drug and alcohol use, these substances were self-reported as understood to be either directly or indirectly the most significant factors driving vulnerability to HIV infection. At the structural level, the need for hard drugs and alcohol created a significant barrier to being more selective of their clients, also squeezing and constraining their agency to negotiate for safer sex practices which would reduce their risk of HIV infection and transmission. In addition, these participants reported that their engagement in practices commonly associated with an elevated risk of HIV infection were exclusively taken up while already under the influence of hard drugs, using hard drugs with clients, and seeking hard drugs to alleviate needs due to extreme desire or withdrawal.

These findings align with previous literature identifying hard drug use and the need for hard drugs as significant factors driving the risk of HIV infection, especially in direct sex-for-drugs transactions (Duff et al. 2012; Maher 1997; Shannon et al. 2008). For at least two women in the study, methadone was identified as a life- and work-altering therapy that reduced the urgency and need to engage in sex work. One participant had been receiving methadone therapy for almost ten years at the time of the interviews and had experienced no relapse. The emancipatory qualities of methadone therapy extended to their increased agency to select and screen clients, improved working conditions, and control over the sexual services they provided. Indeed, removing the ongoing need for opioid-related highs

and lows allowed for their decision-making abilities not to be influenced by cognitive impairment. The role of opioid replacement therapy should not be overlooked as a longer-term strategy for enhanced occupational safety, sexual health, and reduced incidence of high-risk sexual practices. In addition, globally, opioid addiction therapy has been demonstrated to increase recruitment to HAART, adherence to HAART, and suppression of viral loads, which can significantly reduce the adverse health outcomes of living with HIV (Low et al. 2016).

For the male participants in this study, the management of hard drug and alcohol use self-reported to be a significant and ongoing challenge in their lives. Substance use disorder among gay, bisexual, and other men who have sex with men is a key factor driving adverse social and health consequences in Victoria and globally, including HIV and other blood-borne infections. For instance, in 2014, men who have sex with other men were reported to be the population subgroup with the greatest incidence of new HIV diagnoses in British Columbia,[12] with the greatest number of new infections among men who were born after 1970 (BCCDC 2015). In Vancouver, Lachowsky et al. (2015) found that substance use (crystal methamphetamines and poppers) was the single greatest factor associated with high-risk sexual behaviours among men having sex with other men.

In sum, for all but one participant, issues related to the management of drug and alcohol use was identified to be the most significant factor driving their risk of HIV infection. This supports the recommendation offered by Benoit and Millar (2001) for increased availability of substance use management services for sex workers seeking to exit their trade, if and when they desire to exit the sex trade.

6.3.2 Intimacy as a risk factor for HIV infection and transmission?

Intimate partnerships and the symbolism of condom use

Participants expressed that condom use was taken up rarely or never with their non-commercial, intimate partners, and this was not on account of carelessness or the influence of drugs or alcohol. Instead, intimacy and most notably 'trust' were commonly at the foreground in active decision-making to favour unprotected penetrative sexual practices with these non-commercial partners. These findings align with indications in the literature that having a non-commercial, intimate partner can reduce the uptake of HIV harm reduction practices, most notably condom use and the sharing of drug paraphernalia

[12] In British Columbia in 2014, MSM accounted for 150 new HIV diagnoses; injection drug users = 15; heterosexual contact = 33; blood products/occupational exposures = 6; unknown/no identified risk = 11.

(Syvertsen et al. 2013; Syvertsen et al. 2015).

The literature also indicates that intimate, non-commercial partnerships can be a significant driving factor for psychological, physical, and sexual violence against sex workers, and this has been associated with a greater risk of acquiring HIV (Feldman et al. 2008; Duff et al. 2016; Syvertsen et al. 2016). However, participants in the study only reported client-based sexual violence as factors contributing to their risk of HIV infection. Across the literature, scholars have found sexual violence to be under-reported (DuBois, 2012; Johnson, 2012; Shannon et al., 2008; Sinha, 2013) due to unclear understandings of what can constitute sexual violence (Ahmad et al. 2004), violence considered serious enough to report (e.g., obscene name-calling; sexual assault; threats of sexual assault) (Brennan and Taylor-Butts 2005) as well as the fears, shame, blame, embarrassment, and judgments that might follow reporting (Johnson 2012). In all, the decisive fact remains that intimate partner violence is more often gender-based, with women on the receiving end more often than their male partners (Benoit et al. 2015).

For participants who were both in an intimate, non-commercial partnership and actively working at the time of the interviews, not being completely honest with their partners about their commercial sex practices was a strategy employed to protect their partners emotionally, to foster a semblance of trust, and to avoid conflict in general. Syvertsen et al. (2013) have reported similar findings among sex workers, noting that while telling 'little lies' and avoiding discussions of health risks may offer relationship protection, these strategies can ultimately exacerbate potential infection with HIV and other STIs.

For L.J. (*female, 30*), who was deeply frightened of HIV transmission from her current longer-term partner on account of his suspected same-sex sexual partnerships when working out of town, L.J. still did not use condoms when partnering with him, even after identifying him as previously having infected her with an STI. Similar situations are not uncommon. While there are indications in the literature that bisexual disclosure by male partners is associated with increased uptake of condom use (Wolitski et al. 1998), other studies suggest women knowing their male partner is bisexual has no impact on condom use patterns (Shearer et al. 2012; Malebranche et al. 2010; Kalichman et al. 1998).

Approaching non-commercial partnerships in HIV prevention

The symbolism of condom use has important implications for HIV prevention efforts among sex workers. Interview data revealed that the most consistent, ongoing risk factor for HIV infection and transmission that participants could more or less control was having condomless sex with a non-commercial, intimate partner. Non-commercial, intimate partnerships are often absent from health promotion discourse targeting sex workers. Syvertsen et al (2015) have suggested the incorporation of couples interventions tailored to the emotional dynamics between sex workers and their non-commercial partners. For partnerships with greater levels of love and trust, programs could use emotional

commitment as a motivating factor for intimate partner protection; for partnerships with lower levels of love and trust, individual issues such as hard drug and alcohol management and concurrent non-commercial partnerships could be addressed (Syvertsen et al. 2015). Argento et al. (2015) highlight the active role of male partners in couples-based interventions and gender-based approaches that can accommodate intersecting emotional, physical, and economic dimensions as well as drug use, violence, and financial dependence. The above approaches to sexual health promotion among sex workers and their non-commercial, intimate partners appear to be principles for practice rather than concrete solutions.

There is also a non-zero probability that discursive messaging on the importance of condom use has reached saturation in the decision-making processes of some sex workers, and the decisive avoidance of condom use is emancipatory in nature, even functioning as a resistance to over-messaging on safer-sex practices. In any case, empowerment through enhancing the HIV-related health literacy of sex workers could ultimately satisfy the need to feel they are informed on safer practice decision-making, risk assessments of partners (e.g., their STI testing frequency, history of injection drug use), and current HIV treatment outcomes.

6.3.3 Combining HIV Risk from Clients and Non-Commercial, Intimate Partners

The literature more often focuses on HIV vulnerability among sex workers with *either* (i) clients, extending to working environments, indoor/outdoor, policing, and socioeconomic status, among other things, *or* (ii) non-commercial, intimate partners, hard drug use patterns, violence, and supports, among other things. These disparate sexual partner categories are seldom merged and thus inadequate to capture the potentially synergistic effect of risks for HIV and other STIs. Furthermore, the lives and sexual practices of sex workers' non-commercial, intimate partners have not been studied to remotely comparable degrees and, based on the interview data in this study, these partners appear to be the single most reliable source of HIV risk due to condomless sex on a consistent basis. Even when participants' non-commercial partners were suspected of infidelity, 'fearsome' bisexuality, or were known carriers of HCV, the impetus to engage in condomless sex outweighed the sexual health risks. *Figure III* offers a visual representation of the synergistic effect of HIV risks which should be considered together.

Comparing HIV risks to HIV incidence proves difficult, as estimates of HIV prevalence among sex workers vary greatly, depending on the characteristics of the group being measured. In Vancouver, as many as 520 of the city's estimated 1,500 street-based female sex workers were estimated to be living with HIV (McInnes et al. 2009). Another recent, larger-scale Canadian national study of sex work in 6 national regions found the prevalence of HIV among current indoor, street-based, and independent sex workers (n = 218) at 3% and their non-commercial, intimate partners (n = 35) at 2%; only 68% of clients

in the sample (n = 258) reported previous STI testing, and only one client reported being HIV+ (Benoit et al. 2014). While the sample of sex workers participating in this study was relatively small, these findings on aversion to condom use with non-commercial, intimate partners expressed by participants in the current study and others suggest that HIV-related intervention and prevention efforts should encompass all sexual partners and not simply responsibilize condom use among sex workers with clients in health promotion discourse.

Chapter 7: HIV Testing and Strategies to Mitigate HIV-Related Harms

The purpose of this chapter is to reveal, and then discuss, interview findings that answer the fourth research question regarding sex workers' engagement in strategies monitor and maintain their sexual health as well as mitigate their HIV-related harms. Here, I review the role and function of HIV testing (7.1), transformative understandings of HIV across time (7.2), strategies to maintain occupational safety (7.3) and the role of social networks, social supports, and availability and use of harm reduction supplies (7.4). These interview data indicate that sex workers in the sample take an active role, by use of multiple means, to improve their health and safety in the commercial sex trade.

The discussion section begins by examining the role of HIV-related knowledge in informing decision-making for all aspects of protective health practices and health-seeking behaviours (7.5.1). Then, in light of the criminalization of HIV nondisclosure, I adopt an uncommon, neutral position to discuss the promotion of HIV testing as a strategy towards sexual health for all persons, under all circumstances, informed by interview findings (7.5.2). Lastly, I discuss the policy on informed consent for HIV testing among sex workers in HIV pre-test counselling, as currently outlined for clinicians in official guidelines by the BC Centre for Disease Control (2016). By no means do I advocate for sex workers or anyone else to abstain from testing for HIV and other STIs. Instead, I more broadly aim with my core arguments in this thesis to address criminal laws and HIV testing guidelines that impact the health and safety of survival sex workers in more adverse ways than other persons, particularly through an HIV-related health and legal apparatus which penalizes already vulnerable persons holding lower health and legal literacies.

Population and public health initiatives that inequitably impact deeply entrenched sex workers through HIV testing must at least give greater attention towards the empowerment of survival sex workers through the creation of conditions that facilitate a 'way out' of the sex trade upon receiving an HIV+ test result, on a case-by-case basis, if desired. I expand on this argument (7.5.3), delimited to a deontological ethics frame that highlights inequities in the agency of HIV screening targets to act on their test results, using the qualitative dataset in this study to advance my arguments. I will also discuss how sex workers can be empowered through enhanced HIV-related health and legal literacies such that the consent for HIV testing can be better informed.

7.1 Findings: The role and function of HIV testing

Non-regular HIV testing practice patterns

None of the participants reported that they sought testing on an habitual basis, but they were all in agreement that HIV testing was favourable and that it should have been done more often in the past. Among participants currently working in the sex trade, they

shared of their own volition, and in the absence of prompts during the interviews, that they should seek testing more often in the future.

A common response among participants was that they received occasional testing, but this testing occurred in opportunistic contexts, that is, when HIV testing was offered to them. For instance, some participants shared that physicians had offered testing when receiving medical attention for other primary reasons such as follow-up on methadone maintenance or monitoring viral loads of Hepatitis C. All female interview participants who had given birth reported that they had been previously tested for HIV as part of routine prenatal screening process. None of the participants identified any special considerations for HIV testing consent, including among those whose physicians were aware of participants' engagement in the sex trade.

In addition to being offered testing for HIV and other STIs as part of clinical visits for secondary reasons, participants identified three events after which they purposively sought testing. Firstly, R.G. *(male, 30)* had a non-commercial, intimate partner who had been suspected of cheating on him; this partner had not been recently tested for HIV, and the related anxieties of not knowing whether R.G. had been infected with HIV or another STI had encouraged him to seek testing for himself. For him, 'Testing needs to be done,' without clarification. Secondly, almost all participants shared that they had been sexually assaulted (or raped) on more than one occasion. H.B. *(female, 30)* shared that she had received scheduled HIV testing for the following six months until she and her physician were certain that she had not acquired HIV. When asked if she thought to pursue post-exposure prophylaxis at the time, she responded that she was unaware what this was. Her hospitalist had not informed her of non-occupational post-exposure prophylaxis (nPEP). Lastly, participants sought testing following sexual encounters with partners they later found out to be infected with a non-HIV sexually transmitted infection.

Testing following high-risk sexual activity and testing-related anxieties

A.B. *(male, mid-20s)* shared that he did not usually think about HIV while engaging in the sex trade but, following a recent high risk engagement with a client, he expressed his thoughts as, 'Sh**. Now I have to wait like three months to go get tested for HIV. [Unprotected anal sex] is the most risky behaviour I have done, and I've only done it once and I've been told I was very angry after that. So, I got tested. No, actually, there've been a few other times. But if the guy's not really attractive and I'm doing it for money, then I'll put on a condom.' At a later point in the interview, A.B. asked the question, 'The ones who have HIV and don't get tested, they're cowards, right?' My response: 'Well, HIV testing could be pretty complex for some people.'

For V.R. *(female, 40)*, her standard prenatal screening revealed an STI in the past: 'I'm not sure what it was, 'tricha-something,' but it was treatable with antibiotics and it went away. But still, it was like, 'How did I acquire that?' I had a test when I met [the father] and

then a test when I was pregnant, so he must have cheated on me or they missed it during the first test. Today it still blows my mind. Other diseases are scary to get, too.' She continued:

> I don't get tested as often as I should. When I was more active and I was younger, I was not regularly testing myself. And when I did go in I was scared, because there was this guy who told me he had Hepatitis C, and I slept with him unprotected, anyway, and it was more than once, and for sure I later thought I had hepatitis C. But I didn't in the end. *(V.R. 40, female)*

7.2 Findings: Social networks, supports, and harm reduction supplies

In terms of street outreach and community-based outreach programs, participants were in consensus that PEERS was a beneficial site for accessing support services. The interview guide in this area was not designed for program evaluation purposes and thus the information in this area should be viewed as incomplete. Several participants described the STI testing clinic offered in the past by doctors and street nurses, on site at PEERS, as a helpful means to access testing when they otherwise would not have. A.S., expressed, independent of any prompting, that the availability of HIV testing sites should be expanded beyond traditional clinical settings. Participants were not directly asked to comment on PEERS, the staff, or the clients, but of their own volition, they offered positive feedback. For instance, V.R. *(female, 40)* shared the benefits from socialization and reduction of hard drug use from PEERS support in the following:

> It was not until I came to PEERS that I felt caring, that somebody cared about me. So I slowly stopped using and it was mostly cocaine by then, because I was on the methadone. But I still used morphine or heroin sometimes, and I am on a low dose of methadone so I could feel it, right. But then I slowly stopped using drugs altogether. I felt that somebody cared. Then my kids started to come back around me and I established my relationship back with them again.

The safer sex supplies freely available at PEERS were seen as a benefit to promoting sexual health. As H.B. *(female, 30)* described, 'I get condoms here, which is a lot more convenient than going to the store.' L.J. *(female, 30)* was grateful for the counselling and the group activities. K.D., *(female, 40)* a single mother receiving social assistance, mentioned the lunch program as beneficial to reducing her monthly expenses for her and her dependent children. Consensus among participants was that PEERS has a positive influence on their sexual health, mental health, and well-being.

7.3 Discussion: HIV-related health literacies

Despite the majority of participants' insistence that they were much better informed on HIV-related risks at the time of the interview than when they were younger, it was apparent that they held incorrect knowledge on the specifics of HIV infection,

transmission, and current ART accessibility and outcomes. Given that sex workers in the current study primarily worked, or continue to work, in British Columbia, these findings suggest that the valuable HIV-related sexual health education they seek had not been reaching them. Echoing the harm reduction discourse, participants understood that condom use during oral and penetrative sex was their sole strategy to prevent infection with HIV and other STIs. Many questions were posed by participants during the interviews on per-act sexual transmission risks. While offering complete and full information on the most recent research in HIV per-act risks might not significantly affect the uptake of protective sexual practices among sex workers with their clients and non-commercial, intimate partners in non-ideal conditions (e.g., during violent encounters; under the influence of hard drugs and alcohol) participants could feel empowered with this HIV-specific knowledge under ideal conditions.

Without exception, participants expressed extreme fear and anxiety surrounding HIV in alignment with the AIDS fatalism and treatment uncertainty paradigms identified by Conroy et al. (2013). AIDS and HIV were terms often used interchangeably, and both were described as 'death sentences.' At face value, the older participants in the study would have lived through the HIV pandemic in the 1980s, a time before HIV was well-understood in biomedical, risk-specific, and harm reduction contexts, and a time before highly active antiretrovirals would have been available or even accessible. This could explain how HIV was understood as a death sentence for sex workers at relatively more advanced age through experiential knowledge of the virus and the death sentence of AIDS seen in others. However, younger participants shared similar fatalistic understandings of HIV in the absence of lived experiences surrounding the HIV pandemic of the 1980s and 1990s. It is noteworthy that all participants could be exposed in greater frequency to the small subset of HIV+ persons who experience the most severe visible effects of HIV-related health complications due to general lack of enrolment in the HIV cascade of care, less access and adherence to ART, a relatively higher HIV+ prevalence among IV drug users, and co-morbid HCV and HIV infections, among other elements. There is a non-zero probability that these persons would be more visible at regional NGOs providing services for vulnerable populations in the Greater Victoria Regional District.

The findings call for more attention to informing sex workers of HIV treatment options and outcomes *before* they are infected. If nothing else, this could reduce HIV-related anxieties as well as the HIV stigma that participants projected towards other, especially other sex workers who were HIV+. There is a catch: Knowing that their lifespan living with HIV would be on par with the greater Canadian population with early commencement of ART could have the unintended effect of reducing consistency in condom use with clients, for some. Put another way, knowing that HIV is not a death sentence could lead to engagement in higher risk behaviours, especially when not fully considering the difficulties of antiretroviral adherence in contexts of insecure housing,

substance use management, and gaps in drug adherence during incarceration.

Non-occupational post-exposure prophylactic (nPEP) antiretroviral treatment was unknown to participants who reported having been sexually assaulted, including one participant who sought medical attention at a hospital. Receiving nPEP after identifying oneself as a sex worker can prove difficult, as nPEP is recommended only when the exposure is a single episode. Even in cases of sexual assault, the setting (e.g., waterfront property versus the Downtown East Side of Vancouver) and characteristics of the assailant (e.g., heterosexual man versus injection drug user/MSM) can preclude recommendations for the commencement of nPEP (BC Women's Hospital + Health Centre). Finally, given the overrepresentation of Aboriginal persons in the sample and larger Canadian sex work population, informing persons with Indian Status that PrEP is currently available at no cost could be a favourable complementary step in HIV prevention efforts. One possible downside to increased availability of PrEP could be the facilitation of new market- and client-driven pressures for unprotected sex from sex workers, leading to an increase in incidence of HCV, syphilis, chlamydia, gonorrhea, among other STIs.

7.4 Discussion: Can HIV Testing Always Be 'Good?'

The criminalization of HIV nondisclosure had no discernable influence on study participants' patterns of HIV testing, and HIV testing was understood as a universally 'good' practice to maintain and improve their health. Moreover, participants expressed regret in not seeking HIV testing with greater frequency. On one hand, regular HIV testing can lead to early HIV diagnosis and early commencement of ART which, in turn, reduces HIV-related health complications and increases longevity at the individual level; ART also reduces the spread of HIV at the population level (Montaner et al. 2014; Dieffenbach and Fauci 2009). HIV testing is the *first step* towards enrolment in the HIV cascade of care for many Canadians unaware they carry the virus. On the other hand, for some sex workers in this study and elsewhere, HIV testing could be the *worst step*, at particular times when (i) the results are unable to be acted upon with immediacy for whatever reason, (ii) the intense psychological and emotive disruption would thus serve no purpose when consistently practising safer sex with all partners but could lead to drug/alcohol relapse or self-harm, and (iii) their survival and the financial support of their dependents relies on ongoing and immediate engagement in sex work, and this could only be continued with severe occupational vulnerability and increased potential for intimate partner violence under the legal obligation for HIV disclosure. Many women, especially, do not feel they can decline an HIV test when offered by their doctor or clinician, and contrary to the BCCDC's (2014) guidelines, it is myopic to state that obtaining consent for HIV testing is 'the same as for any other diagnostic test or treatment' (p. 6), particularly as no other medical test has established criminal parameters which follow test results.

Within and across the population, the ability to take action upon learning the results of a positive HIV test should be considered centrepiece among the foci of ethically robust HIV screening strategies. However, given the extremely low HIV-related legal literacy expressed by participants, their vulnerability to coercion from threats of false allegations of HIV nondisclosure is likely higher than the vulnerability of the greater population of non-sex workers. Extreme distrust of law enforcement officials reported by sex workers in this study as well as by sex workers across Canada (Benoit et al. 2016) poses additional difficulties in both reporting HIV nondisclosure as well as potentially being investigated for this crime. It was unclear from participants whether any of the previous sexual assaults they shared had resulted in criminal charges, and it seems an unkind paradox that they could one day be charged with aggravated sexual assault, themselves, for HIV nondisclosure in the absence of a seroconverted victim-client, even when using a condom or without meeting the burden of proof that disclosure took place.

Admittedly, sex workers in Canada do not appear to constitute a significant population proportion involved in HIV nondisclosure prosecutions as either the accused or complainants (Mykhalovskiy and Betteridge 2012). However, as recently as 2007, a sex worker released on bail after being charged for sexual assault in 2006 due to HIV nondisclosure with a former client was rearrested after agreeing to unprotected sex with two undercover Vancouver Police officers (Cooper 2009). She was paroled after 2.5 years in prison and will remain on the national sex offender registry for life, and her full name, photograph, and locations where the woman dubbed 'HIV infected prostitute' previously worked were circulated in the media at the time of both arrests and parole (Cooper 2009; Delamont 2017).

Given the extremely low health and legal literacies, I fundamentally argue that scaling up 'seek, test, treat, and retain' in the HIV cascade of care that targets survival sex workers is ethically problematic in the current legislative HIV disclosure climate. In 'seeking' survival sex workers for HIV screening, health service providers potentiate undue harm to survival sex workers (for instance, criminal prosecution, sexual violence, lifetime registered sex offender status) on account of their deep entrenchment within the sex trade. Without exception, participants in this study were already receiving (or had an application pending for) income assistance/disability and childcare provisions from the State. Many participants also expressed that they were accessing lunches and food hampers on a regular basis from nongovernmental organizations in Victoria such as *PEERS*, *Our Place*, and *Mustard Seed*. Having a diagnosis of HIV would not necessarily improve social assistance among the sex workers in this study who were already receiving the maximum allowance, especially in British Columbia, which is home to four of the five most unaffordable cities in Canada (Demographia 2016).

In a scoping review of HIV testing ethics, Knight et al. (2014) were highly critical of HIV testing arguments that assume equitable agency in the populations, with disregard of

the structures, systems, power, and privilege; these authors also identify an overall dearth in empirical studies which can inform ethical discussions on what 'ought' to be done. For instance, Knight et al. (2014) identified only two scholarly articles on the topic of 'seek, test, and treat' HIV testing strategies. One side of the debate, the 'seek' aspect often accompanies incentivized testing for HIV, which is particularly coercive for vulnerable populations, theoretically placing persons at risk of criminal prosecution for endangering others (Vonn 2012). Conversely, given the bane of the global HIV pandemic, Bayer (2010) has argued that collective concerns should be evaluated in tandem with individual-level concerns in HIV testing approaches that are aimed at increasing rates of testing.

As an empirical contribution to the ethics of HIV testing, I consider sex workers a population distinguished from other groups facing a higher burden with respect to HIV on account of their immediate occupational needs. In the immediate aftermath of learning HIV+ status, sex workers in this study and elsewhere in Canada are no longer able to work safely while meeting the two criteria which exempt them from the legal mandate for HIV disclosure. More specifically, sex workers can immediately use condoms, but in the most ideal circumstances, additional confirmation HIV tests must be undertaken, factoring in test results turn-around time, a baseline viral load must be established, and at least a month of daily adherence to antiretroviral therapy for viral levels to be below the threshold of detectability, and a yet legally unestablished period of consistent testing results which demonstrate that that extremely low viral level can be maintained.

In terms of harm reduction, as applied to the aftermath of receiving a positive HIV test result, a secured 'exit strategy' from the survival sex trade should be incorporated into ethically robust HIV screening approaches or, at least, HIV screening of survival sex workers needs to be complemented with significantly more social supports and resources than those which are currently available in British Columbia from federal and provincial programs. In the absence of an ethically robust approach to HIV testing that can equally focus on the aftermath of a positive test result, among deeply entrenched sex workers (for instance, addressing affordable and stable housing, economic and employment security, childcare provisions, and mental health/substance use disorders), HIV testing could create more immediate social, economic, and occupational problems than it might ameliorate on medical grounds.

This deontological ethics perspective highlights the following: (i) inequities in the agency of sex workers to exit the survival sex trade swiftly and easily upon learning of their HIV+ status; (ii) structural and systemic conditions driving inequities in the agency of survival sex workers to adhere to daily anti-retroviral therapy; and (iii) structural and systemic conditions driving to sex workers' compromised agency to use condoms in combination with maintaining extremely low viral load levels, in order to continue their legal work in Canada, in adherence with legal disclosure obligations.

7.5 The Issue of Informed Consent for HIV Testing

There is an inescapable paradox existing that in most Canadian HIV nondisclosure cases, the aggravated sexual assault hinges on the consent for engagement in sexual activity being obtained by 'fraud' for not informing the partner of HIV status. However, in applying this rubric of informed consent to engage in sexual activity – to HIV testing – it is by no stretch that one could see the HIV testing consent obtained by fraud by purposively avoiding mention of the criminalization of HIV nondisclosure in HIV pre-test counselling.

Writing in a majority opinion in *R. v. Cuerrier* (1998), Justice Peter Cory maintained that 'failure to disclose... is a type of fraud which may vitiate consent... the essential elements of fraud in commercial criminal law are dishonesty, which can include nondisclosure of important facts... the actions must be assessed objectively to determine whether a reasonable person would find them to be dishonest. Without disclosure... there cannot be a true consent.' As HIV testing is being scaled up in the province of British Columbia through STOP AIDS and the new guidelines from the Office of the Provincial Health Officer (2014) that recommend HIV screening for all adults every 5 years and high-risk groups annually, more persons than ever before will soon know their HIV status. Predictably, persons most vulnerable to the criminalization of HIV nondisclosure will have the least HIV-related health and legal literacies. There are additional concerns for HIV testing consent among sex workers related to high rates of acquiescence for testing. For instance, in the Mika Project, a Vancouver community NGO offering services and supports to sex workers, Shannon et al. (2007) reported that sex workers consented to Rapid HIV testing on site at a rate of 96% on their first visit.

In alignment with the empowerment model, the informed consent for HIV testing among sex workers will need to coincide with robust literacies in not only HIV health, but also HIV disclosure legislation. Official provincial guidelines currently recommend against discussions of the criminalization of HIV nondisclosure for all practitioners. Sex workers are a special case due to their occupation and security of basic survival needs.

Frontline health practitioners must closely consider the paragon of informed consent when administering HIV testing to sex workers on a case by case basis. In addition, informed consent has similar implications for HIV testing in scholarly research involving participants experiencing extreme socioeconomic vulnerabilities who are offered HIV testing as part of the study. Knowledge translation in this sensitive area must not inadvertently place vulnerable participants in criminal jeopardy under HIV nondisclosure legislation.

Chapter 8: Conclusion

This concluding chapter begins with a brief summary of key findings, and then continues with a short discussion of implications for the methodological approach. I follow this by highlighting key guiding tenets for educational resources related to HIV testing and the legal mandate for HIV disclosure. I then identify key limitations and strengths in the current study, and move to a discussion of directions for future research in this substantive area.

8.1 Key Findings

This thesis explored the criminalization of HIV nondisclosure before sex as well as issues of the periphery of this phenomenon. I found that the disclosure of HIV status was firstly and foremost understood by HIV-negative sex workers in this study as a reciprocal moral act, independent of the legal mandate for HIV disclosure. Furthermore, the perceived protective health benefits from the legal mandate for HIV disclosure were not sufficient to overcome the understood necessity of condom use with clients as the most reliable method for prevention of HIV and other STIs. While participants assigned multiple meanings to condom use, an increased perception of intimacy was perhaps the greatest risk factor for HIV and STIs with all sexual partners due its willful, consistent association with condomless sex.

Participants' understandings of the uptake of HIV testing appeared to mirror the terse messaging in health promotion discourses, namely 'get tested.' The complexities and contexts driving the decision to seek HIV testing were not easily articulated by participants, that is, HIV testing was understood and described as universally 'good.' Participants drew no connections between being knowledgeable of their HIV status and a newfound vulnerability to prosecution, threats of prosecution, and coercion from disgruntled sexual partners who might make threats of nondisclosure allegations, whether anything 'criminal' even occurred. Moreover, participants' understandings of HIV testing were immediate in nature, that is, they did not include anticipations of the difficulties and complexities inherent in exiting the sex trade, immediately and successfully, upon receiving a positive HIV test result. Despite participants' earnest intentions to exit the trade for any variety of reasons, the literature suggests that exiting the sex trade is rarely achievable on the first attempt.

I opened Chapter 5 by providing interview data that aids in answering the first research question regarding participants' understandings of HIV disclosure, sectioned firstly into moral understandings of HIV disclosure, and then understandings of the legal mandate for HIV disclosure and its perceived protective health benefits. I then offered interview data to partially answer the second research question regarding sex workers' experiences related to social contexts and conditions that drive HIV vulnerabilities when

partnering with clients in Chapter 6. Here, extreme needs to facilitate childcare and meet needs related to hard drug and alcohol use were more salient among other factors driving the risk of HIV infection and transmission at the individual level while also contributing to social contexts and conditions that drove HIV-related vulnerability. The third research question was also addressed in the latter subsection where I revealed the conventions and interpersonal norms surrounding intimacy which contribute to sex workers' vulnerability to HIV infection within non-commercial partnerships. Lastly, I offered interview data in Chapter 7 to answer the fourth research question regarding participants' health-conscious practices, and how they understood these practices.

The sex workers in this study ultimately emphasized their strong desire to protect their sexual health and the health of others, in both explicit and implicit ways. Participants expressed that the criminalization of HIV nondisclosure had no impact on their uptake of HIV testing and expressed importance of adopting safer sex practices. Some indeed expressed that the legal mandate for HIV disclosure would prompt some clients to disclose when they otherwise would not have, but this had no bearing on their patterns of condom use with clients or non-commercial, intimate partners. On closer examination, the grounded theory approach identified muted connections among participants' understandings of HIV testing, HIV-related health outcomes, and the criminalization of HIV nondisclosure. Indeed, the absence of connections among these topics is noteworthy, particularly on account of the gravity of testing positive for HIV for many persons in Canada and other global regions. Due to the relatively smaller sample size, in part, generalizations were not easy to identify across metrics of age, gender, or Aboriginal status, although women with children tended to emphasize their role as mothers and caregivers for motivating entry and ongoing work within the sex trade.

This qualitative dataset was overall rich in themes related to acknowledgement of increased HIV-related knowledge in hindsight, the uptake of safer sex practices varying with context and meaning of the encounter, intimacy as the 'norm' in sexual relationships (whereas sex work partnerships were a departure from this 'norm'), acknowledgement of situations wherein the risk of acquiring HIV was extremely high, particularly when related to hard drug use and/or alcohol, and attributing lack of HIV transmission in these situations to luck. Self-blame and self-shame was frequently embedded in recollections of experiences marked by engagement in activities known to be associated with an elevated level of HIV risk as well as occupational safety. Methadone maintenance was identified as invaluable for reducing the urgency of engaging in sex under contexts and conditions that increased harmful risks to their health and safety.

Finally, women were implicated in this study not only on account of their demographic weight in the Canadian sex trade and the sample, but also because of the gender-driven power dynamics which infiltrate relations with clients, non-commercial

partners, wage inequality, agency to negotiate condom use, and responsibility as primary care-givers to children, among other things.

8.2 Limitations and Strengths

The study is not without limitations. Firstly, only certain aspects of the study offer a degree of transferability to other global, national, or provincial settings due to the small sample size, regionally specific HIV laws and prosecutorial practices, specific community-level norms, and a plurality of motives, behaviours, and working environments among sex workers. The community of sex workers at PEERS is relatively small and PEERS clients could have been identified with greater demographic information. In honouring the anonymity promised to participants, I was unable to provide deeper contexts within participants' narratives, which could have afforded more robust understandings of their lives and lived experiences. In not collecting the names and contact information of participants, for their protection, I was unable to perform member checking which might have improved the accuracy of findings. Taking into account the social desirability bias which has been reported among sex workers in other studies, participants might have over-emphasized the frequency of uptake of protective sexual practices, or the sharing of drug using paraphernalia.

There was a sample bias in two key areas: Firstly, the convenience sample was drawn from HIV-negative clients at, PEERS. It follows that this sample was limited to persons already engaged in at least 'one' health and social services organization. Secondly, the convenience sample only included persons with reason to believe their HIV status was negative on account of previous HIV testing, which indicates they had previously sought sexual health care. However, persons not engaged with PEERS (e.g., because they were new to the sex trade; not legally entitled to work in Canada; extremely marginalized and difficult-to-reach; unable to travel; disenchanted with NGOs) were de facto excluded.

Aboriginal persons and women were over-represented in the sample in comparison with the general population. However, the sample was not inconsistent with the social demographics of sex workers that might be expected on the more vulnerable end of the socioeconomic spectrum in terms of gender and persons with racialized bodies in Canada (Benoit et al. 2014).

Nevertheless, there are strengths. This is the first study on HIV-negative sex workers' attitudes, behaviours, and beliefs related to the criminalization of HIV nondisclosure. I was able to bring empiricism to discussions on the legal mandate for HIV disclosure among HIV-negative sex workers as well as discussions on the vulnerabilities created by knowing HIV+ status such as fears surrounding allegations of HIV nondisclosure, coercion, having a criminal record, police investigation, and sustained dependent/violent relationships. More robust engagement in community-based research

was hindered by the esoteric nature of the topic of this thesis; there were no locatable Community Leaders with expertise in the substantive areas surrounding the criminalization of HIV nondisclosure among sex workers, and the ostensible stake-holders lacked HIV legal literacies. Finally, given that Bill C-36 was signed into law in November of 2014, targeting the purchasers of sex (but not the selling), it remains unclear how the illegal purchase of sex may buffer sex workers from clients who might report criminal HIV nondisclosure, as they would be admitting to the crime of purchasing sex, themselves.

HIV testing, which was originally a footnote in the overall scope of this project, grew over time as a prominent feature in this thesis. The HIV-related parameters shifted in tandem with new initiatives in the Province such as STOP HIV/AIDS, the recommendation of routine HIV testing for all persons in the Province, the recommendations to avoid discussions of the criminalization of HIV nondisclosure during pre-test counselling, and the availability of anonymous HIV testing now at one location in Victoria as part of a pilot project. In addition, much of the literature in the Canadian context of the legal mandate for HIV disclosure before sex was published after the interviews took place. The information and recommendations presented at the time of publication will likely lose relevance as more time passes, but the underlying impetus to share knowledge and better inform persons most vulnerable to HIV acquisition will remain constant until we live in a world without HIV/AIDS.

Implications for Methodological Approaches

Participants were not informed of the legislation surrounding HIV nondisclosure in advance of the interviews. This allowed for indirect comparing and contrasting of participants' HIV-related legal literacies without recreating the intimidating atmosphere of a legal investigation. On one hand, I initially took this approach to reduce the possibility of biasing or otherwise interfering with participant responses. On the other hand, the vast majority of publication dates in this thesis's literature review of qualitative studies on the criminalization of HIV nondisclosure indicate they were not even available prior to the project planning, design, and interview guide development.

My interrogation of how the criminalization of HIV nondisclosure impacted the health-seeking and protective health practices of sample participants might have revealed different findings if I had asked for reflection on a possible vignette of conditions or circumstances under which a person's ability to disclose HIV status were reasonably compromised. By playing the devil's advocate, participants might have considered a 'grey area' in which sex workers might be justified for not seeking HIV testing because of extenuating circumstances that would put them at great risk of physical or sexual violence when practising safer sex and not disclosing. The low levels of HIV-related legal literacies among participants might have significantly driven their opinions on HIV nondisclosure,

specifically on the utility and punitive sanctions surrounding the legal mandate for HIV disclosure.

I argue that my non-interventionist study design played a key role in the findings that the legal mandate for HIV disclosure had no discernable influence on participants' willingness to seek HIV testing – because 'knowing' HIV status facilitates criminal investigation, prosecution, and potential incarceration. Put another way, the study was intended to be exploratory in nature, and I did not intend to influence participants' willingness to seek future HIV testing by 'scaring' them with, for instance, legal anecdotes on persons successfully convicted of sexual assault in the absence of proof that disclosure took place, or successful convictions when expert witnesses attested at trial that the risk of infection approximated zero and no HIV transmission occurred. No doubt, sharing this information would have biased participants to acknowledge that the criminalization of HIV nondisclosure is, at the very least, a complex issue.

I argue that health and social justice scholars should be extremely cognisant of their latitude to steer the knowledge co-created in studies of vulnerable populations whose members may have deficits in health and legal literacies. I argue that this is particularly important in sensitive areas related to HIV/AIDS, sex, and sex crimes/law, where informal, anecdotal, and non-expert systems of knowledge abound. This may even underscore the addition of a control group in studies on impact of the criminalization of HIV nondisclosure in order to understand what effects, if any, the delivery of complete and accurate knowledge of HIV-related laws might have on the 'future' health-seeking and protective health practices of HIV-/HIV+ vulnerable population members. Indeed, in provinces such as Ontario where discussions of the legal mandate for HIV disclosure are outlined in pre-test HIV counselling, and anonymous HIV testing has been available for some years, it remains unknown what effects knowledge of disclosure laws have on acquiescence to test, or even how closely followed the HIV pre-test counselling guidelines are followed.

8.3 Guidelines for Education Resources

Given that the BCCDC (2016) guidelines discourage discussions on the criminalization of HIV nondisclosure during HIV pre-test counselling, informed consent for HIV testing can be improved at the community level. I offer a rough sketch of constituent elements for participatory education and other educational resources based on findings in the substantive areas covered in this thesis. The overarching goal would be to allow participants to connect, in their own way, the following elements: (i) HIV testing and test results, (ii) degrees of entrenchment in the sex trade, and (iii) the legal mandate for HIV disclosure.

a) Regular HIV testing can lead to earlier treatment with antiretrovirals, and this can be an effective strategy to improve health outcomes for individuals and their sexual partners, and ART adherence leads to HIV prevention at the population level;
b) Before testing, persons must ensure they are ready to learn their HIV status, particularly as it affects employment of sex workers immediately upon learning their HIV status. A solid support system (e.g., friends, financial considerations, emotional supports, among other things) should be in place;
c) One does not need to consent to an HIV test simply because it is offered; one might wish to delay if results could lead to (i) suicidal thoughts, (ii) drug or alcohol binge/relapse, (iii) other forms of self-destruction or self-harm, (iv) interruption in legally engaging in survival sex work due to extreme needs for money, drugs, or shelter;
d) Before one tests, note that HIV testing and knowledge of HIV+ test result could invite prosecution, coercion from threats of false allegation, and fear of prosecution from past and present clients and non-commercial partners.
e) Consider the option of anonymous testing for HIV, now available at one location in Victoria; keep the information to yourself, and act on it when ready and feeling safe and secure; clinicians will not discuss the criminalization of HIV nondisclosure in HIV pre-test counselling;
f) If one becomes HIV-positive, and if and when a decision is made to disclose HIV status to a sexual partner, have a witness present (e.g., a GP) or webcam/smartphone recording made;
g) Be aware of no-cost Truvada as PrEP for persons with 'Indian Status,' and encourage non-commercial partners with third-party coverage to enquire about Truvada, for daily use or on-demand use;
h) If one believes that exposure to HIV from a client or non-commercial partner has occurred, visit a clinic offering non-occupational post-exposure prophylaxis (nPEP) within the first 72-hours. Review the current guidelines for recommending commencement of nPEP, and tailor the description of the sexual partner to that which is outlined in the guidelines (e.g., gay, IV drug user).

8.5 Directions for Future Research

Where possible, this thesis attempted to bridge various micro-, meso-, and macro-level factors which drive vulnerabilities among sex workers in relation to HIV within, but not limited to, HIV testing, HIV treatment, HIV health and legal literacies, and the criminalization of both sex work and HIV nondisclosure. While the arguments presented in this thesis covering life 'after' HIV seroconversion may be solidly reasoned, they currently lack empirical verification in the literature; this gap in the literature is curious, particularly given that Canadian sex workers most vulnerable to HIV acquisition are salient stake-holders in the criminalization of HIV nondisclosure. Further research on the

criminalization of HIV nondisclosure among sex workers in Canada is needed among HIV+ sex workers.

As evidenced by the interview findings, protective sexual practices do not occur within a vacuum. Rather, condom use has deeply rooted symbolism for sex workers that varies by contexts and meanings of their relationship with their sexual partner, sexual violence, hard drug and alcohol use, life-course/life-experience, and the varying extreme needs for money, drugs, and basic survival needs over time. Future research on how HIV-positive sex workers navigate their legal obligation to disclose HIV status to their clients and non-commercial partners is needed. It is entirely possible that some sex workers immediately leave the sex trade upon learning of their positive HIV status, and for those individuals, HIV status could be a catalyst strengthening their resolve. I suspect that for the majority of survival sex workers, this is not the case.

Future theoretical advancements to map the empathetic (or lack thereof) emotive elements of moral regulation could be helpful in moral regulation scholarship. It is reasonable for participants to express hostility towards clients who are aware of their HIV status and carelessly or purposively infecting others; however, participants' hostility to other sex workers infected with HIV altogether lacked empathetic consideration. Future research could explore a possible positive association between increased HIV health and legal literacies and increased consideration of HIV positive sex workers as 'persons living with HIV, subject to exogenous contexts' rather than 'junkies who got what they deserved.' As argued earlier, HIV testing is the only known technology, albeit tenuous, to transform 'potential victims' into 'bio-criminals,' sometimes in only one minute through Rapid (or Point of Care) HIV testing. A nuanced understanding of how stigma and discrimination are cast onto the practices of sex workers *by* current and former sex workers is needed.

Finally, the arbitrariness of seeking criminal charges for HIV nondisclosure is somewhat apparent. There are no documented cases where prosecutors have sought to uncover who infected the accused with HIV, rendering an accused also the victim. However, it remains unknown what drives some sexual partners to report HIV nondisclosure and others not. Research on the role of the media in galvanizing reporting to police, the meaning and contexts of the relationships, and other features such as hard drug use, previous criminal records on the part of the complainant, shared drug paraphernalia, and not being able to identify the specific accused could be factors. In addition, it is unknown how Bill C-34 could serve to buffer future criminal charges against sex workers as the complainant would have to admit to the purchase of sex to become a complainant, an illegal activity.

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Figure I: Moral and Legal Dimensions of HIV Disclosure

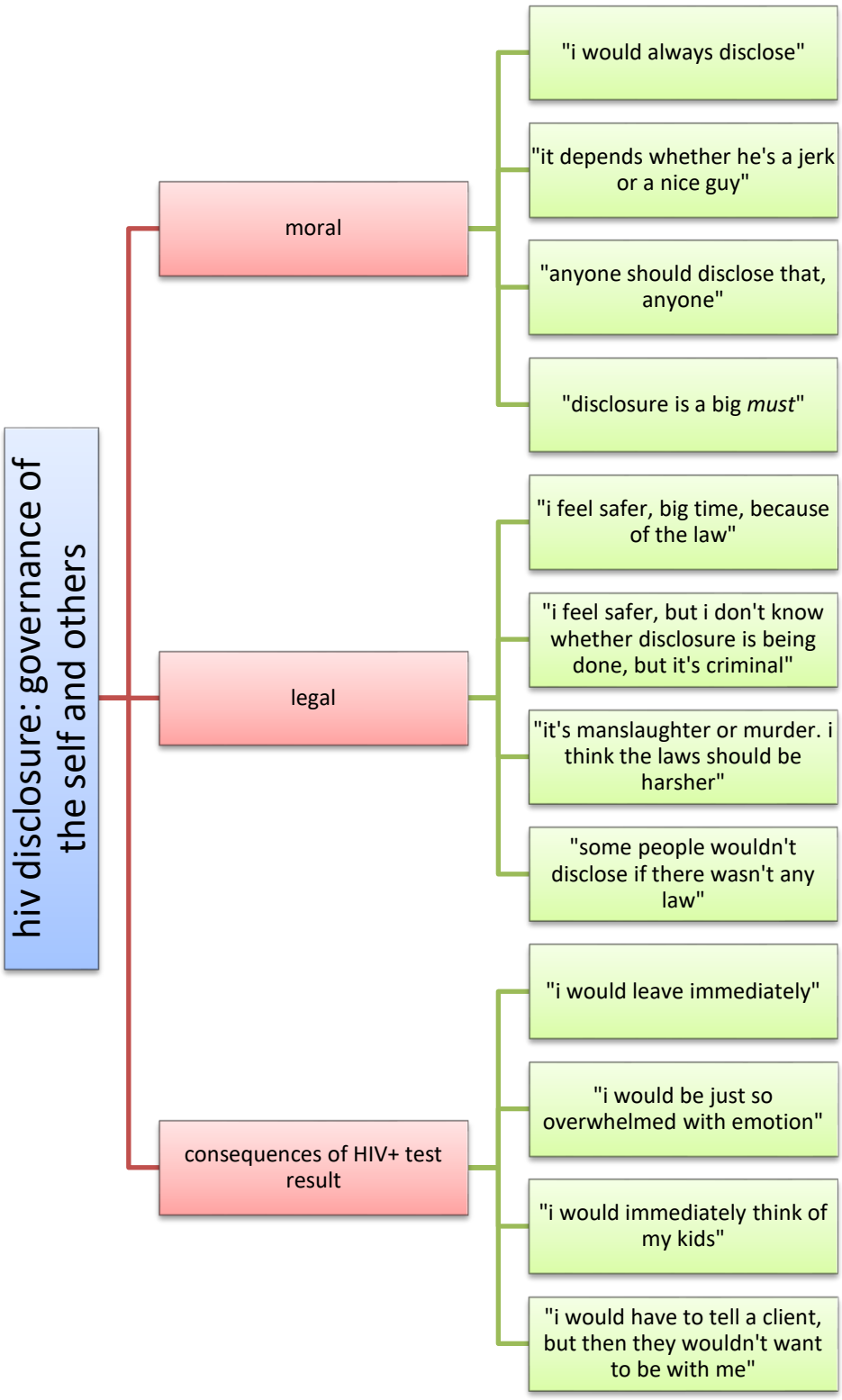


Figure II: Factors Mediating HIV Vulnerability among Survival Sex Workers

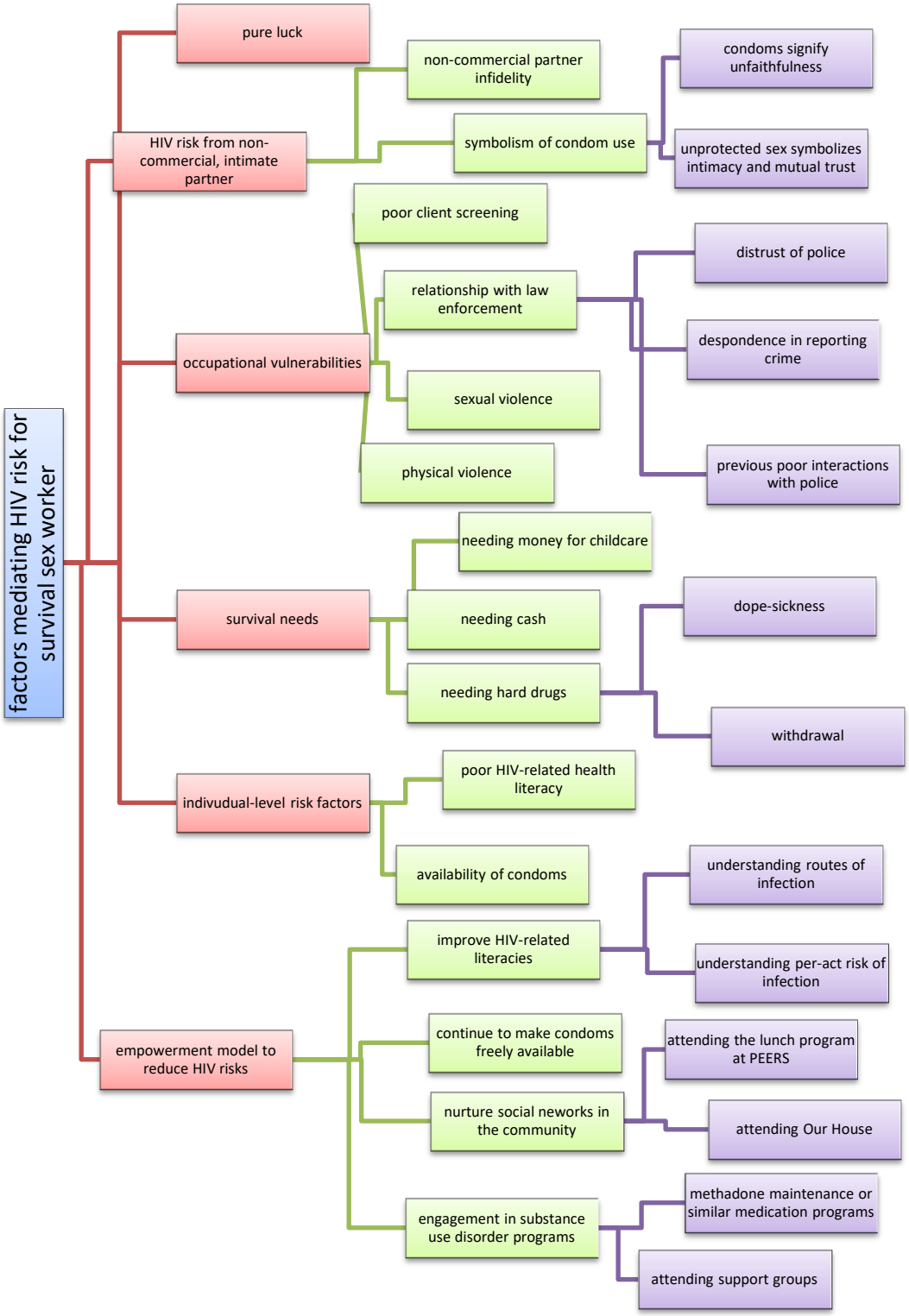
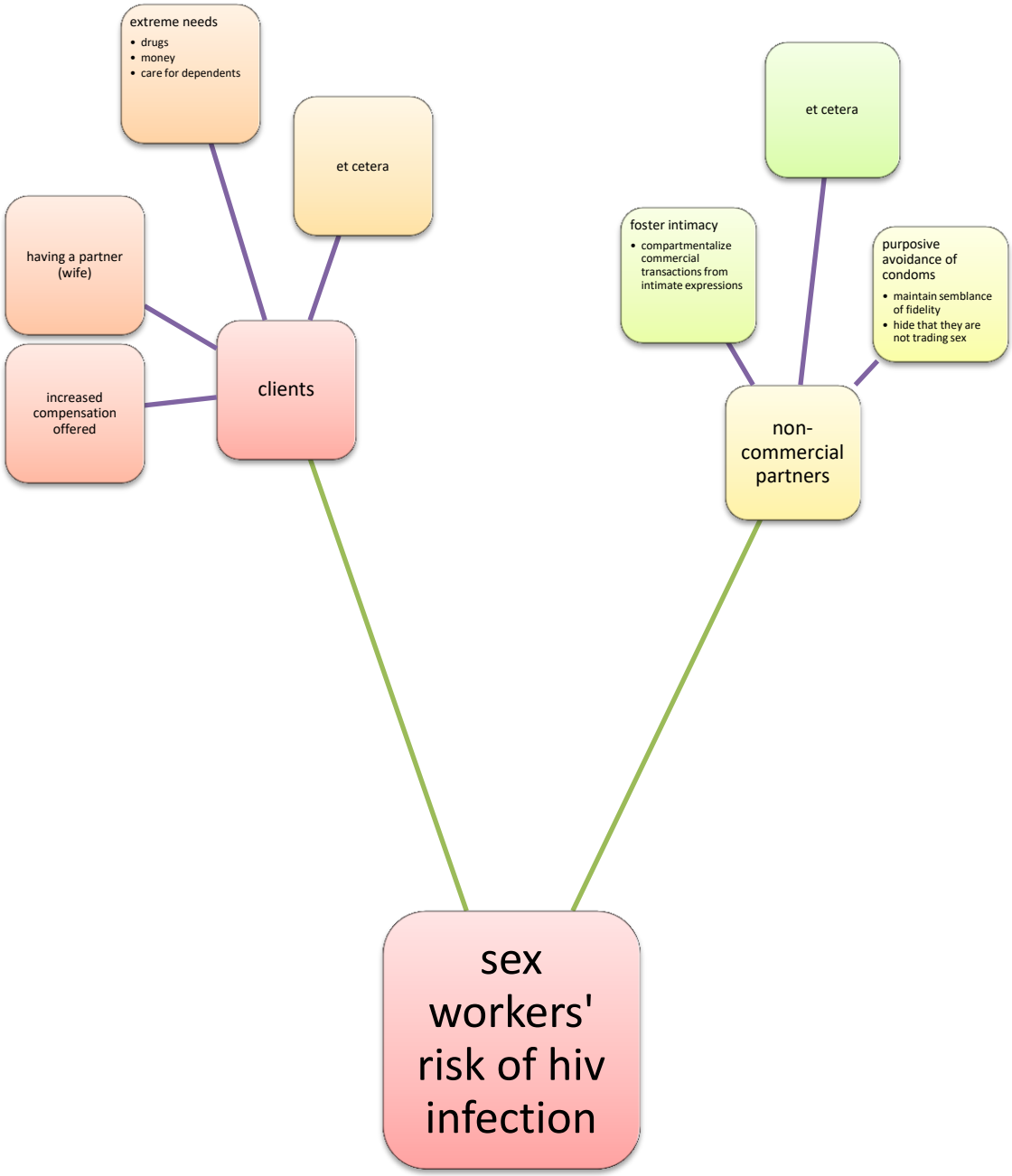


Figure III: HIV Vulnerability from Clients and Intimate Partners



Appendix I: Thematic Interview Guide

Intimacy and Risk among Sex Workers in the Context of HIV Infection

Themes to be explored:

1. In work life and in personal life, explore participants' thoughts about the risk of becoming HIV+

2. Explore how participants minimize the risk of becoming HIV+

3. Explore how, or whether, the risks of HIV affect intimate relationships, with boyfriends, girlfriends, clients, and others

4. Explore participants' thoughts on people being obligated to tell their sexual partners that they are HIV+, and how these thoughts might be influenced by condom use or taking antiviral medications to suppress the virus

5. Explore participants' knowledge of laws which make HIV disclosure a legal obligation

6. Explore how, or whether, participants would feel safer knowing HIV disclosure laws exist

Appendix II: Verbal Participant Consent Form

University of Victoria | Sociology

Verbal
Participant Consent

Intimacy and Risk among Sex Workers in the Context of HIV infection

This study is called 'Intimacy and Risk among Sex Workers in the Context of HIV infection.' I am the leader of this study and I am a Graduate Student at the University of Victoria. The study has been funded by the Canadian Institutes for Health Research.

Participant selection: You have been asked to join the study because you are currently a sex worker or have recently exited the sex trade. You have provided services to at least 15 clients in one year. You are at least 19 years old, legally entitled to work in Canada, and you are HIV-negative or uncertain of your HIV status.

The purpose and importance of this research: With the support of PEERS, we are trying to explore issues related to health, safety, and intimacy among sex workers, their clients, and their non-work, intimate partners. We want to know how you think the risk of HIV infection affects your working life and personal life. We also want to explore how this might affect intimacy in your life with your clients and your personal partners. We are going to use the information you share with the hopes of improving the health and safety of sex workers. Very little is known about this topic.

Benefits: You might feel good to know that the information you share will be combined with the information we get from other sex workers. We want to expand on knowledge on these sensitive topics. This will give a voice to sex workers and also give the best, up to date information to community-based organizations like PEERS. Ultimately, we could share this information with others with the hopes of improving the health and safety of sex workers, especially in relation to infection with HIV. You will be offered $10 for your time.

Anonymity, confidentiality, and disposal of interview data: I am not going to write down or record your name. When I write up what you have shared, I will take away any information that could identify you, the places you talk about, and the other people you talk about. The information will be locked up safely on a computer and the notes I take will be locked up in a cabinet in my office. I will throw out all the information you share after five years.

Inconvenience, risk, and voluntary participation: The interview will be approximately 30 – 60 minutes. Some of the stuff we talk about during the interview may bring up memories or past experiences which make you feel uncomfortable. I can offer you referral to counselling and support services right away. You can stop the interview at any time and you can withdraw from the study at any point prior to the time I publish the findings. There are no negative consequences to you and you do not have to give a reason. If you drop out, I will destroy all the information you share. I will not share with PEERS that you were a part of this study.

Ongoing Consent: I want to make sure that you are comfortable at all stages of this study and I can share with you the preliminary findings before the final write-up of the results. I can do this in a draft on paper or by email, using the contact information I have given you.

Dissemination of Results: Findings from this project will be shared with community-based organizations in the Victoria area. Findings will be presented at academic conferences and will be submitted to academic journals including *Research for Sex Work*, a unique publication that combines academic perspectives with original papers written by former and current sex workers.

Contacts

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Human Research Ethics Office at the University of Victoria (250 472 4545 ethics@uvic.ca).

Your audio-recorded, informed consent indicates that you understand the above conditions for participation, that you have had the opportunity to have any of your questions answered, and that you consent to participate in this research project of your own volition. Thank you for your time as well as for the knowledge that you share and for the knowledge that we can gain.

☐ PARTICIPANT CONSENTS TO PARTICIPATE IN THIS INTERVIEW

"I HAVE HAD MY QUESTIONS ABOUT THIS STUDY ANSWERED AND I UNDERSTAND WHAT IS BEING ASKED OF ME. I CONSENT TO PARTICIPATE IN THIS STUDY."

Appendix III: Interview Schedule and Participant Demographics

July 14 | 2015	R.G.	male, approximately 30, Aboriginal, alcohol and drug use history, recently working in sex trade, HCV+, no fixed address
July 15 | 2015	A.B.	male, mid-20s, ongoing drug use, currently in sex trade, no fixed address
July 15 | 2015	J.P.	female, approximately forty, no reported hard drug use, not currently working, stable housing, has children
July 15 | 2015	V.R.	female, approximately forty, has child, on methadone, not currently working, stable housing
July 15 | 2015	K.D.	female, approximately forty, on methadone, currently working, has children, stable housing
July 16 | 2015	L.J.	female, 30, not working 'right now,' on methadone, has child, lived in youth home during adolescence
July 16 | 2015	A.S.	female, approximately 40, not currently working, former crack use disorder, formerly managed by intimate partner, stable housing
July 22 | 2015	H.B.	female, Aboriginal, approximately thirty, has children, current/very recent drug use, currently in sex trade
August 2 | 2015	Y.A.	female, mid-fifties, currently in sex trade, uses drugs, has stable housing