Deliberative Identities: An Ethnography of Sex Work and Health and Social Services in Winnipeg Manitoba, Treaty One Territory

by

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ABSTRACT

This thesis examines the ways in which a specific social and linguistic field around the sex trade shapes access to and experiences with health and social services for transgender and cisgender women and non-binary sex workers and experiential people in Winnipeg, the capital city of the Midwestern Canadian province, Manitoba, on Treaty One. It is the result of over 5 years of ethnographic engagement with sex worker rights activists, services providers, stakeholders and public and private events, meetings and discussions focused on sex trade political action and reform, and 52 in-depth interviews with workers, experiential people and stakeholders. The sex workers and experiential people I spoke to asked plainly for service providers to do better in terms of caring for them and meeting them where they are, highlighting the need for specialized services that are tailored to participants' priorities and lived realities. The findings also call for the general training of service providers that addresses the complexity of the sex trade, the principles of harm reduction, and anti-racism. Beyond strict and sometimes mandatory categories of experiences in sex work and the sex trade, there is a need to recognize individual experiences, goals, and the harms they might identify in their lives. Grounded in extensive ethnographic field data, my results also reveal the complex field of power relations that play out in the sex trade industry in Winnipeg, and how these power relations get enacted through various linguistic deployments to structure the conditions of access to social and political support networks and resources. I argue that the redeployment of linguistic signifiers, such as "sex worker", "sex trade worker", "sexually exploited person", "prostituted women", "human trafficking survivor", open

up a polarizing moral field that people have to navigate to get their health and social services needs met. This turbulent and irreconcilable social field is an effect of what I refer to as deliberative identities. I use this concept to go beyond dominating and restrictive dichotomies—as either 'empowered' or 'victims'—that too often populate public health, health policy and media representations of sex workers, their bodies, their agentive capacities, and their social positionings.

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Merci à mes parents et l'ensemble de ma famille pour votre soutien infaillible.

Finally, thank you my Danny for being the calmest, kindest man.

DEDICATION

To everyone working to make things safer for all sex workers.

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INTRODUCTION

> *I live in a world that either victimizes or vilifies me. As a sex worker, I am told many things. I'm told how I should feel about my experience within sex work, how I should view my clients. I am told I am blinded by false consciousness and that my experience is not representative of the majority of sex workers. No matter what those who speak for us want you to believe, there are no "representative" sex workers. We are not just one type of human being who all share the same experience.*
>
> *- Amy Lebovitch (in Ferris 2015)*

The social and legal management of the sex trade is a contentious issue that has created throughout the last century unlikely alliances between radical feminists and conservative Christians, self-identified sex workers and scholars, police forces and critical race theorists. From "sinners" to "entrepreneurs", and from "bad girls" to "exploited/prostituted women", the moralizing language used mirrors the passions animating this debate. These affectively-charged labels open up a polarizing field that people in the sex trade navigate. Within this discursive field, they are cast within surprisingly simplistic oppositions: as blameless victims or "victim-criminals" (Majic, 2014), as mindless preys to systemic oppressions or perpetrators of exploitation (or even "self-exploitation"), as inherently innocent or guilty. Indeed, the exchange of sex for commodities or currency is a highly controversial issue in academic and policy arenas, reflected in highly dichotomized "sex workers rights" versus "abolitionist" positions. But why does the existence of the sex trade invoke such intense reactions? To what extent does the intense contestation surrounding the sex trade account for the safety, health, well-being and rights of the women and non-binary people directly

involved in it? How do this field of controversy shape sex workers' access and utilization of social and health services in Winnipeg?

I have grappled with these questions by engaging in more than five years of ethnographic field research in the urban context known as Winnipeg, the capital city of the Midwestern Canadian province, Manitoba. This research engagement has included the following activities: 1) an intensive involvement in sex worker rights activism, including being part of the establishment of Winnipeg's only sex worker-led advocacy group known as the Sex Workers of Winnipeg Action Coalition (SWWAC); 2) attending regular public and private events and meetings focused on sex trade political action and reform; 3) contributing to the management of SWWAC social media and the establishment of SWWAC's website and Winnipeg's "bad date list"[1]; 4) conducting extensive participant observation, ethnographic fieldnote writing and document reviews and completing in-depth interviews with sex workers and "chosen social actors"—who I define as those who have a long-term experience of providing services to, working with, or advocating with sex workers (some of whom identify themselves as ex-sex workers).

In this thesis, my overarching goal is to represent the complex field of power relations that play out in the sex trade industry in Winnipeg, and how power relations get enacted through various linguistic deployments that, in turn, create the conditions

[1] A bad date list is a community-driven tool used by sex worker communities to inform each other of problematic or dangerous clients or community members. It can be on paper form or online. In 2015, some SWWAC received some funding from the Winnipeg Regional Health Authorities to lead a community consultation to document the use and the needs of local sex workers from different field of work regarding the bad date list (Mexico, Sheng, et Chevrier 2017). Based on the results, SWWAC members, including myself, updated the existing bad date list system by creating a website and increasing collaboration between agencies providing services to people in the sex trade.

of access to social and political support networks and resources. I argue that the redeployment of linguistic signifiers, such as “sex worker”, “sex trade worker”, “sexually exploited person”, “prostituted women”, “human trafficking survivor”, open up a polarizing moral field that people have to navigate to get their health social services needs met. This turbulent and irreconcilable social field is an effect of what I refer to as deliberative identities. The social processes surrounding the use of different identity labels that relate to the sex trade continually shape the concrete access to resources and social and political support networks for people involved in the sex trade, and the positioning of social actors invested in its management. I use this concept to go beyond dominating and restrictive dichotomies—as either ‘empowered’ or ‘victims’—that too often populate public health, health policy and media representations of sex workers, their bodies, their agentive capacities, and their social positionings.

Background

Public Health Perspectives on Sex Work

Globally, women, men and transgender persons who are involved in the sex trade are often described as facing a heightened burden of HIV, other sexually transmitted infections (Beyrer et al., 2014; Das & Horton, 2014)[2]. Public health

[2] While it can be argued that certain people involved in the sex industry can be at higher risk of STI infection, recent research highlights how this differs vastly from one group involved in the sex trade to another. In Canada, for example, individuals involved in outdoor sex work can be at higher risks of contracting HIV but not directly because of their involvement in the sex trade, but rather because of a myriad of mitigating factors (Benoit & Shumka, 2015; Spittal, 2003 2007).

researchers have placed considerable attention on the prevention of HIV and other STIs among sex workers, especially in the global south (Blanchard et al., 2005; Delvaux, Crabbe, Seng, & Laga, 2003; Halli, Ramesh, O'Neil, Moses, & Blanchard, 2006; Jana, Basu, Rotheram-Borus, & Newman, 2004; Morineau, Neilsen, Heng, Phimpachan, & Mustikawati, 2011; Reza-Paul et al., 2012). A recent review of over 800 studies and reports highlights that the widespread abuse of sex workers' human rights is perpetrated by both state and non-state actors and directly and indirectly increases HIV susceptibility and undermines effective HIV prevention and interventions (Decker et al.). The reported violations include homicide, physical arrest and sexual violence, from law enforcement, clients, and intimate partners, unlawful arrest and detention, discrimination in accessing health services, and forced HIV testing. While human rights violations are reported across all types of policy regimes, they are worst and most frequent in places where sex work is criminalized (Decker et al., 2014). Considering the gravity of the widespread human rights violations facing people involved in the sex trade (Decker et al., 2014), a better understanding of how the punitive contemporary socio-legal climate influences sex workers' access to and utilization of social and health services is warranted. Complex structural forces—including socioeconomic background, policy and legal contexts, and gender-based violence and harassment (Benoit, Smith, Jansson, Magnus, et al. 2019; Benoit, Ouellet, et Jansson 2016)—can make Canadian sex workers more vulnerable to STIs and HIV infection (Shannon et al., 2007; Shannon, Bright, Gibson, & Tyndall, 2007) and can also lead to other sexual and reproductive health complications (Shannon et al., 2009). While recent research indicates that there

is no direct correlation between sex work and STIs, mitigating factors put certain sex workers at increased risks of contracting STIs (Benoit et al. 2014; Spittal et al. 2003) . In Canada, where the sex trade is now partly criminalized, people selling sex have few legal protections and this can also act as a barrier to safer sex practices (Shannon, 2010, Benoit et al. 2014) . Criminalization is indeed an important factor in their sexual and reproductive health choices (Shannon, 2010) and is likely to have an effect on HIV prevalence in this group (Shannon et al. 2007).

Criminalization, stigma and other structural determinants can also act as barriers to social and health services, and to general well-being (Shannon et al.). A study based in Miami reported that the same factors that created needs for various social and health services in outdoors sex workers also acted as barriers to them (Kurtz et al. 2005). The barriers were both structural (narrow program focus, travel costs, office hours and social stigma) and individual (drug use, mental health and fear) in nature and related closely to homelessness, poverty, drug use and violent victimization (Kurtz et al. 2005) . In Toronto, a recent survey with outdoor sex workers (Street View, 2014) related similar findings (Farley & Barkan, 1998) that showed how the mobility, social isolation and common threats and experiences of violence both increased their need for and kept them from social and health services. Accessing even basic health care proved to be extremely difficult and stigmatization was reported as a "recurrent theme" (2014: 19). Although a significant body of literature on sex workers' vulnerability to STIs and HIV infection has been produced in Canada (Benoit & Shumka, 2015 2010, Shannon et al., 2010a, Benoit, 2006), research has tended to take place in large urban centres such as

Toronto, Montreal and Vancouver, thus overlooking patterns of vulnerability among sex workers in medium size cities such as Winnipeg (Orchard 2019 is a notable exception here).

Health Inequities and Sex work

Research and programs tend to focus on the sexual health of sex workers, which is not always their primary health concern (Sanders, 2004). In fact, some research reveals that sex workers sometimes consider their mental and emotional health to be the most important and the hardest to maintain (Day & Ward, 2007; Sanders, 2004).

Canadian sex workers, overall, self-report poorer health outcomes than the general population. In general, people involved in the sex trade in Canada report poorer health outcomes than other Canadians with about half (53%) rating their health as excellent or very good and 27% as good (Benoit et al., 2014). In contrast, between 56% to 69% of the general population aged 20 to 64 years old reported their perceived health as excellent or good (Canada, 2014).

Sexual health can be an important issue for sex workers (Benoit & Shumka, 2015). Nonetheless, the emphasis in research and programs placed on STIs can inadvertently magnify the stigma associated with the sex trade, contributing to sex workers being wrongfully characterized as "vectors of disease" (Benoit & Shumka, 2015). While some sex workers are at increased risks of contracting STIs, "risk" is not directly correlated with *being* a sex worker but with the mitigating factors surrounding sex work (Shannon, Rusch, et al., 2007; Spittal, 2003). These factors are closely

associated with outdoor sex work or street-level sex work and they include intravenous drug use or a drug dependency (Shannon et al., 2007; Spittal, 2003); engaging in unprotected sex with their intimate partners (Shannon et al., 2007; Spittal, 2003; Ward, Pallecaros, Green, & Day, 2000); identifying as a visible minority or as First Nations, Métis or Inuit (Cohan et al., 2006; Shannon et al., 2007; Spittal, 2003); being coerced into having unprotected sex and/or being the victim of sexual violence (Cohan et al., 2006; Shannon et al., 2007); and having a high number of sexual partners within a limited time period (which is associated with vaginal or anal tearing) (Rekart, 2005). A recent study of people involved in the sex industry in Canada showed that most of the sex workers had been tested for a wide range of STIs and blood-borne pathogens. Out of those who had been tested, 6% had tested positive for herpes on their last test (in comparison to 17% for pregnant women in British Colombia or 15% of Canadian street-involved youth), 4% for chlamydia and 2% for HIV/AIDS (Benoit et al., 2014). The Ontario HIV Treatment Network reviewed in 2012 several Canadian studies looking at the HIV prevalence among sex workers ranges from 1% to 60%, depending on their situation and identified risk factors increasing the chances of contracting HIV as high-risk sexual activities with high-risk partners, lack of condom use, sharing of drug use paraphernalia, and unstable living conditions (Rapid Response Service, 2012).

Maintaining their mental and emotional health has sometimes been found to be an important concern for sex workers (Day & Ward, 2007; Sanders, 2004). The same Canadian study cited above also found that 38% of sex workers rated their mental health as excellent of very good, in comparison to 75% for Canadians (Benoit et al.,

2014). About 19% of the sex workers participating in the study reported being moderately or severely depressed in the two weeks preceding the study, which compares to 6 % of women and 4% of men who reported suffering from depression in the year preceding the 2011 Canadian Community Health Survey. This same study also highlighted that the rate of post-traumatic stress disorders (PTSD) is high among sex workers who participated in the study, with its mean score being very high in comparison to other professions such as police officers or firefighters, but similar to photojournalists seeking help after witnessing a disaster. The study also noted that a portion of sex workers in their sample were above the cut-off score used to identify individuals with potential for PTSD, with their results being higher than results of research with indoor sex workers[3] but lower than studies with street-based workers (Chudakov, Ilan, Belmaker, & Cwikel, 2002; Daalder, Bogaerts, & Bijleveld, 2013; Farley & Barkan, 1998; Stein, McQuaid, Pedrelli, Lenox, & McCahill, 2000). Other studies have reported high levels of PTSD, depression, anxiety, psychosis and eating disorders in indoors and outdoors sex workers (Day & Ward, 2007; Sanders, 2004). Some of the mental health stressors for sex workers are linked to the intense stigma associated with selling sexual and erotic services (Koken, 2012; Sanders, 2004; Spittal, 2003) and to the high level of emotional labor required in sex work (Cecilia Benoit et al., 2014; Hochschild, 1983).

[3]Indoor sex work refers to work in brothels, escort services, exotic dancers, working from a shared place or one's residence, massage parlors and online services such as "camming", and phone sex. Outdoor sex work includes street-based sex work where workers meet their clients on the street, highways, truck stops and hotels.

Health Services Access and Utilization and Sex Work

As discussed in the previous section, sex workers, and especially outdoor sex workers are often faced with difficult circumstances because of social marginalization, criminalization, homelessness, unemployment, poverty, violence, mental health issues and substance use or dependency (Bungay, 2013; Bungay et al., 2013; Lazarus et al., 2011). This situation makes the development of social and health services tailored for sex workers' particularly important, (Bungay, 2013; Cohan et al.) and the various barriers that exist for sex workers to access them particularly problematic. A substantial portion (40%) of sex workers in Canada have reported that they have not received healthcare when they needed it at least once in the past 12 months (Benoit, Smith, Jansson, Magnus, et al. 2019; Benoit et al. 2016) in comparison to 14.9% in the general population. These barriers are individual or structural and impeded sex workers' access to appropriate and effective care, and they contribute to the negative health outcomes sometimes associated with sex workers. Sex workers participating in variety of research studies globally have reported negative experiences with healthcare providers ranging from disrespectful and abusive language, public humiliation, physical separation from other patients, inferior services, inflated charges for services to being blamed when disclosing a sexual assault (Aral et al. 2003; Ghimire, Smith, et van Teijlingen 2011; Phrasisombath et al. 2012; Scorgie et al. 2013; Sprankle et al. 2018). As a result, sex workers sometimes avoid disclosing their occupation even when relevant and may manage their own health, in order to access only vital services (Bungay, 2013). Other

barriers include judgmental services, geographical location of services, lack of transportation, lack of women-specific services and insufficient referrals to mental health, pain management, addiction and preventative services. In addition, inadequate hours of services, provider resistance, poor structure of the health care system, long wait times, fear of arrest and lack of expertise in the needs of sex workers also act as barriers (Bungay, 2013; Bungay et al., 2013 2006; Lazarus et al., 2011).

Several studies also highlight the important role that stigma[4] plays in the interactions or lack of interactions of sex workers within the healthcare system (Benoit, Smith, Jansson, Magnus, et al. 2019). Stigma can be enacted through the language and attitude of healthcare workers: the services they provide and can lead to sex workers hiding their occupation from them (Lazarus et al., 2011, Benoit, Smith, Jansson, Magnus, et al. 2019)). Not disclosing their occupation can prevent sex workers from having their

[4] In this thesis, stigma is understood in light of contemporary readings of Erving Goffman's work that highlight the importance of stigma as a means of social control. As scholars have pointed out, social, economic, and structural forces need to be taken into account in interpretations of stigma related to sex work (Benoit et al. 2017, 2018; Cornish 2006; Pheterson 1993; Scambler et Paoli 2008; Van der Meulen, Durisin, et Love 2013a), legislation regarding sex work (Bruckert et Hannem 2013), policing strategies (Krüsi et al. 2016), and intersectionality of stigma (Bahri 2017, 2019; Castro et Farmer 2005; Ferris 2015; Logie et al. 2011). While Goffman (1963) conceives stigma relationally as a devalued connections between individuals and groups that significantly discredits them in the eyes of society, others, building on this, ague that stigmatization plays a key role in the reproduction of social inequalities (Castro et Farmer 2005; Das et Goffman 2013; Parker et Aggleton 2003) and dramatically impacts the 'distribution of life chances' (Link et Phelan 2001, 381). In other words, stigma is not exclusively a cause of inequality, but rather feeds on, informs, and contributes to larger pre-existing social inequalities and is "often fixed with… exploitation and oppression" (Scambler 2007, 1087). Recent scholarship tends to focus on a reversal of the focus from seeing the mark to seeing who inflicted the mark. In this sense, stigma can be understood as violence affecting every aspect of the stigmatized (Bahri 2017; Pheterson 1993; Scambler 2007). The specific way that stigma affects sex workers has been described as 'whorephobia' or 'whore stigma' to express the "dishonor" that women who sell or exchange sex or sexualized intimacy can encounter in the legal and social systems seeking to punish and discredit them as a consequence to their transgression of traditional notions of womanhood (Pheterson 1993).

health needs met and from being referred to appropriate social and health services (Jeal & Salisbury, 2004; Lazarus et al., 2011). Many sex workers choose to not disclose their participation in the sex trade because of negative past experiences with disclosure, embarrassment, fear of discrimination, judgement, or because they believe it is not relevant (Bungay et al., 2013). Of course, sex workers may also not disclose their occupation because it is irrelevant (Benoit, Smith, Jansson, Magnus, et al. 2019).

Legal context in Canada

Canada's earliest legal treatment of sex work focused on it as a public nuisance and sex workers were mostly charged with offenses relating to vagrancy, procuring and running "whorehouses" (Corriveau; Lowman, 2011), 2014). These statutes were clearly aimed at women involved in the sex trade (as evidenced by the use of feminine pronouns in the sections) and even mandated the arrest of women upon "simple suspicion of being "prostitutes" (Corriveau), 2014: 31). Vagrancy was used to criminalize the public presence of women involved in the sex trade until 1972, where section 195.1 on solicitation in a public place was added to Criminal Law (Corriveau), 2014). In 1982, the laws that would eventually be struck down by the Bedford case (in 2013) were adopted and effectively criminalized the sex trade by making it very difficult to work in the field. Communication for the purpose of prostitution was made illegal, as well as operating a bawdy house and living off the avails of prostitution. This Bill expanded the scope of the law and reflected a moralistic condemnation of prostitution that was criticized and challenged in different academic, social and legal arenas (Brush, 2012).

The lack of leadership at the federal level on the application of the recommendations regarding mixed approaches to criminalization of both the *Fraser Committee* (1985) or the *Subcommittee on Solicitation Laws* (2006), (Lowman, 2011) left sex workers with the burden of action to improve their situation. In 2007, a group of sex workers based in Ontario, Terri-Jean Bedford, Valerie Scott and Amy Leibovitch, filed a challenge at the Superior Court of Ontario against three problematic section of the laws regarding communication, bawdy houses and living off the avails provisions (Brush, 2012). This culminated in the Supreme Court of Canada judgment on December 20, known as Canada (72) v. Bedford, (72, 2013), which unanimously struck down all law sections that were under scrutiny because they were found to be violating the right to life, liberty and security of the person described in section7 of the Charter of Rights and Freedom. The Protection of Communities and Exploited Persons Act (PCEPA) came into effect on December 6, 2014 (received Royal Assent on November 6) ("Protection of Communities and Exploited Persons Act," 2014). The new laws closely resemble what is referred to as the "Nordic Model" that has been implemented in several Northern European countries. They differ from the previous laws in that they do not directly target solicitation but rather focus on third parties ("pimps")[5] and clients. The new laws reinstall offences relating to communication for the purpose of prostitution (in public

[5] The term "pimp" is a term often used in media, anti-sex work feminist literature and government documents to refer to exploitative men involved in the sex trade. It is associated with very gendered, racialized and classed images of males involved in street life (Bruckert et al. 2013; Bruckert et Parent 2018). While it is used to categorize a diversity of personal and professional relationships within the sex trade, this categorization is challenged by proponents of approaches focusing on labour rights of sex workers. The term "third parties", referring to "anyone involved in the sex work transaction who are neither the worker nor the client" is preferred by those proponents and will be used in this thesis (Bruckert et al. 2013).

places—where a person under 18 can reasonably be expected to be present), and practically make indoor trade impossible because of a section that criminalizes advertisement (Reform, 2014).

The laws in Canada have taken an increasingly punitive approach to prostitution, with the enactment of Bill C-36 into law (PCEPA) being informed more by ideology than empirical evidence (Benoit, Smith, Jansson, Magnus, et al. 2019). Despite the stated goal of PCEPA of "of addressing the health and safety of those who "engage in prostitution"", findings emerging in the years since its passing seem to indicate that it is not reaching its goal (Kunimoto 2018; Landsberg et al. 2017; Machat et al. 2019). A self-reported study found that 26,4% of its respondents indicated negative changes to their working conditions since the enactment of PCEPA—including a reduced ability to screen clients or reduced access to workspace/clients (Machat et al. 2019). Reporting negative changes was correlated with "being an im/migrant to Canada and recent physical workplace violence" (575). Data coming from Vancouver indicates that—in spite of local policing guideline changes—police presence leads to an increase in rushed client negotiations for sex workers who use drugs, and was also associated with client-perpetrated violence and other markers of vulnerability (Landsberg et al. 2017). These findings, and others, contribute to the already large public health and academic evidence supporting decriminalization of sex work as a safer option, associated with better health outcomes for sex workers (see for example Amnesty International 2016; Beyrer et al. 2015; Decker et al. 2015; Landsberg et al. 2017), as well as demands of sex workers and sex workers rights activists (Benoit et al. 2017; Sterling et Meulen 2018).

Sex workers in Canada live in a coercive environment shaped by legal, social, economic forms of violence, which reduces their options in terms of health choices (Comack & Seshia, 2010). Like the rest of Canada, sex work in Manitoba is partly criminalized. The sex trade is regulated by federal laws that allow the selling of sex between consensual adults. In Manitoba, in the absence of regulations around the in-door sex trade, and with tough provincial restrictions and surveillance regarding the sale of sex, sex workers may be forced to work "underground", which can put them at higher risks of violence, STIs and HIV infection (Shannon, 2010).

Violence against women, colonialization and racism in sex work

It is impossible to talk about sex work in Canada without addressing the ways in which the forces of white supremacy and the on-going colonization shape the distribution of violence and rights within the sex industry. The distribution of violence and vulnerability is undeniably impacted by race, class, gender and legacies of violence such as colonialism. Indigenous peoples are overrepresented in both the prison populations and the sex work populations (Bruckert et Chabot 2010). Indigenous women are over-policed and under-protected (Razack 2000) and the violence against them is dismissed, ignored and minimized (Hugill 2010), as can be attested to by the abysmal treatment of Missing and Murdered Indigenous Women and Girls (MMIWG) in the media and in political life . One only must think of the often-cited statistic that Indigenous men are responsible for 70% of the murders of Indigenous women and girls between 2015-2019. This statistic, coming from data collected by the Royal Canadian Mounted Police (and later confirmed by officials from the agency (Galloway 2015), was

found to be erroneous and based on incomplete and unreliable data by the National Inquiry on Missing and Murdered Indigenous Women and Girls (McIntosh 2019). The fast, uncritical acceptance of this bold claim by media and the Canadian public is a painful reminder of how vivid the racist assumption that Indigenous people are inherently unruly and violent is, and how promptly the Canadian "whitestream" is willing to accept that, as University of Calgary professor Robert Henry stated in the 2019 National Observer article, "Indigenous people are doing it to themselves" instead of looking at the legacy of colonization and its on-going violence today (McIntosh 2019). This discrimination and racism can affect Indigenous people who are involved in the sex industry doubly because of their status as sex worker. Of course, discrimination and racism also exist within sex worker rights organizations and can generally act as a barrier to access to health and other services, but also to reporting violence they may face. Indigenous women, girls and two spirit peoples are a specific target of violence in general and specifically in the sex trade.

Sherene Razack (Razack 2000), in her analysis of 1996 murder of Saulteaux woman Pamela George in Regina, Saskatchewan by two middle class white men, articulates how the interactions between certain raced, classed and gendered bodies within these urban spaces, particularly in the context of prostitution, often sheds light on the historically violent and deeply racist, colonial and patriarchal power structures. She highlights how George's ancestors were displaced from their land and confined in reserves. She writes "Pamela's George's own geographies begin here. Colonization has continued apace. Forced to migrate in search of work and housing, urban Aboriginal

peoples in cities like Regina quickly find themselves in places like the Stroll. Over-policed and incarcerated at one of the highest rates in the world, their encounters with white settlers have principally remained encounters in prostitution, policing and the criminal justice system" (2002:127). Razack argues that the overrepresentation of indigenous women in outdoor sex work is a testament of the legacy and power of colonialism. She also argues that any universalized position on sex work privileges the voices of white women over racialized women, thus reinforcing the race privilege and ultimately patriarchy.

Razack's position echoes feminists and indigenous activists and scholars who consider prostitution to be inevitably linked with violence and racial hierarchies. In Canada, years of community organization and activism finally brought to the on-going issue of MMIWG to the forefront of the national discussion in the early 2010s (Hunt 2017; Kaye 2017). While it isn't my intention to conflate the experience of MMIWG with the sex trade, I want to highlight how they are often related in Indigenous feminist discourses about structural violence. If earlier reports clearly called out both how approaches focused on enforcement did not extend their protection to Indigenous women and how the experiences of missing Indigenous women and girls deserve attention in its own right (Native Women's Association of Canada 2010; Sikka 2009)— separate from the concerns of human trafficking and prostitution— the position from prominent Indigenous organizations and activists eventually changed. Starting in 2012,

the Native Women's Association of Canada (NWAC)[6] adopted anti-trafficking discourses in their discussions about the sex industry, including missing and murdered women who were involved in the sex trade, marking the first enunciation of a "clear anti-prostitution position" documented in their documents (Ferris 2015:142). NWAC's statement focused on the reclaiming of power, authority and autonomy lost after the imposition of patriarchal systems of colonial rule, of which the sex trade is an important part. In this sense, it situates the involvement of Indigenous women in the sex industries as state-sanctioned racism and colonial violence. Furthermore, it states that prostitution is not an "acceptable space" for Indigenous women and that "prostitution is not a traditional activity of Aboriginal women"(Native Women's Association of Canada 2012:2). NWAC's position questions what they portray as the illusion of choice of women involved in the sex trade and sex workers rights advocates by underscoring the failure to address the intersections of race, class and poverty experienced by Indigenous women and the colonial legacies of patriarchy, domination and exploitation. Finally, it positions the abolition of prostitution as inseparable from the "respect the Aboriginal, treaty and international human rights of Aboriginal peoples to live lives free from violence, poverty and to meet their physical, cultural and spiritual needs."(Native Women's Association of Canada 2012). As Julie Kaye chronicles in her analysis of the embeddedness of anti-

[6] The Native Women's Association of Canada is a national Indigenous organization that represents the political voice of Indigenous women and gender diverse people in Canada, "inclusive of First Nations on and off reserve, status and non-status, disenfranchised, Métis and Inuit"(Native Women's Association of Canada s. d.). It was created as a coalition of Indigenous women's groups across Canada.

trafficking discourses and practices to the Canadian settler-colonial project (2017:141-142),

> *A complex dynamic of stratified relationships emerges whereby sex worker-rights advocates criticize abolitionists for silencing of their lived experiences and their right to safe working conditions. Meanwhile, in the context of legacies of colonization, some Aboriginal voices suggest that efforts to decriminalize fail to listen to Aboriginal voices and address the experiences of Aboriginal women who, As NWAC (2012) stated "will mostly remain on the street".*

The last decade has seen a growing body of voices from experiential women stressing the ways in which sex work can and does resist and challenge hegemonic masculinity, and these voices do include Indigenous scholars and activists. For example, Naomi Sayers, Colleen Hele and Jessica Wood have been active in discussing the harmful effects of conflating human trafficking, sexual exploitation and sex work by mainstream indigenous organizations and settler Canadian organizations . They describe the legacy of residential schools, sixties scoop and continued overrepresentation of indigenous children in child welfare system as a practice of human trafficking (Wood, Hele, et Sayers 2015). The continuation of reliance on those systems continues the trafficking and violence against indigenous women. In order to protect themselves, and escape the colonial violence within these institutions, indigenous women and girls sometimes use sex work to obtain more economic freedom. The on-going criminalization of sex work and the ever-broadening definitions of human trafficking and sexual exploitation can then contribute to violence for sex workers and other people involved in the sex trade. These kinds of overly broad definitions of trafficked victims and trafficking scenarios,

void of any critical anti-colonial analysis, create victims where there are none. In the important article authored with scholars and activists Jessica Wood and Colleen Hele (Wood et al. 2015), Indigenous feminist lawyer Naomi Sayers shares that when she was an exotic dancer in Northern Ontario, the fact that she worked away from her place of residence, and that her father sometimes drove her to work could be classified as human trafficking under the eye of the law, even though her experience does not fit with this. These overly broad definitions also feed into the white-saviour complex, with which colonial institutions and their practices of "saving" Indigenous women and girls are legitimized without question. Most dangerously, when the colonial state views all prostitution as human trafficking, these overly broad definitions contribute to the forced removal of Indigenous women and girls from their communities all in the name of "saving" and "protecting" them. Indeed, the focus on trafficking foregrounds state—led efforts to rescue, intervene and protect while simultaneously reproducing the mechanism that led to the dispossession of Indigenous people from their lands and that perpetuates the ongoing physical and sexual violence against indigenous women. In other words, the blind acceptance of the political rhetoric surrounding the human trafficking of Indigenous women and girls is one of the many links to the intergenerational residential school legacy, like Canada's current child welfare system. Notable among the experiential voices making themselves heard in the last two decades is the Downtown Eastside Sex Workers United Against Violence Society (SWUAV), a group of current and former sex workers who live and/or work in the Downtown Eastside of Vancouver whose mission is based on the vision and needs of street-based

sex workers (Sex Workers United Against Violence Society 2017) and whose membership is mostly from people of Indigenous descent "all living with addiction issues, health challenges and/or disabilities, all living in poverty and almost all victims of physical and/or sexual violence at some point in their lives" (Canada (Attorney General) v. Downtown Eastside Sex Workers United Against Violence Society 2012). In 2007, they launched a constitutional challenge to Canada's prostitution laws with the support of Pivot Legal Society. In this challenge, they argued that the laws in place infringed on their rights, as defended by the Canadian Charter of Rights and Freedom, by placing them at risk of arrest and imprisonment and preventing them "from taking steps to improve the health and safety conditions of their work" and keeping themselves safe (Canada (Attorney General) v. Downtown Eastside Sex Workers United Against Violence Society 2012). SWUAV later intervened in the Bedford case in support of the complete decriminalization of sex work (Bennett 2013). Representatives from the Aboriginal Legal Services of Toronto have also repeatedly made clear that the need to differentiate between sex work and sex trafficking in 2014 during the House Committee's review on Bill C-36, which introduced asymmetrical criminalization to Canada. In their intervention, Christa Big Canoe, legal advocacy director at Aboriginal Legal Services of Toronto, suggested better enforcing Canada's existing human trafficking laws and defining the difference between trafficking and sex work (Kady 2014). In 2015, a group of Indigenous sex workers and allies published a statement under the name *Indigenous Sex Sovereignty Collective* calling for "centering the voices of people who trade or sell sex in indigenous anti-violence organizing" (Indigenous Sex Sovereignty Collective

2015a) and for the recognition of the diversity of experiences and voices in the sex trade:

> *The Indigenous Sex Sovereignty Collective represents a diversity of voices and we acknowledge that there is no one singular voice for Indigenous peoples, especially Indigenous two-spirits, trans* people, and women. We must begin to acknowledge the diversity in our experiences and acknowledge that organizations that unequivocally support colonial policies do not adequately represent the interests of all Indigenous peoples, especially those who trade or sell sex in sex industries or street economies. Turning away from colonial policies, we must instead value, respect and center the diverse voices of Indigenous people with experience trading or selling sex. Without these voices and perspectives, any efforts to reduce violence in our communities only contribute to the ongoing marginalization of sex workers - this, we say, is unacceptable.*

The conflation of all sex work with exploitation and human trafficking is neither new nor contained to Winnipeg or Manitoba. In fact, it can be traced quite clearly to groups of self-described "radical feminists" in the United States and their collaboration with evangelical Christians at the end of the twentieth and the beginning of the twenty first century (Jackson et al., 2017). At a major 1988 conference organized by one of the key US-based anti-prostitution organization, Women Against Pornography, one of its founders and founder of annual Take Back the Night marches defined trafficking as "globalized prostitution" and urged all feminists to shift the fight to the international sector (Jackson et al., 2017: 70). This moment marks the beginning of deliberate efforts to conflate sex work with human trafficking and exploitation. Echoing the early twentieth century "white slavery" moral panic, the early years of the twenty first century have been marked with renewed fears surrounding sex trafficking, fueled by

concerns over immigration. Radical feminist groups were joined and soon eclipsed by faith-based anti-trafficking groups.

In Canada, anti-trafficking political preoccupations have flourished in the last few decades on the backs of the important and legitimate efforts of Indigenous activists "trying to make Indigenous lives matter to settler colonial systems predicated on [their] dehumanization" (Hunt 2006, 2015). After decades of indigenous activism and work to address the conditions of exploitation, coercion, abuse and violation, activists began to appeal to the laws, policies and funding associated with the state's increased investment in anti-trafficking, in the hope that it could also bring some justice to MMIWG and their families. The story of MMIWG has been taken up by the state but in ways that reproduces the foundational myths upon which Canada is founded. Renewed portrayals of state actors and well-meaning Canadian citizens stepping in to save and protect vulnerable Indigenous women began to flourish. Prostitution in these discourses is depicted as inherently linked with violence and racial hierarchies, thus reproducing racialized and gendered notions of "good" and "bad" women and pushing the voices of sex workers to the margins of national anti-violence efforts (Kaye 2017). This led to resources being made available for women who "*wanted* to be rescued" from the sex trade and were willing to identify their lived experience with the trafficking narrative. While having resources to fight against violence and coercion is crucial, as indigenous legal scholar Nancy Hunt (2015) and others point out this leaves behind sex workers unable to frame their lived experience with a trafficking narrative.

Research Objectives

Employing a qualitative ethnographic approach, my doctoral research examined the ways in which deliberative identities gives shape to a highly punitive socio-legal context in Winnipeg and influences sex workers' access to and utilization of social and health services. Particular attention will be paid to contemporary and past interventions that seek to 'improve' sex workers' health and well-being. The project pursued the following specific objectives:

1) To explore and examine the individual, socio-cultural and structural factors that influence contemporary sex workers' health seeking behaviors, and access to and utilization of social and health services.
    a. Through participant observation (daily note taking by researcher regarding interactions and participation in activities) and individual interviews, I explored the current experiences and needs of cisgender and transgender women, and non-binary sex workers with social and health services in different areas of the sex trade including indoor, outdoor, and internet-based.
2) To produce a recent history of program and intervention techniques to understand contemporary socio-legal arenas concerned with individuals involved in the sex trade in the city of Winnipeg.
    a. Based on primary and secondary source archival work, I reconstructed a comprehensive timeline of different projects and interventions, their stated rationale and how it relates to different policy regimes.

b. Through interviews with chosen social actors, I have generated a contemporary picture of the social and health services offered to people involved in the sex trade currently and in the last 30 years in Winnipeg.

3) To contribute to the applied community health goal of creating spaces where the diversity of sex workers can be heard, and their experiences can be acknowledged and respected.

a. To work with local sex worker rights activists to establish a community-led advocacy group that can challenge the hegemonic assumption that sex work is inherently exploitative.

Conceptual Framework

'Rescuing' the innocent

Against a background marked by a long history of interventions and the management of racialized and otherwise structurally oppressed marginalized populations, Manitoba's Sexual Exploitation Strategy reinforces a moral project that portrays people involved in the sex trade as exploited or trafficked, and always as victims. Until very recently, it defined all forms of exchange of sexualized intimacy and sex as exploitative (apart from sex within marital contexts), regardless of the context or age of the individuals involved. The urgency and alarm surrounding "sexual exploitation" in Winnipeg follows the humanitarian logic that Fassin and Pandolfi (Fassin et Pandolfi 2013) refer to as "states of emergency"—that is, when a 'social problem' is

characterized as a 'crisis', a state of exception can be declared in which taken for granted human rights or civil liberties can be suspended for 'the greater good'. In the process, the state of exception reduces people with particular histories and hopes to mere lives to be rescued. This reduction of people's stories and of the complexity of their lives is necessary to justify interventions. In the case of the sex trade in Winnipeg, what is 'necessary' is for people involved in the sex trade to be 'truly innocent', if they are to be rescued.

> *"because innocence is both mythical and ephemeral, we are constantly displacing politics to the limit of innocence in a never-ending quest, and in the process the structural and historical causes of inequality get rendered invisible. In the search for purity, a very particular politics gets produced, and another, disabled. To this end, we need to open up political, moral, and affective grammars beyond innocence." (Ticktin 2017a)*

As anthropologist Miriam Ticktin problematizes, the idea of innocence in the context of humanitarianism can only exist in an ahistorical and apolitical "space of purity" whose borders are constantly drawn and redrawn to accommodate a search for a truly innocent victim. Innocence is a fundamental Judaeo-Christian concept that is central to the origin story of Adam and Eve, where Eve's disobedience to God by eating from the tree of knowledge brings nothing less than the fall of humanity. As Ticktin states "The Fall helps to define humanity afterward; the loss of innocence is *how* we become human." Innocence implies being void of knowledge, agency and desire, and it exists in a space before responsibility. As the author notes, a fertile terrain for the use of innocence in the political imagination is human trafficking, and particularly sex trafficking and its victims.

In this sense, for innocent victims to exist, it becomes essential to have sex work *as work* be "rendered invisible or criminalized". The creation of people who sell sex *as victims* implies the creation of an equally powerful "class of saviors" who are "provoked by the idea of innocence and fed by the comfort of superiority in knowledge and power" (Ticktin 2017a; Valverde 1991). This is reminiscent of what Gayatri Spivak (1988) phrased "white men saving brown women from brown men" in processes that absolve them from any complicity in violence against those same women.

Health Identities

The notion of deliberative identities, which this thesis aims to elaborate, builds on a larger body of literature on health identities and questions of selfhood and subjectivity. The workings of power in relations to social differentiation and senses of self has been the subject of much interest in medical anthropology since the inception of the discipline (Wood et al. 2015). Susan Reynolds Whyte summarizes two sets of the theoretical approaches used by social scientists, and especially medical anthropologists, while attempting to make sense of the constructive interactions of health, identity and power in the last two decades: 1) the focus on the politics of identity and 2) the concern with subjectivity and biopower (Whyte 2009). The literature comprised under the former has been employed to document the evaluation of difference and how certain social and political groups claim individual and collective social justice recognition. The latter describes anthropological research that has studied the relationship between health and subjectivity, often under the influence of Michel Foucault's work on power.

The focus on the scholars interested in biopower described by Whyte has tended to be less concerned with political actions and debates about social justice and more with the "subtle shaping of subjectivity, of assumptions and bodily practices and attentiveness"(Whyte, 2009:10). Whyte interestingly warns about the pitfalls of both sets of approaches: the danger of losing sight of the political and economic bases of health in our concern with identity; the risk of ignoring fundamental differences at the root of health inequities that supersede health identities; and the threat of ignoring or denying the other biosocial relations that affect individuals whose health condition has brought them together, including those surrounding enumerative practices (Sangaramoorthy et Benton 2012). Indeed, by identifying research problems based on health-based identifications, such as sex workers as a "risk group", we "essentialize, decontextualize what is really only a part of life" (Whyte, 2009:13). This thesis follows on Whyte's recommendations to capture social realities more fully—with a strong focus on history, political economy and detailed descriptions of social interactions, moralities and meanings—while also attending to the socially productive effects of reductive articulations of health categories. Moreover, I aim to document how a range of social actors, engaged in interventions, *deliberately* redeploy an array of terms in ways that opens and forecloses real and imagined possibilities for health improvement and social justice.

Becoming a sex worker

I employ the term "deliberative identity" to highlight the careful, collaborative, purposeful work that my interlocutors[7] do in choosing the words to represent the identities they utilize. Their deliberate and deliberative nature implies that they are not static identifications, where nothing leaks outside their boundaries to find meaning and life elsewhere. As the etymology of the word denotes, according to the Fowler's Concise Dictionary of Modern English, "deliberative" refers to a weighing and balancing that is "relating to or intended for consideration or discussion"(Butterfield 2015). The identities described in this paper, accordingly, are the object of much careful discussion, intention, guarding and contestation. In particular, I describe how the label "sex worker" is used as a deliberative identity that allows people to gain access to practical things like networks and services, but in this context, also creates barriers to other resources.

I attempt to evade the restrictive dichotomies that dominate the social, political and public health fields surrounding sex work by taking cues from recent articulations and usage of an anthropology of becoming and the ideas of Gilles Deleuze and Felix Guattari (Biehl et Locke 2010, 2017; Fast et Cunningham 2018; Fast et Moyer 2018). I focus on the openness and flux of social fields and dynamic trajectories of people's lives as they navigate through and *around* public health milieus and boundaries, here located in interventions and projects targeting people selling or trading sex. Deleuze defines *becoming* as individual and collective desires to "carve out life chances from things too

[7] Refers to individuals I talked to in formal interviews and informal interactions during ethnographic fieldwork. While my interlocutors included people with and without experiences in the sex trade, in this thesis, it is mainly used to describe sex workers and other experiential people.

big, strong and suffocating" (1997:3). Building on this work, I employ the notion of deliberative identities—which, in addition to the term sex worker, includes a broad spectrum of categories like prostitute, sexually exploited woman, trafficked victim, survivor of sexual slavery, experiential person— to illuminate how interveners not only use these categories to secure funding, assert political agendas, and establish and re-establish their positionalities and careers as moral crusaders, but also to show how it generates intensities that drive the life possibilities that sex workers recognize and pursue.

As I will demonstrate, the label "sex worker" can be used to disrupt narratives lines, or even "hard lines", that confine and narrow the complex realities of people. In fact, the term sex worker itself was invented to do this (Leigh 1997). Similarly, other deliberative identities are invoked by different social actors and groups who make claims to a monopoly of suffering and of legitimacy, reinforced by intensive boundary work (Gieryn 1999) and the will to save "innocent" lives.

Chapter Overview

This thesis represents an attempt to take a step back from the restrictive discourses regarding the sex trade—especially those within the context of public health theory, policy and practice—to represent the complex political and affective fields that open up around the diverse and sometimes conflicting linguistic deployments referring to those in the sex trade. Moreover, I emphasize how this discursive terrain continually (re)shapes access to resources and social and political support networks for people

involved in the sex trade, and the positioning of social actors invested in its management.

To situate my research, the first chapter provides, in addition to all the expected elements concerning the methods used to collect data, I detail my engagement with sex work activism for and beyond my doctoral work. It describes the embedded process I pursued to explore the politics surrounding sex work in Winnipeg, my relationship with SWWAC, and statements situating my research within the ethical and political histories of public health and (sociocultural) medical anthropology. It also discusses the key terms that people employ in Winnipeg with respect to the sex trade. The second chapter explores the histories of social and legal management of the sex trade in Winnipeg and in Canada, with a focus on the last 30 years. Over time, various labels and identities have been brandished by all sides in this contested arena—but how do they change and what do they achieve? I argue that, while the hotly debated language surrounding the management of the sex industry has changed considerably, the intentions and consequences remain strikingly similar—that is, to confine the sex industry and those within it to a *social problems framework*, where selling sex is a treated as problem that requires *continual* intervention. To highlight how this socio-political dynamic continues to play out in Winnipeg contemporaneously, I describe interactions between SWWAC and other sex worker rights activists, including myself, with the Winnipeg Police Services.

Chapter three and four present the findings of the 39 interviews I conducted with transgender and cisgender sex workers and experiential people regarding their

experience with health and social services. Chapter three documents the multi-layered and intersectional experiences of stigma, discrimination and its consequences on their health and well-being, as well as their attempts and strategies to keep themselves safe while accessing what they need. Although my interlocutors were diverse in terms of their sexuality and gender identities, self-identified racial or ethnic background, social economic status, and location and experiences with sex worker, the vast majority shared similarly dehumanizing experiences of being reduced to simplistic assumptions, categories and "risk factors" that services providers—and others in their lives—asserted. The following chapter hones in more directly on what "safety" could look like for sex workers in their interactions with service providers and the systems they represent and presents suggestions that my interlocutors provided regarding how to respect the complexity of their lives.

The next chapter presents the tumultuous recent history of local sex work activism through the activities of SWWAC and their interactions with other social and political actors engaged in discussions, services and programs surrounding the sex trade. Specifically, attention is given to the ways in which the deliberate deployment of identities like "sex work" and "exploited person" not only entangles together a diversity of social actors but shapes concrete possibilities for people trading sex as they attempt to access services, resources, funding and social legitimacy.

CHAPTER 1

ENCOUNTERING THE FIELD OF SEX WORK

At the intersection of research and activism: my beginnings

Between January and April 2011, I worked with the now renowned South Indian sex worker collective known as Ashodaya Samithi, and most closely with Ashraya, a sub-wing comprised of sex workers living with HIV and AIDS. By the time I arrived in Mysore, Karnataka, for my M.Sc. work, Ashodaya was a very well-established sexual health service provider, and a political force that attracted researchers from across the globe, looking to base their studies pertaining to "vulnerable populations" (i.e., "sex workers" and "men who have sex with men" and sexual minorities such as hijras). That meant that Ashodaya members were highly skilled in managing complicated relationships with researchers and other stakeholders who both had power over them and who, in many ways, were key to keeping their organization working. I quickly learned that Ashodaya's role in the community was also central to the social and political existence of so many of its members—it served as a vital site for socialization, advocacy, and access to health, but also because of what it represented as a political project.

I was immensely fortunate to be introduced by a researcher who had already been working with Ashodaya for years and whom they respected deeply, Rob Lorway. I am under no illusion regarding the influence that that introduction had on the solid relationships I was able to build in the first months there, and over time. My experience with Ashodaya was incredibly important in my development as a young researcher and

activist. I was fortunate and humbled to be in an environment where the research participants and other members inhabiting the field often possessed more research experience than I did. Not only were they able to provide me with planning and organizational help, they often provided methodological guidance, from changing my focus altogether to rephrasing and reorganizing my interview questions.

Reviewing the global public health literature, one quickly learns that Ashodaya Samithi has been highly successful in their community-led efforts against HIV and other STIs and in their extensive community-building initiatives that have characterized their work since the inception of the organization in 2004 (Chevrier et al. 2016; Dixon 2009; Dixon et al. 2012; Lisa Lazarus MPH et al. 2012; O'Brien 2009; Reza-Paul et al. 2008, 2012). When I was there in 2011, Ashodaya was at the end of a lavish funding cycle funded by the Bill & Melinda Gates Foundation, between 2003 and 2012, under the HIV initiative in India known as Avahan. Ashodaya received funding through Avahan—which focused on HIV prevention efforts in India's six highest HIV prevalence states—because its membership comprised a "high risk" group that included female, male and transgender sex workers and because it aimed to reduce vulnerability to HIV and other STIs through "community mobilization and structural interventions" (Chevrier et al. 2016; Dixon 2009; Dixon et al. 2012; Lisa Lazarus MPH et al. 2012; O'Brien 2009; Reza-Paul et al. 2008, 2012).

During my last flight to India in 2011, I remember reading one of the academic papers published about Ashodaya and being struck by the technical language employed around community building and advocacy work. It appeared quite different from the

types of social activism with which I was more familiar. Once I got to know Ashodaya leaders and other members, I was surprised to see that this technical language was regularly used to describe their work in creating an "enabling environment" and how it coexisted with efforts to foster respect for sex workers rights within local health systems and the broader Mysore society (Chevrier et al. 2016). In the following 5 months and in the years since, I witnessed how Ashodaya focused on occupational health and human rights while working tirelessly to make their centre and their services welcoming to all their members. Through careful documentation, they also showed that this approach yielded positive results with a dramatically increased access to health services, an increase in the participation of sex workers in managing community-based health services and in significant reductions of curable STIs and the stabilization of the local HIV epidemic (see for example: Dixon 2009; Dixon et al. 2012; Reza-Paul et al. 2008).

On my second day, while being introduced to Ashodaya participants, leaders and staff, the yearly elections were held. The main room of the centre was alive with animated chatting as hundreds of Ashodaya members from Mysore and surrounding districts came to vote in a what appeared to me to be an intensely formal and (hotly discussed) process to elect their leaders. After Rob introduced me to some leaders and community members who were understandably too embroiled in the election to speak with me for very long, a young woman working for the organization was assigned to me as my guide. She spent the better part of the day whispering translation and explanations about what was happening to me. She hadn't been a member for very long and couldn't answer all the questions I had that day. However, I later learned that the

vibrant community mobilization within and ownership of the intervention, along with its close collaborations with a broad range of local stakeholders and technical advisors, were crucial components in Ashodaya's ability to confront structural violence facing their members (see also: Argento et al. 2011). In the first half of 2011, as I spent my days at Ashodaya's, I met several of their local stakeholders, including district health officials, law enforcement officers, academics and politicians in meetings, public events and public presentations. Their coalition with Ashodaya contributed to transforming the local structural context that shaped forms of violence and risk endured by local sex workers. Ashodaya's careful and tireless organizing stood as a powerful example for me of how political organizing, technical know-how and rights advocacy could bring about profound transformations that intersect with health. I left that first visit wondering about the Canadian sex worker rights movement, and how it confronted community health.

Ashodaya's influence certainly went beyond "the local" and included a very active leadership role in the Indian sex worker movement and was even the chair of the *All Indian Network of Sex Workers* (AINSW) in 2011. Ashodaya soon became a "learning center" where they offer extensive training for sex workers organizations from all over the world. On my very first week there, right after the elections, I joined a training that Ashodaya members were providing to another groups of women involved in the sex trade from another part of the country. During a bus ride across town to view how systematic condom distribution and outreach happened, one of the founding members and community leaders, a man then in his early 30s who is an equally brilliant and

passionate activist, sat next to me and delivered a narrative, part of which I quote above. Through this narrative, he provided me with a basic, disarmingly clear and fair demand for reciprocity that replayed itself in my mind throughout my early master's fieldwork, analysis and writing process:

> *So I hear you want to work with sex workers and people who are HIV+? Everyday you have to think about sex work and sex workers and what you can do to help. You have to think about it 24h, everyday.*

When the time came to compose my doctoral proposal, the words of my friend returned to me. This demand for reciprocity underlies a central question that has guided the movement toward my deep, political entrenched positionality: if I end up with a PhD after this, what will the community I work with gain?

Winnipeg, Treaty One territory, Canada: "Where are the sex workers?"

> *"No one would chose to do this [sell sex], think about it!"*
>
> - Social worker at important local social agency

> *"Women might think it's empowering but they're brainwashed. I have never met a woman who exited the sex trade and didn't realize after it was all exploitation. Never."*
>
> - Experiential government worker and recognized expert on sexual exploitation

> *"It might be different in Montreal, but here, everyone in the sex trade is there against their will, they're entrenched. You know, a lot of them are Aboriginals."*
>
> - Respected community organizer in labor movement

When I first decided to focus my doctoral study of sex work in Winnipeg, I remember researching online for local advocacy groups of sex workers similar to organizations like Ashodaya Samithi or my hometown's *Stella l'amie de Maimie*, and not finding anything. I did find many celebrated resources for "sexually exploited women", "experiential women" and women seeking to "exit the trade" (for example see Anon 2018). Based on my past experience with research and activism with sex workers, these terms referred to people who were no longer working and/or people who were forced into the sex trade. It took many discussions and curious questions with friends and service providers to understand that many of those terms were used to encompass virtually every type of experience of people involved in the trade, and it became clear that the term "sex worker" was either new or offensive to the people I talked to. The quotations above are examples of the countless similar statements I received when I first started having these informal discussions about sex work with Winnipeg-based activists, feminists, researchers, social workers, nurses and other services providers. These statements often came in response to my attempts to convey what I knew about the complexity of sex workers' lived experiences, when I tried to unsettle simplistic dichotomies of "empowerment vs. victimhood" reiterated in the media and in public health. I talked about the compelling arguments and stories shared by the sex worker rights movement in the last 50 years in Canada and globally (see for example Durisin,

Meulen, and Bruckert 2018; Grant 2014; Kempadoo 2003; Majic 2014; Meulen, Durisin, and Love 2013; Van Der Meulen 2012) and the nuanced realities of sex workers. In the year before I started my research, I often wondered aloud and to myself, "Where are the sex workers here?" Was there really no one who considered this to be "work" or who didn't recognize themselves in the dominant narrative around exploitation?

I did find services and programs available to people in the sex trade, as will be described in detail in chapter two; however, few of them focused on health and social services that *explicitly* welcomed sex workers who did not wish to stop being involved in the sex trade. Sage House, a program operating out of Mount Carmel clinic, has been a crucial service for cisgender and transgender women involved in the sex trade for decades. While the program certainly changed over time (Mount Carmel Clinic s. d.), it is well known that they also firmly believe—at least during the time period that my research took place—that any kind of sex work was also ultimately "exploitation". My early interactions in late 2014 with some of their employees of Sage House, as part of my work with SWWAC[8], confirmed this belief when some of them expressed their shock and outrage at SWWAC's assertion that criminalization of any part of the sex trade industry—including clients and third parties—is harmful to sex workers. In 2015, the Daniel McIntyre and St. Matthews Community Association (DMSMCA) opened a weekly drop-in for "sex trade workers, experiential folks, victims/survivors of sexual exploitation or victims/survivors of human trafficking" (Daniel McIntyre St. Matthews

[8] My work with SWWAC will be described in further details below.

Community Association s. d.) which explicatively states and takes measures to welcome of people whatever the stance or experience on sex work might be.

In the absence of any formally defined "sex worker" communities, as was my experience in India, I started my ethnographic research in 2013 by establishing connections with key individuals in activist, feminist and health care professional communities that were ultimately instrumental in encouraging and facilitating the development of this project. Eventually, the formation of what is now known as SWWAC greatly influenced and facilitated my connection to some diverse groups of people involved in the sex industry.

As revealed in the previous chapter, after considering the legitimate focus of programs, services and policies on sexual exploitation of youth and adults in the sex trade, I primarily aimed to focus on *adult consensual sex workers who do not necessarily define their experience as exploitation, nor are they necessarily looking to move to a different form of employment than sex work*. What are their needs regarding health and social services and what influences them? More broadly, what socio-cultural and historical factors have shaped the programs, services and policies regarding the sex trade in Winnipeg? What led to sex work being considered solely in terms of violence and exploitation and what can be done to open up space for the needs of sex workers to be considered?

Design and procedure

In order to answer the questions I pose above, I employed three different interacting qualitative methods: ethnographic fieldwork, in-depth, semi-structured interviews and document research.

Ethnographic fieldwork

While ethnographic fieldwork is often described as encompassing participant observation and daily field not composition, it also requires long-term stay and relationship building with varied key actors in what is referred to as the "field" or the research site. Ethnography has its origins in social and cultural anthropology but has been increasingly used as a methodology for research in the field of health care since the 1980s (Beaud et Weber 2017; Garro 1982; Robertson et Boyle 1984). It is characterised by its conduction in a 'natural setting' with frequent, intimate, face-to-face interactions with participants with the goal of presenting an accurate reflection of participant's perspectives and behaviors as they describe and experience it (LeCompte et Schensul 1999). It uses inductive, interactive and recursive data collection to construct its analysis and gives importance to framing social realities within sociopolitical and historical contexts, often by using the concept of culture as a lens through which to analyses the data gathered (LeCompte et Schensul 1999).

For the work completed for this thesis, I have spent considerable time working with and for SWWAC, since the very inception of the group. Consequently, my project has been the subject of various informal discussions over the past five years. Furthermore, my involvement in the advocacy group and my attempt to represent

SWWAC's activities in this thesis have been carefully reviewed, commented on and given formal approval by SWWAC. In other words, my depictions of SWWAC in this thesis are the product of a negotiated and deliberative process with community members, a process that supports the protection of community members' confidentiality and safety. Indeed, my continued involvement with SWWAC goes beyond that of an "ethnographic field site" and a "research project". In other words, my ethnographic practice became a site of intense political engagement and participation, rather than the more classical and removed depicted in the methodology known as "participant observation"(Robertson et Boyle 1984). Aside from a handful of formal interviews with some SWWAC members, most of the data describing this advocacy group comes from my ethnographic notes and from direct involvement with SWWAC's website, social media accounts and public interaction with media and other agencies and/or stakeholders.

The ethnographic notes that I took describe the developing work of SWWAC but also the regular public discussions regarding sex work, sexual exploitation and human trafficking in the media, or in personal communications had with me. Additionally, I have completed over 5 years of engaged research with sex workers rights activists in SWWAC, and generally with different agencies and groups involved with different interventions surrounding the management of sex work in Winnipeg and Manitoba. Practically, this meant attending talks and events, participating in countless meetings, helping to organize public events, responding to written, televised and radio media, and

helping to design and present workshops and presentations for students and service providers.

As I spoke publicly about SWWAC's work or my research somewhat regularly over the past 5 years, it occurred often that colleagues, frontline workers, and a surprising diversity of people would approach me with questions, concerns or news regarding what they perceived to be "my topic". Undoubtedly shaped by the various public discourses steeped in whorephobia[9] and ignorance, and the prevalent local focus on sexual exploitation and human trafficking as undifferentiated from sex work, many of these interactions either lauded me for "helping these poor women" or encouraged me to "educated myself" on the realities of the "victims". Perceiving all these interactions as being part of the local social climate around the sex trade, I made careful notes of each one of them. These meetings and conversations led me to better understand the complexity of the local discourse happening regarding the sex trade and convinced me early on that if there was an ethical way for me to get involved in it, I would.

Interviews

For the formal interview section of my data collection, I aimed to speak to about 40 women (trans and cis) currently working in the sex trade (see Appendix 4 for interview guide). While I had initially planned a more structured, purposive snowball sampling approach (Benoit, Smith, Jansson, Healey, et al. 2019a), it became clear very

[9] The specific way that stigma affects sex workers has been described as 'whorephobia' or 'whore stigma' to express the "dishonor" that women who sell or exchange sex or sexualized intimacy can encounter in the legal and social systems seeking to punish and discredit them as a consequence to their transgression of traditional notions of womanhood (Pheterson 1993).

rapidly that the word was spreading through informal networks almost faster than I could keep up with and I settled for a mostly convenient sample of volunteers. This type of sample does not allow for generalisations to the entire sex working population, or any claim to representability. I put up posters and passed out cards (see Appendix 1 and 2) detailing what kind of individual I was hoping to talk to in health and social agencies, as well as restaurants, community centres and other businesses throughout the city, and I posted on social media from my personal accounts on Facebook and Twitter (see Appendix 1). One of the advantages of this recruitment strategy is that is allowed me to potentially reach networks of workers that I wasn't connected to through ethnographic fieldwork and activism. Of course, my personal connections played a role in who chose to reach out to me to participate. I received phone calls, emails and private messages on a daily basis from people who had seen the poster, online or in an agency, or who had talked to someone who had participated in the research. I completed 52 interviews in total. I continued to interact with people who would consider participating even after I had officially stopped recruiting at large. In August of 2017, I had to stop accepting interviews and tried to speak to people from specific fields of work. For a student researcher working with a supposedly "hard to reach" population (Abrams 2010; Benoit et al. 2005), it was both shocking and extremely exciting to be quickly overwhelmed by the community response and interest in speaking to me. While I had planned to focus my interviews on participants currently involved in the sex trade, many participants told me during the interview that they were no longer working.

Considering the pressure for participants in certain programs to contemplate ending their work in the sex trade, it was sometimes unclear if they felt like this was something that I wished to hear or if this was representative of their current situation. In all cases, I made the decision that their experiences mattered and indeed their insights were very important to my research. This means that the results of this thesis do not focus exclusively on the experiences of cisgender and transgender women and non-binary folks who identify as sex workers but also of people with a variety of experiences in the sex trade. When appropriate, the information that was presented to me by my interlocutors about their experiences is mentioned to contextualize their story. The decision to diversify the sample for my interviews with sex workers means that my results cannot be generalized to only people who identify and use the label "sex workers".

The interviews lasted between 25 minutes to 3 hours, with the average being around 45 minutes. All interviewees were offered to meet in rooms rented at the Bannatyne campus of the University of Manitoba, at Nine Circles, which generously offered their room, or other agencies such as Sage House. Alternatively, I also met people for the interviews wherever they felt comfortable and where they felt that their identities could be protected, often biking to their homes, apartments, rooms or arranging meetings in restaurants and coffee shops all over the city.

In addition to interviews with people with experience in sex work, I also conducted 12 interviews with those whom I refer to as "chosen social actors" (see Appendix 5 for interview guide). They were people whose work, current or past, has

involved providing services to people in the sex trade and who have information or could tell me about the evolution of health and social services for sex workers in the last 30 years. Of course, some of these interlocutors also had current or past experience in the sex trade, although this was neither a requirement nor the main reason I was speaking with them.

Safety Plan

With the support of local nurse and community activist and then executive director of well-known local resource centre Sunshine House, Margaret Ormond, I devised a detailed safety plan. The purpose of the safety plan was to think through and plan around potential physical safety issues that could arise while I conducted interviews or did fieldwork. This would allow me to do my research the way I planned to: by being as responsive and adaptable as possible and to be able to talk to as many diverse people as possible. I did not agree that I needed a safety plan because the people I was aiming to talk to were particularly dangerous or that I feared them. Thinking through and planning around potential risk was a way to enunciate what potential worries might be and to plan around them so they do not prevent me needlessly from meeting new people. As I was going to be biking around different neighborhoods by myself and meeting up with people in places of their choosing, to discuss a potentially complicated topic, with cash—for the research compensation—, it might create tempting situations for individuals potentially desperate for money.

After talking through different “red flags” or possible signals that “things might be off”, such as my interlocutors looking nervous or upset with me, my research safety plan established that if I had any doubt about my safety being compromised, I would say that I had to meet up with someone right away and exit the situation as calmly as possible. Because I was going to be doing my interviews alone, I identified a safety contact who I would report to regularly about my safety. My dear friend, nurse and researcher, Trina Arnold, graciously accepted to support me doing my data collection. I would text Trina before going into each interview with the address or close address (if it was someone’s home) of the interview location and text her back as soon as I left the interview. If I didn’t get back to Trina within 2 hours, she would text me to check in on me. If that went unanswered within 15 minutes, she would attempt to call. If I didn’t answer 3 calls, she would contact law enforcement with the information she had.

While we thankfully never had to use the safety plan to its full extent, we did have a close call on a beautiful late August late afternoon where, after meeting someone in a rooming hotel on Main street, I carelessly put my phone, still on ‘silent mode’ after the interview, in the back pocket of my jeans and hopped on my bike for a long ride to a friend’s house across town. When I got to my friend’s about 30 minutes later, I saw that I had 4 missed calls and increasingly more frantic texts from Trina. I called and caught her just as she was about to reach out to law enforcement.

Interlocutors

Table 1 describes the demographic information gathered on people I talked to for the series of interviews with sex workers (which includes people with experience in the sex trade). I conducted 39 interviews with transgender and cisgender women and non-binary people, over 18 years old who had current or experience in sex work. The interviews addressed their utilization of health and social services, the strategies that they use to navigate the system and their experiences of discrimination and whorephobia in Winnipeg and Manitoba.

I invited every sex worker and experiential person I interviewed to fill out a demographic information sheet and 37 people filled it out. The average age of my interlocutors was 36 years old and ranged from 20 to 55 years old. When asked to identify their race or ethnicity, 52% indicated that they were Indigenous (Aboriginal or Metis), and 17% that they were White (See Table 1 for details).

Table 1: Self-identified race or ethnicity of respondents

Self-Identified Race or Ethnicity	Number of respondents	%
Aboriginal/Native/Neechi, etc.	12	35
Metis	6	17
White/Caucasian	6	17
Mixed Origins (“a mixture”, “Mixed White and Asian)	5	14
Canadian	1	3
No answer	5	14

About 40% identified as heterosexual while the rest identified as bisexual (23%), pansexual (13%), asexual (5%), gay/lesbian/homosexual (5%), or other (8%). Table 2 presents the locations where the people I interviewed reported meeting their clients.

Table 2: Location where respondents meet their clients

Location	Number of respondents
Street	21
Bar	14
Massage parlour	5
Online- websites to set up in person meeting with sexual contact	14
Online- websites to interact online only	7
Online- social media	9
Exotic dancing club	2
No answer/prefers not to say	2
Other: (escorting, referrals from other workers, "wherever they want")	3

"Hard to reach" and hard to represent?

According to public health scientists, sex workers are a notoriously "hard to reach population" (Abrams 2010; Benoit et al. 2005) because of the considerable stigma surrounding their work, and its partial or complete criminalization. There is a lack of consensus in sex work research regarding what the sample population involved in the sex trade represents depending on the primary positions underpinning the relationship between inequality and sex work, with some considering only women as the main

population (Benoit, Smith, Jansson, Healey, et al. 2019a). As mentioned earlier, I defined the research population as cisgender and transgender women and non-binary people who are currently involved or have experience in the sex trade. I spent years building relationships and trust with different members of the sex work community, through my work as an ally to sex workers and with SWWAC. Considering the characteristically wide divide between feminists, activists and others regarding the level of agency of people involved in the sex trade, seeking to build working relationships with people who provide services in agencies that envision any involvement in the sex trade as violence proved to be an interesting challenge. My involvement with SWWAC and my belief in the evidence documenting the diversity of experiences in the sex trade was impossible to conceal, should I have ever wanted to do so. Through networking and candid conversations, I created relationships with different individuals in such organizations and I am very thankful to them for their willingness to have sometimes difficult honest conversations with me.

Document research

In addition to local, national and international academic and activist literature, my time was spent pouring over websites, reports and other documents coming from local and provincial agencies working with or for people involved in the sex trade. During my interviews with sex workers, and even more so with 'chosen social actors', I invited my interlocutors to point me in the direction of relevant documents from the past 3 decades. I read and analysed the dozens of documents I gathered to look at the

evolution of language used to describe the sex trade and those involved in it, and how it might signal underpinning perspectives regarding “the prostitution problem”.

Data Analysis

The interviews were transcribed by me, and a substantial portion was contracted out to a transcribing agency and an individual. As a precaution, they were asked to sign non-disclosure agreements to protect the information shared in the interviews. The transcripts were entered in qualitative data analysis software TAMS for thematic analysis. After careful reading and line-by-line analysis, core themes were identified regarding, among other things, my interlocutors’ experience with health and social services, the strategies they use to take care of their needs, their experiences with stigma in different agencies, what they think service providers should know, the history of certain agencies and programs, the use of terms like “sex worker”, “sexual exploitation” and “human trafficking”. The data analysis was conducted twice on all the interviews with chosen social actors and sex workers and experiential persons. The data coming from ethnographic fieldwork was used to validate and contrast with the interview data. The data coming from document research was used to provide context to the broader study results and the experiences described by my interlocutors. The analysis was conducted by the same researcher, me, and this increases the risk of confirmation bias. In ethnographical research that uses inductive, interactive and recursive data collection to construct its analysis, the triangulation of different datasets – such as field notes and interview transcripts— aims to limit confirmation bias

(LeCompte et Schensul 1999). Additionally, the critical reflexivity, and the active description of the social and political situatedness of the knowledge produced in interactions between researchers and participants is meant to provide enough context to alleviate the confirmation bias which is inherent to this type of methodology (Jacobs-Huey, 2002, Haraway, 1988).

Knowledge translation

Knowledge generated from this study will be returned to the participants and to the broader community through the development of a summary report, the results of which will distributed to the social and health services organizations who offer services to sex workers, and especially to organizations that supported or facilitated the interview process.

An open forum will be organized with the participating organizations to provide an opportunity for participants to further discuss the findings with health care providers. The forum will be open to the public so that participants can come without necessarily identifying themselves as having participated in the research.

Ethical Considerations

This research received ethical approval from the Research Ethics Board of the Faculty of Medicine of University of Manitoba (H2016:115 (HS19573)). The participants in the chosen social actors interview series were asked to sign a consent form (see Appendix 2 for the consent form for sex workers and Appendix 3 for the consent form for chosen social actors). As approved by the research ethic board the participants in the

sex worker and experiential persons interview series provided verbal consent only, to further protect their identity. I went through the consent form with all of them, answered their questions and asked for permission to record the interview. If and when they had stated that they agreed, I turned on the recorder and read out the consent statement to them and asked to the confirm verbally that they agreed, as well as gave them the chance to ask any other questions. Participants in all series were provided with contact information of the researcher, my co-supervisors and the University of Manitoba Research Ethics Board and a copy of the consent form. They were assured of the confidentiality and anonymity of the data collected. It was stated verbally and in the consent form that their participation or non-participation will in no way affect the services they may receive from any organizations.

My concern with the confidentiality and the safety of my interlocutors did not end with the completion of the formal consent process as mandated by the Research Ethics Board of the Faculty of Medicine of University of Manitoba. Winnipeg being a medium sized city, and my research being conducted in restrained social networks, it mattered greatly to me to take every possible precaution so that my interlocutors would not be identified. I was extremely careful with interview recordings, transcripts and ethnographic notes being always kept in secure locations to make sure that no one could have access to them. I have limited their sharing online to encrypted and entirely secure servers and email services. The quotations, narratives and ethnographic vignettes and descriptions in this thesis are assigned to pseudonyms and some of the demographic information that is shared has been changed slightly in order to further

protect people's identities in cases when some details or stories they shared could lead to their identification by services providers or other community members. For the same reasons, composites stories were used in some of the ethnographic vignettes and descriptions. This means that some demographic details, locations and stories described as being from one individual came from more than one of my interlocutors. Everything that is stated is accurate in that is was lived and described by interview participants or witnessed in the ethnographical work, but it is assigned to a different person, or to a composite person. This methodology is used regularly by ethnographers and other social scientists in situations where it is considered too risky to research participants in criminalized or stigmatized environment to be described in research.

My commitment to conducting ethnical and transparent research was central to the research process I undertook. In this sense, it is appropriate that I share the official complaint that was made against my research to the Research Ethics Board of the Faculty of Medicine of University of Manitoba during my data collection. It is also a window into the complicated sociopolitical and linguistic terrain in which the research was conducted.

Formal complaint about language

My phone rings as I sit in my living room making notes about the second interview I did the previous day. It's an unknown number. A few weeks into frenetic data collection, this is not unexpected. People I do not know have been calling most days to see if we can set up a time for an interview. I answer and the person on the line confirms that I am the researcher conducting the research. They then introduce themselves by their name and mention that they are a survivor of sexual exploitation and the sex industries. They are calling to let me

know that they are concerned with the wording of my research posters and about my research in general. While I listen, anxiously, they tell me that they feel I should not use the word “sex work” since it “does not exist” and that the whole industry is nothing but exploitation and violence. In their eyes, they tell me, my whole research is problematic and should not be allowed because it exploits vulnerable people.

I explain that I am seeking to speak with people who identify with the word “sex work” and “sex worker” and not exclusively with individuals who were victims of sexual exploitation and/or who define their whole experience in the sex trade as such. My interlocutor then mentions that I should use the expression “sex industry” instead of “sex trade” because “it is an industry that profits on vulnerable people”. I thank them for their suggestion and commit to changing the posters that can be changed as well as their descriptions online. I can feel that I am not addressing their underlying concerns regarding their perception of my research as unethical. As per the appropriate protocol, I invite them to reach out to the Research Ethics Board of the Faculty of Medicine of University of Manitoba to voice their concern and provide them with the relevant information about my research and to reach them. I thank the person for reaching out and I apologize for not being able to accommodate their request directly. I attempt to explain that their suggestion is outside the scope of my research focus and as I am talking, the line disconnects.

The person whose interaction is described in the Vignette 1 did indeed contact that Research Ethics Board of the Faculty of Medicine of University of Manitoba to place a complaint against my research project concerning the language I used. The Research Ethics Board concluded that the language I used was appropriate for the research I was conducting. I did update the language on the online description of the posters on various social media platforms after our interaction to add “sex industry” to honor their concern, which may have been shared by others.

Entrenchment of positionality and practice

My doctoral work is situated at the imagined border of global public health and (sociocultural) medical anthropology and I draw from both disciplines in my work. Anthropologists have long started the work of acknowledging the discipline's historically close association with colonization, white supremacy and the varied forms of oppression that accompanies it. Despite this, anthropology remains a discipline in North America that has been characterized as white public space (Brodkin et all 2011). A 2011 survey of American Anthropological Association members highlighted the racism still well alive in the hiring process, allocation of courses, importance given to the work and theoretical perspectives of scholars. Importantly, it also noted the shocking lack of importance given to the idea of race in its work and in its practices and consequently, its participation in mainstream forms of "race avoidance" by not seeing and reporting on racism.

Coming from a discipline deeply imbedded in the so-called "scientific" construction of the ideology surrounding race, both in creating biologizing and deeply racist distinctions between people, and subsequently working against those same social constructions (Audrey et al. 1998), I am deeply concerned with the ways in which the data I produce might inadvertently contribute to racism. Indeed, anthropologists have not only been crucial in colonial projects of all kinds, but they have also been instrumental in fighting against what some of their precursors have wrongfully established as "natural". As early as 1936, the ancestor to American Anthropology Association has declared race to be a "biological myth" and has taken a stand against racism (Audrey et al. 1998). The fact that anthropology is still seen as a "white public

space" almost decade shy of 100 years later is proof that race as a social reality needs to be considered in all anthropological endeavors.

Public health and what is now called global health is also deeply embedded in histories of racism and colonization. Closely relating to military invasions and occupation of different territories, public health in many cases shared the same "logic and grammar" as military strategy and practices of population management through the enactment of "networks of disciplinary structures, including a network of hygiene" (Anderson 2006, 46).

Anthropologists', and especially medical anthropologists', research intersects in many ways with the object of global health and global health research (Janes et Corbett 2009). Indeed, shared concerns and interests range from the study of popular health culture and local perceptions as a way to both critique and improve international public health, to the study of ethics, governance, and emergent forms of biological citizenship (Nichter 2008). The object of inquiry of the anthropology of global health is the ways in which "various assemblages of global, national, and subnational factors converge on a health issue, problem, or outcome in a particular local context"(Janes et Corbett 2009) and how they exists in local social arenas. Both disciplines have a pragmatic, theoretical, ethical and moral commitment to "the most vulnerable" (Janes et Corbett 2009). In Canada, that commitment is echoed in the long history of study of Indigenous populations by public health and the Canadian state. In the era of "indigenization" and the "decolonization of universities"—how do disciplines like medical anthropology and public health situate their work?

In Canada, the 2015 recommendations of the Truth and Reconciliation Commission have been followed by universities who claim to be indigenizing their organizations. Indeed, we have seen in Manitoba's two main universities, University of Winnipeg and University of Manitoba take several steps toward this. University of Winnipeg innovated in 2016 by making a course on Indigenous history and politics mandatory to all students (Klingbeil 2016). Both universities, as many others in Canada, have adopted statements that acknowledge the indigenous groups whose land the campuses are on and the history of colonial abuse and violence and it is now common to see speakers at the Faculty of Medicine acknowledge the original keepers of the lands before speaking. The calls to "indigenize the curriculum" are common and it was adopted in 2015 as a key strategic priority (UM Today 2015).

Indigenous scholars, activists and other community members continue to warn us that superficial initiatives that refrain from engaging with the violent past and current practices that universities enact on Indigenous peoples and other racialized peoples do nothing but reinforce the forces at play that we are supposed to be fighting against. As Zoe Todd aptly puts it: "We still live in a society deeply shaped by white supremacist settler colonial heteropatriarchal history and ideology" (Todd 2015) and this means white settlers still control most of the narrative. The Canadian professoriate remains overwhelmingly white (Abawi 2018), which means that initiatives that aim to challenge racism have to be accepted and enacted by white people. This puts racialized professors, students and staff at a disadvantage and even at risk of sanctions, formal or

not, when they challenge racism and ethical violations in academic institutions (see for example Ahmed 2019).

I think that is it important to situate and name the racism that is inherent to conducting research in a society steeped in white supremacist settler colonial heteropatriarchal histories and ideologies. This dynamic and these discussions have been present with me throughout my research process, my fieldwork and indeed the activism that I engage in. As a white settler studying a group of ethnically diverse group of people for which racism, and especially anti-Indigenous racism is a marked reality, I cannot pretend that my research is not influenced by white supremacy and colonialism. Declaring my positionality and clarifying my process is not meant to be an absolution from the processes at play here. My aim in doing so is to allow readers of all background and experiences to be able to situate the research process and my results in the complicated socio-political terrain that is research on sex work in so-called Canada.

In keeping with other disciplines such as women and gender studies, and following the lead of countless scholars of colour, I acknowledge the importance of critical reflexivity in research. This involves a consideration of how the positionality of the researcher, and the inherent power relations and contexts of research itself become an essential part of analyzing the knowledge generated from any research study. This not only acknowledges the agency and power of all actors, but it also *situates* the production of research knowledges in their social and political terrains (Jacobs-Huey, 2002, Haraway, 1988). Situating knowledges also aims to disrupt the power relationship between researcher and researched. In this sense, this scholarship also encourages

explicit documentation of the "micropolitics of research projects" (Conti et O'Neil 2007)(. However, it remains clear for any ethnographers that no amount of critical reflexivity can control the many interpretations and consequences that research work can have (Rose, 1997). As mentioned above, neither can it cancel out the possible reproduction of system of oppressions.

Situating my research

My experience of conducting research on a topic for which I am greatly invested in in other aspects of my life was guided by the reflections of generations of anthropologists and other researchers who have sought to not only produce knowledge but to leverage that knowledge to participate in processes of social change. The thoughts of Alex McClelland in what he defines as the role of the "critical researcher" (building on the work of Andrew Sayer(2009) resonate particularly with my approach (McClelland 2017). McClelland, who currently works with people living with HIV who are criminalized, highlights that a critical researcher must "undertake work that can be in the service of challenging oppression and injustice of marginalized and criminalized peoples" by paying attention to "to systems of oppression, and the resulting suffering of social actors, with the aim of making people contend with that suffering as an act supporting efforts toward forms of emancipation."(McClelland 2017). Importantly, he highlights how critically reflecting on the ways in which research practices can participate or create forms of violence is crucial.

Eva Vernooji (2017) has recently summarized the different types of positions that anthropologists working in global health take in relations to their interlocutors. She separates them into three positions that could be described as moving on a continuum that goes from revealing what is at stake for people who have little power to influence global health efforts, the most common interlocutors for anthropologists, to dialogue and participation in the development of social and biomedical interventions (for example Hardon and Moyer, 2014). While the third position reflects the work that I have conducted in my M.Sc. work and also the work of many contemporary anthropologists that I admire and identify with, the second position of "reflexive dialogue" is the one that better reflects my particular engagement with the sex working community and social and health services apparatus in Winnipeg. Indeed, while my involvement with SWWAC is significant, I have also made considerable efforts to engage with different actors involved in service provision, but also with women (trans and cis) involved in the sex trade who do not necessarily identify with SWWAC's politics and goals. My constant engagement with SWWAC's activities, for example by participating in the needs and assessment and subsequent development of a new Bad Date List system, but also some paid and activist collaborations with the NSWP and the Canadian Alliance for Sex Work Law Reform surely make me closer to the first position of 'subaltern alignment'.

Situating myself

As I trust my discussion to this point demonstrate, my doctoral research is highly affected by my particular position in the discourses and social practices that surround

sex work in Winnipeg, and my social position as a young francophone European settler on Treaty 1 territory, and as someone with no experience in sex work. My family has been in Canada for 12 generations and we have lived mostly in what is known as Québec. I have been attempting to act as an ally to sex workers and have spoken, written publicly and supported efforts arguing for the decriminalization of the sex trade in the last 6 years in Montreal and Winnipeg. I have been involved since 2014 with the one of the only Winnipeg-based advocacy group publicly supporting the full decriminalization of adult consensual sex work.

This undoubtedly shaped not only the development, organization and achievement of my research project, but also the way other social actors see me and how this project is received. I have engaged informally, worked with and interviewed agencies and individuals who completely disagree with my positions and who are outside of the networks I had initially established in the local sex working community.

Namely, I already collaborate with the advocacy group known as the Sex Workers of Winnipeg Action Coalition, (SWWAC, formerly known as the Winnipeg Working Group for Sex Workers Rights), a chapter of the Canadian Alliance for the Sex Work Law Reform. Formed by sex workers, front line and healthcare people, researchers and other individuals involved in the sex trade, this group and everyone involved in it has been an important part of my involvement in sex worker rights activism in the past 5 years.

In the contexts of this project, therefore, my positionality as a researcher is inseparable from my position as an activist. Sex work activism, like a lot of activism

around rights of marginalized and stigmatized groups of people, is very concerned with representation and who gets to speak for whom. In the case of sex workers, the long history of silencing and misrepresentation of their lives and words makes what is known as "identity politics" at the fore-front of all activities. The term "identity politics" is a complex concept often used in a derogatory synonym for feminism, anti-racism and anti-heterosexism (Bernstein 2005). For our purposes here, it can be broadly defined as a political practice of sociological analysis of the relationship between identity and politics as it relates to the organizations of power in political organization (Ibid). In the field of sex work activism, it translates into the expectation—if not demand— for people in public forums, private discussions and in social activities, to acknowledge what their personal experience is regarding sex work. As part of work done with SWWAC for the development of a new bad date list system, I accompanied two SWWAC members for a discussion and introduction in a local group of ex sex trade workers, or people wanting to or in process of stopping their involvement with the sex trade, mostly with experience working outdoors. The reasons for our presence there as to introduce SWWAC and the process of consultation done for the development of the Bad Date List. We introduced ourselves, SWWAC and the Winnipeg's Bad Date List and invited questions. The very first question was from a member of the group who asked what our personal experiences were with sex work. My colleagues stated their personal experience and experience with sex work. I followed by saying that I have never worked as a sex worker and that I am here, and involved in SWWAC, as an ally. There was a heavy silence when I stopped talking in which I considered, as I often did and do, how

my presence might be detrimental to SWWAC's goal of forming new relationships with this group. One of my colleagues from SWWAC broke the silence by saying that my work with SWWAC had been important and appreciated and that they thought I was "awesome". Essentially, in this moment, they vouched for me, for my politics and for my presence. In this instance, this seemed to satisfy our interlocutors and we proceeded with the meeting. Some version of this interaction is repeated in my interactions with community members, community groups, front line workers, sex workers rights activists, and anyone who has experience in the sex trade. I recognize and respect why this is important to my interlocutors and the sex working community and I never miss an opportunity to clarify what my involvement is. Some groups have internal policies against this type of behavior in what they describe as an attempt to respect the confidentiality of their members and to stop the mandatory identification of sex workers. It is done to respect the right of each individual to take the necessary measures to avoid the consequences of stigma and whorephobia in their lives. For others, knowing exactly who they are talking to is helpful in ascertaining how they can take what the person is saying

By the time I started the formal interviews for my research, SWWAC was well established as an advocacy group, and my involvement with them both facilitated and complicated the process of reaching out to participants for my research. Indeed, I considered it necessary to indicate to people I interviewed that I was involved with SWWAC in most cases, even though I knew that this may be a problem for some interviewees. As I will discuss in chapter three, SWWAC's positions and composition

was often criticized by other groups in Winnipeg. I assured all interviewees that my work with SWWAC was a part of my research but also that my research remained independent from SWWAC in many respects. Indeed, the interviews that I was conducting pertained to access and experiences with health and social services, and SWWAC does not deliver services.

A note on terminology

Unless otherwise noted, this section is greatly informed by the document *Language Matters* produced by *Stella, l'amie de Maimie*, the Montreal-based organization run by and for sex workers (Bruckert et al. 2013). Produced in 2013, this info sheet is part of a series of 5 by Stella with the collaboration of allies aiming to educate and mobilize communities around legal advocacy and decriminalization of sex work. It was developed after a meeting of sex workers rights activists in 2012 where they identified the importance of the need to "encourage a conversation about language" that "promotes a common goal for sex workers rights while simultaneously representing [their] diversity". The document also states that it intends to "help non-sex workers– who are often contacted by media and lawmakers – think about the impact of their language". Recently, Vancouver-based PACE Society which has been working by, with and for sex workers for the last 25 years published a Media Toolkit for sex workers, journalists and allies to support more positive and respectful interactions between sex workers and the media (PACE Society 2019b). Both documents mention that language varies greatly depending on who is being addressed. Stella's info sheet states that

"Within sex working communities, we honour the language each of us uses to self-identify. We may, however, publicly or strategically chose other language to describe ourselves, because language can also divide and support public misconceptions of sex workers." It goes on to define and discuss these terms, some of which have been addressed in the last chapter and some of which will be further examined in this chapter: abolitionists, adult sex work, youth sex work, and commercial sexual exploitation of youth, consensual or forced sex work, racialized sex workers, including indigenous sex workers, johns and clients, pimps, predators perpetrators, aggressors and bad clients, prostitutes, sex worker and sex professional, prostituted women, survival sex work/sex workers, third parties, victim, vulnerable or marginalized sex workers.

The sex trade is defined for our purposes as including all individuals and locations where sexual services are exchanged for money, shelter, protection or goods, in alignment with the definition commonly used in international research on sex work (Kempadoo, 2003, Canadian Public Health Association 2014; Sex Workers of Winnipeg Action Coalition n.d.; Winnipeg Regional Health Authority 2016; World Health Organization 2002). While the term "sex work" is more acceptable to defenders of sex workers rights, and the expression "prostitution"[10] is used in legal and prohibitionist discourses, the term "sex trade" is usually seen as being acceptable to all interlocutors (Bruckert et al. 2013). My observations in Winnipeg also identified that the terms "sex trade" and "sex trade worker" were used more commonly than "sex worker", even by

[10] "Prostitution" will be used from now on when referring to ideas discussed in media or legal forums.

individuals and agencies that held very different positions on whether the sex trade is inherently exploitative or not. For this reason, I use the term "sex trade" (as opposed to "sex industry") in this thesis as a neutral term and "sex work" to signal positions that explicitly recognize the labour rights of people involved in this industry. The expressions "women and non-binary people involved in the sex trade" or "sex workers" will be employed because of their acceptable use for the main interested party in this issue: the sex workers themselves. The perspective that underlies these terms is more directly aligned with labor analytical lenses that is used publicly by women, non-binary people and men currently involved in the sex trade (Bruckert et al. 2013). As someone who has no lived experience in the sex trade and who seeks to support sex workers' rights, it matters greatly that I use language that respects sex worker's rights to self-identify as individuals and as a movement.

Positions often defended by some feminists are regrouped under the term prohibitionist or "abolitionist" [11] to refer to their belief that "prostitution is inherently exploitative, violent and akin to slavery" and thus "seek to eliminate prostitution through various regulations and prohibitions including a legislative model they call 'end demand'" (Bruckert et al. 2013). The proponents of this position describe themselves as "abolitionists" in reference to the 18th and 19th century movements to abolish slavery. However, many sex workers, especially sex workers of color, find the reference to the abolition of slavery offensive and inaccurate in its application to sex

[11] Other terms used to describe this position by people holding it include radical feminists, fundamentalist feminists or second wave feminists. Sex workers often used the terms prohibitionist feminists, anti-sex work or anti-sex worker's rights feminists to describe them.

work because sex workers do not see their work as akin to slavery but also argue that using this term minimizes and trivializes the experiences of those who have and do endure slavery (Bruckert et al. 2013; Maynard 2010, 2012). Accordingly, in this thesis, the term "prohibitionist" refers to a theoretical framework, a social movement and organizations that seeks to abolish all forms of prostitution. In this perspective, all forms of prostitution are inherently and exclusively exploitative, violent and akin to slavery.

The analysis of the sex trade in terms of labor and human rights is different from prohibitionist or "abolitionist" analysis in many ways. Perhaps most importantly, it does not consider the consensual selling of sex as a problem that needs to be acted upon. Indeed, the considerations of the sex trade can be conceptualized along a continuum from a perspective that considers it as pure exploitation of women's bodies[12] by men to one that sees it as purely a monetary exchange of sexual services for money or a compensation.

Sexual exploitation, in its legal definition, occurs when this exchange is not based on mutually informed and transparent consent, or that one of the individuals involved in the transaction has not reached 18 years of age (Canadian Public Health Association 2014). Sexual exploitation, in literature other than this manuscript, also describes all exchange of sex or sexual intimacy for compensation, generally by individuals and groups morally and politically opposed to the very existence of the sex trade who

[12] Although there are men and non-binary peoples involved in the sex trade, they are rarely the main focus of scholars and activists adopting prohibitionist perspectives.

subscribe to the position that the sex industry is inherently exploitative (Hunt 2015; Jackson et al. 2017).

The term human trafficking refers to a distinct set of laws that relate to an individual being forcibly moved, sometimes across border for the purpose of forced labor and/or sexual exploitation (Kaye 2017). While there is ever-growing attention and resources devoted to fighting this phenomenon, the estimations regarding how many people are affected by it remain acrimoniously debated (Hunt 2015; Maynard 2015). Finally, the term "experiential" refers to a person who has current or past experience selling or trading sex.

In this thesis, I will use the relatively neutral terms – given their focus on description – of "sex trade" and "people selling or trading sex or sexualized intimacy" to describe everyone in the sex trade and reserve "sex workers" to individuals or groups that claim this as an identity. Given the debated and deliberated nature of the identity categories described, differentiating them matters greatly. The term "prostitution" is in use in legal documents and will thus be used in this thesis to refer to legal matters or when quoting such sources.

CHAPTER 2

HISTORIES OF SOCIAL AND LEGAL MANAGEMENT OF SEX WORK IN WINNIPEG AND CANADA

The social and legal management of the sex trade and those involved in it goes beyond the restriction of bodies to certain physical and social locations and involves a wide array of complex social mechanisms informed by and feeding into wider systems of oppression. The language surrounding the sex trade is hotly debated, and much deliberation, affect and political will is invested in the different labels being brandished by all sides. Why is the management of the sex trade invoking such intense reactions? How do the tensions between opposing representations of people involved in the sex trade relate to the development of social and legal regulatory strategies? How have the discussions surrounding the sex trade included considerations for the safety, health, well-being and rights of the people directly involved in it?

With these questions as a starting point, this chapter provides an overview of the recent Canadian history of the policies and programs surrounding the management of the sex trade, from the beginning of the 20th century leading to the enactment of Bill C-36, and the 2014 passing of the new prostitution laws known as the Protection of Communities and Exploited Persons Act (PCEPA). Special attention is given to the history of programs in the Prairies and in Manitoba and the specific tensions that emerge from this local context. This chapter also looks at the changes and continuity in the different

policies, programs and legal frameworks surrounding the sex trade industry in relation to the safety and health outcomes of the persons involved in selling sex.

This chapter is based on document reviews of secondary source materials such as academic texts, edited collections, grey literature including positions statements from government sources, professional associations and other agencies. It also draws on the websites and publications of various Winnipeg-based agencies. Additionally, I rely on my own ethnographic research over the last 5 years to portray the general political climate and to highlight the ways in which a constellation of policies and programs play out in public life.

This chapter makes three main points. First, it argues that the policies and laws that are made around prostitution are often based on the idea that it is a social problem that needs to be intervened upon before other considerations around the health and safety endured by people involved in the sex trade. Secondly, it seeks to show that while the language used has greatly evolved, there seems to be continuity in the "spirit" of the approach underlying the law that was recently passed in Canada and the social purity movements animated in the 1920's. Indeed, the same moralistic undertones and assumptions that animated these movements continue to transpire in the policies and laws that are currently enacted in Canada. Lastly, it argues that policies, programs and laws should focus on approaches that prioritize the health and well-being of sex workers, *on their own terms*. One of the ways towards achieving this is complete decriminalization of the sex trade. This will be explored through a brief overview of the development of the sex workers right movement in Canada.

Policies, programmes and laws in historical context

On December 6, 2014, the PCEPA came into effect in Canada, introducing a system of asymmetrical criminalization of the sex trade with the intention of targeting clients and third parties (Government of Canada, House Parliament Bill C-36). Less than a year before, on December 20, 2013, the Supreme Court of Canada unanimously struck down three articles related to the federal laws regarding prostitution, thus, in effect, invalidating the country's prostitution legal framework and giving the government 12 months to write new legislation (Attorney General v. Bedford, 2013, SCC 72). This decision, known as Canada v. Bedford, (2013, SCC 72), has brought increased national scrutiny on our collective responsibility and accountability to individuals of all genders involved in the sex trade. The subsequent process of passing into law of Bill C-36, tabled in June 2014 by the Conservative federal government, gave light to the first sustained discussion of the sex trade in Canada since the 1970's.

The next section will consider the social construction of the sex trade as a social problem and of sex workers as a group supposedly needing help or governance.

The problem of sex work

Anthropologist Laura Agustin's work provides some answers to this question in her ground-breaking 2007 book focusing on migration and sex work of poor immigrant women from the Global South in Northern countries. She exposes how the figure of the "prostitute" is socially constructed as individuals considered "needy and unable to help themselves" (2007: 105). Interestingly, she relates the emergence of this social

construction to the development of the European bourgeoisie in the 18th-19th centuries, and to the charity work of women from that social class. This period saw the crystallization of the idea that the nuclear family is the "natural" basic element of human organization, and of women's role in the domestic sphere as equally "natural".

> *With the identification of families as virtuous and normal, large numbers of people were discursively converted into social misfits: people without proper places in a domestic structure. Not only flagrant beggars, homeless children and criminals, but people who spent too much time in taverns, who gambled, who bought meals outside the home, who weren't' interested in marriage and who liked to dawdle in the streets: all were peered at through a lens that sought to know why they did these things and how they could be prevented. Non-conforming individuals, those outside the hearth, were seen as threats to normal society who had to be steered toward a right way of life, cared for, protected from their erring ways. This meant setting up machinery of social control that included investigation, surveillance, codes of dress and behavior, definition of acceptable pastimes and vocations as well as techniques for classifying and recording the information collected. (…) The discourses of problem groups necessitated the creation of jobs for those who would carry out the projects. 'Prostitutes', once viewed as miscreants who assaulted men in the street and offended good taste, were now seen as pathological, capable of contaminating good citizens and needing to be controlled. (Agustín 2007, 122)*

This role was strictly defined and the association of their sexuality with morality and chastity became very important during this period. Women whose behavior did not fall within the tight strictures of this definition were constructed as deviant and theirs lives were seen as lacking control or as even threatening the social order. This led to a wave of interventions that aimed to save these women and more broadly to preserve the moral fabric of society.

Deborah R. Brock (1998) offers a similar, if more pragmatic, analysis of the most recent reconfiguration of prostitution as a social problem in Canadian society starting

after the Second World War. In reaction to movements for social and sexual liberation, the Canadian state is described as having adopted a stricter approach to regulating "the sexual". "Prostitution" was one of the matters relating to gender and sexuality that became seen as a prominent social issue, along with abortion rights, homosexuality and pornography (1998:5). This was accompanied by challenges to the established boundaries and moral codes surrounding sexuality such as movements against rape, incest and intimate partner violence. All of this contributed to defining issues relating to sexuality as contested political issues. "Prostitution", in this context, was defined as a social problem that needed to be controlled and "prostitutes" as a deviant group that needed to be contained both spatially and socially. With the exception of the period between December 2013 and 2014, this control was enacted by the factual criminalization of the sex trade and of (some of) its participants. Brock defends the position that the law, in its application, is not gender-neutral, nor does it seek to eradicate the sex trade, but rather to control it and to contain its participants to certain social positions. Brock's main argument is that not only do social problems emerge within very specific social and political contexts, but that the regulations, legal or otherwise, that are put together in reaction to this problem can in fact perpetuate that which is being regulated. The policies, laws, and media coverage act together to create a setting in which sex workers are perceived as sexual objects and deviants, which contributes to reinforcing the social context that feeds the violence and the oppressions they face. Finally, she highlights how the concerns of "average citizens" is heard and considered more extensively – if not exclusively – when designing policies and laws and

informing the media depictions of people in the sex trade. This reinforces the notion that sex worker exist separately from the "general population". This also creates a situation where the voices of sex workers – their experiences and realities – are not considered when creating policies and regulations that directly concern them.

This brief overview of the social construction of the sex trade as a social problem to be fixed, and of sex workers as themselves needy and powerless, is useful when examining the current discussions in feminist forums and their consequences in Treaty One territory on policies and practices. While it remains difficult to categorize all the existing positions in the co-called debate about "prostitution", the main point of contention is around the agency (in this case the ability to make decisions) of the people involved in the sex trade. Benoit and colleagues recently summarized the two primary perspectives underpinning academic thinking about the relationship between inequality and prostitution (Benoit, Smith, Jansson, Healey, et al. 2019b) as: 1) prostitution as an institution of hierarchical gender relations that legitimizes the commercial sexual exploitation of women by men (Farley 2004; Government of Manitoba s. d.; Miriam 2005) and 2) prostitution as a form of exploited labour where multiple forms of social inequalities intersect (Constable 2009; van Der Meulen 2011; Kotiswaran 2011; Nussbaum 1998; Van Der Meulen 2012). Both perspectives are concerned about inequality affecting people in the sex trade but their difference in understanding lead to different assumptions about people involved in the sex industry, and the necessary policies to improve their well-being (Benoit, Smith, Jansson, Healey, et al. 2019b). The first perspective tends to focus on "changing individual behavior, particularly male

behavior" using methods like the imposition of criminal laws, shaming campaigns and other repressive measures. On the other hand, the second perspective focuses on the "empowerment of sex workers" and is characterized by a strong focus on occupational and other social rights, increasing social inclusion with the underlying assumption that "the core issue is global capitalism and neoliberal stat policies structures on gender, class and racial inequalities" intersecting with sex work (Benoit, Smith, Jansson, Healey, et al. 2019, 1906).

As mentioned above, at opposite ends of the continuum of positions regarding the policy possibilities are two poles: firstly there is the position in which prostitution is seen as needing to be prohibited in its entirety, often referred to as "abolitionist"[13] or prohibitionists; and secondly there are those that emphasize the human rights of people currently involved in the sex trade, sometimes known as the "sex workers rights" position (van der Meulen et al (Eds), 2013). One of contrasting characteristics between the two poles of this continuum is that prohibitionist perspectives envision prostitution as a social problem and as a reality that needs to be acted upon. More precisely, it envisions sex workers as a group of people who "need" to be acted upon, and their industry as a social problem that needs to be *solved* (Corriveau (2013) in Parent et al (Eds), 2013).

Men, women and non-binary peoples who have lived experiences in the sex trade (whether publicly acknowledged or not) are certainly involved in the discussions

[13] The word "prohibitionist" (or anti-sex work or anti-sex workers' rights feminists) is used by many sex workers to highlight the support of these positions for the use of criminal laws to prohibit behaviours seen as immoral or dangerous to society (Bruckert et al, 2013).

that inform the development or regulations around the sex trade. However, their voices are often dismissed, ignored and erased from the forums where policies, programs and laws are designed. Indeed, the consultation process during the discussion of Bill C-36 (now PCEPA) provides a stellar example of this. Their purposeful exclusion both relates to and reinforces the idea that they are helpless, deviant, and individuals devoid of agency who cannot speak for themselves about their own experiences. As the next section reveals, this can also be seen in both the development and the content of Canadian policies, programs and laws on the sex trade.

Racism, social purity and sex trade in the Prairies and in Winnipeg

Winnipeg is a place where the spectacular seasonal contrasts in temperature – even by Canadian standards—are only rivaled by the contrasts between the poverty line of its neighborhoods (Silver 2016). Like the rest of Canada, it is built on lands stolen from Indigenous groups, in this case the Dene, Cree, Oji-Cree, and Anishinaabe peoples. It is also the heart of the birthplace of the Métis nation. Crowned in recent years as the "most racist" place in Canada (McDonald 2015), Winnipeg carries in the very organization of the city the legacy of waves of immigration and the circulation of marginalization and stigma to different groups (Levin, Gaskell, et Pollock 2007; Silver 2010). Certain historically poor neighborhoods like North Point Douglas, have been welcoming subsequent waves of newcomers since the establishment of Winnipeg. These populations are often marginalized by mainstream society, and these neighborhoods have been heavily associated in the collective imaginary with vice,

disease, drug use and sex work since the very establishment of the city. From the charity projects of social purity reformers in 1910-1920 aimed at "raising the moral tone" of Canadian society—by intervening on urban industrial working class—(Gray, 1974; Valverde, 1991:17), the high prevalence of outbreaks of infectious diseases like typhoid, cholera, smallpox and influenza in the late nineteen and early twentieth century (Jones 2007)—and their associated anti-immigrant backlashes—, and the ever-changing, complex and persistent nature of poverty that is disproportionately spatially concentrated in the inner city of Winnipeg (Silver 2016), the association is perpetually created and reinforced. The North End of Winnipeg's population of Eastern European descent changed in the decades following World War II when Indigenous peoples, namely Ojibwe and Cree families and individuals moved there, attracted by the most affordable housing to accommodate limited budgets (Silver 2010). Persistent reports regarding the violence that occurs there, but also in other central neighborhoods, contribute to creating a divided city where white suburbanites aren't shy to declare how scared they are of the inner city (Silver 2010), with various degrees of veiled racism. To choose one of an endless series of example coming from politics, Lorrie Steeves the wife of a Gord Steeves mayoral candidate in the 2014 elections was caught in a scandal over a social media post in which she had complained about Indigenous men downtown as "drunken native guys […] harassing the honest people" by asking for money (Lambert 2014). This surfaced the same day that her husband made a campaign promise to crack down on public intoxication on downtown streets with increased police presence, thus clearly echoing the concerns, as well as the lack empathy and the ignorance—of many

Winnipeggers. This barely veiled racism also leaks through in policies and practice in public institutions and systems. On the other end, the documented association of sections of the sex trade with Missing and Murdered Indigenous Women and Girls, also creates situations where the entirety of the sex trade is reduced to exploitation and trafficking (Hodzic et Chrismas 2018), and everyone involved in the sex trade is portrayed as victims in need of rescue, to the detriment of consensual sex workers, and especially Indigenous sex workers (Hunt 2015; Maynard 2015).

Social purity movement of the 20th century

The interventions on the population living in the North End and other poorer neighborhoods in Winnipeg did not start when Indigenous individuals and families moved there after World War II there, nor did the surveillance and attempts at the management of the sex trade. Indeed, the social purity crusades that swept Britain and North America in the first two decades of the twentieth century established prostitution as a "social evil" and a core issue for the social reformers of that period (Lowman, 2001).

In her foundational work on the social purity movements, Mariana Valverde (1991) describes the ways in which the emerging Canadian nationalism of that period gave birth to a class of people who wished to "raise the moral tone" of Canadian society (ibid:17). By that point, English Canada had established some form of cultural consensus, partly in opposition to Britain and the United States and partly by importing some ideas directly from these two countries. This identity very much focused on white Anglo-Saxon identity, based on the total erasure of Indigenous populations and of

linguistic and ethnic minorities. Valverde also argues that an important component of those nation-building efforts was the development of an emerging urban-industrial working class, and an urban bourgeoisie who initiated a philanthropic project to reform Canadian society mostly through interventions aimed at the first group. Valverde in turn makes the argument that, not unlike what was described by Agustin in Europe in the 18-19th century, this philanthropic project shaped and helped establish the bourgeoisie as a social class. While professionals and charity workers who acted to uphold the specific interests and perspectives of their professions mostly enacted the project, they were also connected to the larger bourgeois culture of which they formed part. In many ways, the movement, at least in its interest in prostitution, was "putatively about prostitution"; however, it was much more about relationship between women and men in general and specifically between middle-class and upper-class women and men specifically (Ball, 2012). This project was driven by a large number of educated Canadians who were interested in building the foundations for what they thought could be a "future of prosperity and relative equality" (Valverde, 1991: 17). That was to be enacted through solving the "problems" of poverty, crime and vice with social campaigns. In the social purity reformative project, prostitution was seen as the most important social problem that unified all its diverse constituencies (feminists, right-wing evangelicals, doctors, social reformers) and "sex hygiene" was the main remedies promoted.

The decades that preceded the onset of the social purity crusades were relatively lenient in their tolerance of prostitution in Canada. The criminalization of prostitution

focused on boisterous public solicitation and "disorderly" public behaviour and not prostitution itself (Shaver, 1994; Ball, 2012). Famed Manitoba-born journalist and social historian James Henry Gray provides a vivid and engaging description of the early development of the sex trade in the Canadian Prairies in his 1974 book, aptly named: "Red Light on the Prairies". Gray chronicles how, in the Prairies, as in other places where there was a large surplus male population who were providing "important social functions", prostitution was tolerated and managed only when there was public concern or outrage (Gray 1974). "Nothing compared to the great mass migration into western Canada during the first decades of the twentieth century ever happened anywhere in the world before" (15), he writes in the introduction of the book. He goes on to describe how the combined efforts of "government, railways, and free-lance land agents" lured over a million people to the three Canadian prairie provinces (ibid).

> *Their coming ushered in the bawdiest, brawlingest, drunkenest and back-breakingest era in the prairie history. It was also the most puritanical, law-abiding, Sabbatarian, and pietistic. It was an era in which the forces of self-righteousness head-on with the entrenched forces of prostitution. (15)*

While he notes the importance of the sudden population influx, he also highlights the role of "wide-open boozing and housing congestion", and that "Prostitution as a psychological functional necessity and recreational facility had existed since the earliest days of the fur trade." (27). In those moments, prostitution was portrayed as being a threat to "respectable" members of society, and the criminalization and social interventions were always targeted at the settler and Indigenous women selling sexual services (Gray 1974). At the turn of the 20th century, the bourgeoisie of

the city of Winnipeg were in a very hopeful and ambitious period where it considered the future with optimism. In an effort to control the then very common phenomenon of women selling sex, a red-light district was opened in North Point Douglas, in plain sight and with the tacit consent of political and police forces. The sex trade was infiltrating too many "respectable" neighbourhoods in the city and police raids and various techniques— including "stool pigeons who would visit the prostitutes, pay them with marked money and testify in court" (Gray 1974: 59). When shutting down one brothel only led to another one popping up elsewhere, it was decided, with the blessing of the board of commissioners and under the leadership of the Chief of police, John McRae, that containing it to one section of the city would be the best. From 1909 to 1914, over 50 brothels were then opened and maintained by a small group of madams on Anabella Street in Point Douglas. However, it was shut down in 1914 after an aggressive campaign from Church-based organizations that had a growing influence on the city's political life. Their campaign was in many ways a shining example of social purity ideology—motivated by the desire to embellish Winnipeg's moral tone and establish "pure" foundations for the city's future (Gray 1974). The periodic surge of contestation against sex work in the Prairies were in many ways "temporary diversions from the great prohibition crusade" (217). In the following years, the brothels opened in different neighbourhoods of the city, mainly in the North End and the West End.

Canadian prostitution laws

Canada's laws have grown increasingly punitive in their legal approach to "manage" what is perceived as the "prostitution problem" (Benoit, Smith, Jansson, Healey, et al. 2019b). Indeed, despite the government assertion—reflected in the very name of the Protection of Communities and Exploited Persons Act (PCEPA) –the laws passed in 2014—that they aimed to protect vulnerable people involved in prostitution, early results indicate that the PCEPA does not make things safer (Benoit, Smith, Jansson, Magnus, et al. 2019; Krüsi et al. 2016) and that it might even make them more dangerous for some workers (Machat et al. 2019). The PCEPA makes it possible for sex workers to provide services at fixed indoors locations, communicate with others for the purpose of offering or providing sexual services for consideration as long as this communication does not occur in a public space that is next to school ground, playground, or day care-centre; advertise their own sexual services and pay for services with profits from the sale of their own sexual services (accounting, security, drivers, etc.) if the compensation is proportionate to the service rendered (Department of Justice 2014).

From the perspective of sex workers' rights advocates, this Bill and its adoption into law was an extremely difficult and problematic process. The government held consultations while the Bill was being drafted and, while the consultations they held were confidential, no known sex workers organizations were invited to participate (Canadian Alliance for Sex Work Law Reform, personal communication). This was only the beginning of sex workers voices being silenced and ignored during this process

(Sayers 2015). The parliamentary hearings and other relevant consultation welcomed a much larger proportion of faith-based conservative organizations and their affiliate than they did sex workers rights advocates, sex workers and academics (Canadian Alliance for Sex Work Law Reform, 2014). As an example of the disrespectful treatment of sex workers voices and experiences, the now famous answer of Manitoba Senator Don Plett during the Senate Committee on Legal and Constitutional Affairs hearing regarding Bill C-36 comes to mind (see figure 3). In answering the concerns raised by two speakers— who were sex workers rights advocates— that Bill C-36 would further endanger sex workers and would not, as it was presented, make life safer for sex workers, he stated "Of course, we don't want to make life safe for prostitutes, we want to do away with prostitution. That's the intent of the Bill." (Nikiforuk 2014). Although this moment is widely seen by the opposition to Bill C-36 as confirming that the intent of the law was not about protecting people in the sex trade as it was presented, but about "ending demand", this abrupt statement of the government's desire to "do away with prostitution", in response to sex worker's rights activists was received as a chilling moment for sex workers and their allies.

Figure 1: Screen capture from video of Senator Plett while making statement described above.

In addition, the government held a public consultation in the form of an online survey, again giving priority to the "general public" over the voices of sex workers. While this law is saluted by many organizations and individuals who identify as "abolitionists", many have also agreed early on in the process with sex workers rights advocates who assert that sections of this law will continue to criminalize women and men selling sex (namely the section that criminalizes solicitation in a public space when individuals who are 18 years old and younger could be present)(Porth in Bruckert, Van der Meulen, and Durisin 2018, 317-328).

As presented in the background section, the new laws have had documented impacts of not only failing to protect sex workers from harm and violence, but of also

increasing some of the harms and the violence they face (Benoit et al. 2019; Machat et al. 2019). In terms of concrete implications of the prohibitionist perspectives on sex work, the new prostitution laws represent a prime example of the ways in which the regulation of social phenomenon constructed as problematic create some of the elements it claims to address. While claiming to "protect" vulnerable populations, the new laws actually create a climate in which selling sex will have to be done in secret to avoid the prosecution of part of the transaction.

Canadian sex worker rights movement

A handful of events are usually invoked when describing the beginnings of the contemporary, sex worker rights movement as it is known in the global North. The first one is the 1966 Compton Cafeteria Riot that broke out in reaction to the police brutality and surveillance faced by sex workers and gender non-conforming people in San Francisco, led by transgender sex workers of color (Stryker et Silverman 2005). Similarly, the famous Stonewall Riot of 1969— often hailed as the beginning of what is now the contemporary north American 2SLGBTQII+ movements, were also led by trans sex workers of color, most famous among them are Marsha P. Johnson and Silvia Ray Rivera. Their involvement, as well as the fact that they were women involved in sex work is often obscured from mainstream 2SLGBTQII+ histories. In Europe, the 1975 occupation of Église St-Nizier in Lyon was part of the same movement of sex workers asking for theirs rights to work and live safely, and in peace, to be respected. Sex workers have been organizing themselves into community clinics, advocacy groups,

safety tips sharing groups, bad date lists, support networks and a panoply of other community-led resources ever since sex work has existed, of course, but the last 60 years have seen the development of advocacy groups all over the world (Bruckert et al. 2018; Kempadoo 2003b). These share certain values: being sex worker-led, responding to the needs and realities of sex workers themselves, disrupting public narratives that frame sex work as entirely coercive or harmful, sharing information with sex workers about 'safer' places to access healthcare services and legal support, organizing initiatives to connect sex workers with one another, build community, and facilitate collective support, working from an intersectional framework – acknowledging how race, citizenship status, gender, class, and ability impact sex workers diversely, working from a harm-reduction perspective – meeting sex workers where they are at and providing judgment free, safe, and secure locations for sex workers to meet and find support (SWWAC 2018).

In Canada, contemporary sex worker organizations started to come together to provide health and social services, advocacy and community in the 1980s (Scott 2019). The word "sex worker" was coined in the 1970s, as was mentioned earlier, as a deliberate attempt to rally together people working in a fields of the sex trade around their shared rights and experiences as workers (Leigh 1997). It was quickly picked up by sex working people globally and is now commonly used in academic and global health literature. With the renewed local and international focus on sex workers as a "risk group" for HIV/AIDS, and with the funding associated with prevention efforts, some organizations were able to set up formal clinics and centres (Kempadoo 2003b). New

sex workers projects are emerging all the time and it makes it difficult to know exactly how many exist, but the Canadian Alliance for Sex Work Law Reform[14] currently has 27 member groups that are all organizations les by sex workers or for sex workers rights (Canadian Alliance for Sex Work Law Reform 2017) and the Global Network of Sex Work Projects reports 46 members in North America and the Caribbean's only (NSWP s. d.).

Manitoba and the contemporary response to the sex trade

In Winnipeg, the contemporary sex trade that has been documented is oriented towards "survival sex" (referring to exchanging sexual services for basic living necessities such as food, shelter or drugs) and outdoor sex work, and focuses on exploited youth (Comack, 2010; RESOLVE, 2007; Derivière, 2005; Seshia, 2005, Seshia, 2010). While excellent programs exist in Winnipeg, their focus is consistent with perspectives that privilege supporting and encouraging the exit of sex workers from the sex industry; they largely use language that describe the sex trade as a form of sexual exploitation.

While many extensive services and prevention programs target street-involved and sexually exploited youth[15], only a few services are currently offered to adult male, female and transgender individuals involved in the sex trade in Winnipeg. In the next section I provide a concise overview of some of the key agencies and program that populate the landscape of interventions that target people selling sex.

[14] Which came together in 2014 to fight against Bill C-36 and to strengthen the political voice of sex workers at the federal level.

[15]for example Safe Transition Home, Youth Resource Centre, Marymound Treatment Program for Sexually Exploited Youth, Ndinawe, Resource Assistance for Youth (R.A.Y) or Transition, Education and Resources for Females (TERF).

Klinic Community Health. Just Care for Everyone

Klinic is a community health centre that was founded in the 1970s "through the grass roots efforts of a group of politically active people focused on social justice" and Klinic's website declares that their "social justice roots are as deep as ever" (Community Health 2015). The centre offers a wide range of health and social services including, drop-in clinics, specialized services for substance use, food and nutrition, sexual health, crisis, short and long term mental health support and services, and is home to Manitoba's first trans health clinic (Community Health 2015). It also hosts a support service project called Dream Catchers, providing "providing a safe and supportive place" for "women and transgender individuals transitioning from the sex trade" to start their "healing journey"(Klinic s. d.). They offer weekly confidential and private support groups focusing on supporting members in developing or reinforcing skills like managing overwhelming emotions, recognizing risky situations, setting boundaries, building healthy relationships. While Klinic does not have a position statement on sex work, it does have one on sexual exploitation that defines it as an exchange of money drugs, shelter and other necessities in exchange for sexual acts that "does not involve mutual informed and transparent consent, or the individual has not yet reached the age of majority" (Klinic's Social Justice Committee 2017, 1). This definition, while not acknowledging the existence of sex work directly, at least implies that some exchange of sexual services for compensations may be consensual. The same position statement also included the bold assertion that: "The practice of sex trafficking is interwoven into the fabric of the sex industry and may include cyber-bullying, prostitution, pornography,

and/or stripping." (2) The position statement goes on to cite as their reference the intensely contested and controversial Canadian Women's Foundation report "No More": Ending Sex Trafficking in Canada, A Report of the National task Force on Sex trafficking of Women and Girls in Canada", published in 2014. This report was later pulled by its publishing organization in order to "to avoid contributing to narratives that would further marginalize and criminalize women from communities we seek to support" (Canadian Women's Foundation 2017). Klinic, as will be discussed in chapter five, has a troubled history with defining sex work, sexual exploitation and human trafficking and relating to their patients and community members who may not share its views regarding the sex industry (Sheng et Chevrier 2019). In 2015, Klinic, through a partnership with the Joy Smith Foundation, also launched a human trafficking hotline, sometimes referred to as 'The Line' (CBC News 2015b). The launch coincided with the campaign "Buying Sex is Not a Sport", which claimed that large influx of sports fans around the Canadian Football League's Grey Cup would lead to increases in sexual exploitation and trafficking [16].

From Power to Sage House

One of the associated projects of Mount Carmel Clinic, under the authority of Winnipeg Health Regional Authority (WRHA), is Sage House. Sage House is a valued community resource that which operates a drop-in, health and outreach program for

[16] This is based on a widely debunked myth that large sporting events are the site of increased prostitution, sexual exploitation and sex trafficking. Research has shown that the only demonstrable increase is of policing of marginalized populations (Ham 2011).

"street-involved females and transgender persons", mostly in the North End neighbourhood (Mount Carmel, no date). They offer services to many cisgender and transgender women with current or past experience in the sex trade. In collaboration with Mount Carmel, Sage House and the Salvation Army, the annual S.N.O.W. night (Safe Night Off the Streets of Winnipeg) was organized until 2017 to offer women involved in the sex trade services and treats for one evening. Warm clothes, food, activities and esthetics services (manicures, hairdressing, etc.) are offered to women for one night every year (Salvation Army, 2012). Sage House has known many locations, services and approaches in its long history. Many of the chosen social actors I talked to had at some point worked at Sage House or one of its past incarnations. They told me that it started as POWER (Prostitutes and Other Women for Equal Rights), a community organization that began in the mid-1980, and was later placed under the authority of what is now known as the WRHA after the completion of a three-year feasibility pilot project.

Street Connections

Certain services that operate explicitly using a harm reduction perspective[17] do operate in Winnipeg. For example, the Winnipeg Regional Health Authority offers on-site and mobile services on-site such as access to safer drug use supplies and information, counselling and referral services and nursing services (pregnancy testing,

[17] Approach emerging from the chemical dependency field that is committed to reducing the adverse health, social and economic consequences of risky behaviours. The focus is not on eradication of the behaviours and instead prioritizes achievable goals in a pragmatic and value neutral way (International Harm Reduction Association, 2010)

testing for HIV, hepatitis, and STI, vaccination, help with tuberculosis) (Street Connections, 2014).

Our Place Safe Space

In 2015, the Daniel McIntyre and St. Matthews Community Association (DMSMCA) opened a weekly drop-in for "sex trade workers, experiential folks, victims/survivors of sexual exploitation or victims/survivors of human trafficking" (Daniel McIntyre St. Matthews Community Association s. d.) which explicitly states and takes measures to welcome people no matter their experience or views with and regarding in the sex trade, and people from all "ages, genders and Nations" (Daniel McIntyre St. Matthews Community Association s. d.).

Nine Circles Community Health Centre

Nine Circles Community Health Centre does not focus explicitly on sex workers or those involved in the sex trade, but "delivers comprehensive primary care, social support, education and prevention services" focusing on the "care and treatment of HIV, Hepatitis C and other sexually transmitted infections" (Nine Circles Community Health Centre 2019). This includes, of course, offering services to sex workers as a group that is identified as a population including individuals who may be at higher risks of contracting HIV and other STIs. Their strong and explicit belief that "everyone has the right to be treated with respect, be safe, and have their health information be kept private" is well known in the community. Nine Circles emerged from the 1996 Manitoba Health initiated amalgamation of four AIDS Services Organizations that had emerged in

the late 1980's to the early 1990's as a response to the HIV epidemic: Village Clinic, Kali Shiva AIDS Services, AIDS Shelter Coalition of Manitoba, Manitoba Aboriginal AIDS Task Force. In the later phase of the transition process, Kali Shiva removed itself from Nine Circles, electing to remain autonomous to better serve its original purpose, and later changed into Sunshine House (Kutcher, Olfert, et Schellenberg 1998).

Prostitution Diversion Program

Another program that offered until 2015 direct engagement with women in the sex trade is the Prostitution Diversion Program (PDP). It received funding and support from the Winnipeg Police services (WPS), the Manitoba Justice and the Salvation Army (Manitoba Family Services and Labor, no date). This program was defined as a "community based alternative measures program offered to women, men and transgender individuals who have been sexually exploited through prostitution and charged with *'Communicating For the Purpose of Prostitution'" and it offers them* "educational, therapeutic, and recreational components in a 3-days retreat outside of Winnipeg" (Manitoba Family Services and Labor, no date).[18] All of these programs use a framework that closely relies on prohibitionist approaches. This is coherent with the strategy outlined by the Manitoban government in Tracia's Trust: Manitoba's Sexual

[18] Anecdotal evidence coming from personal correspondence of the author with sex workers in the city show indicate experiences with the PDP. Although this seems to have changed now that the WPS cannot legally easily charge or threaten to charge women with criminal offenses, this program was known to « fill » its quota by arrest scoops the week before it was scheduled to happen. It should also be said that some of the women reported appreciating the program, or at least the time away from the city. Whether this program « diverts » women from prostitution is unclear because no evaluation or monitoring data are available.

Exploitation Strategy (Manitoba Family Services and Labor, no date) in which sexual exploitation includes "prostitution, pornography, sex trafficking, sex tourism and Internet luring". The PDP is often described as existing in tandem with the Prostitution Offender Program (POP) which has existed in some form for the past two decades in Manitoba. Commonly known as "John School", this program is offered through a partnership between the Salvation Army, the Winnipeg Police Service and Manitoba Justice. It is described "community-based, alternative measures program offered to males and females who have been arrested for "Communicating for the Purposes of Prostitution" as a consumer" (Government of Manitoba s. d.), and is aligned with the PCEPA's stated focus on people who buy sex.

Manitoba Strategy

The Manitoba strategy regarding sexual exploitation, known as Tracia's Trust since 2008, aims to stop sexual exploitation for people under 18 years old involved in the sex trade by coordinating initiatives in the areas of "prevention, intervention, legislation, coordination, research and evaluation" with different government departments and agencies (Government of Manitoba s. d.). Until January of 2019, it did not differentiate between people under and over 18 involved in the sex industry, defined "sexual exploitation" very broadly and refuted the possibility of adult women (and people of other genders) being voluntarily involved. However, the recent publication of a report that acknowledges the existence of a "continuum of choice" (Tracia's Trust: Manitoba's Strategy to Prevent Sexual Exploitation and Sex Trafficking,

2019: 65) and makes a distinction between youth and adults, has been a major transformation. While this might appear as a rather minor acknowledgement of the diversity of experiences that characterizes the sex trade, this inclusion is significant in the Manitoban context. SWWAC members and other sex workers rights activists and allies have made sustained efforts in the past five years to have private and public discussions with service providers, policy makers and journalists to raise awareness around the important distinction between sex work, sexual exploitation and human trafficking. While related, these three concepts refer to vastly different sets of experiences, and bodies of laws. According to a local rumor that circulated, the five lines making this distinction was one of the main causes behind the delay in the publication of the report, completed in 2016 (and published in 2019). Generally, still, the current programs and interventions in Manitoba surrounding the sex trade aim to eradicate all adult prostitution by "ending demand". While Manitoba has modified its approach to stop criminalizing sex workers in the last 7 years, it still portrays sex workers as helpless victims (describing all participants in the sex trade as "sexually exploited women" or "trafficking victims") and designs programs aimed at controlling and eradicating sex work.

Although different coalitions exist that include people with experience in the sex trade ("experiential women"), the voices of current sex workers and generally the voice of anyone who doesn't adhere strictly to the prohibitionist framework are silenced in the province of Manitoba. This silencing will be further illustrated in the discussion later in this chapter, but the amount of controversial inclusion of the slightest nuance

regarding the diversity of experiences, and identities existing in the sex industry attests to the contested local discursive field. This is probably what most clearly defines the continuity of the contemporary "response" to the sex trade to past approaches in the social purity movement—a continuity that imposes a regulatory regime on the sex trade marked by racism, classism and sexism. Current sex workers' experiences are not considered, and they are still constructed as deviants who need to be helped, willingly or not.

Winnipeg Police services

"Did he just say that sex workers don't exist?"

About 80 people sat in the brightly lit gymnasium of a community center in West Broadway, waiting for Danny Smythe, new Chief of Police of the Winnipeg Police Services (WPS) to start his presentation. Everyone ate steamy stew with bannock and chatted animatedly, over the noise of children and teenagers running around and laughing. The townhall was organized by the Daniel McIntyre St. Matthews Community Association at the request of some of their participants in their youth services who wanted to ask the WPS some questions. The Sex Workers of Winnipeg Action Coalition (SWWAC), along with other organizations, had been invited to submit some questions that would be asked by the facilitators. While the new Chief presented himself and his work for 45 minutes, I sat with a few SWWAC members, laughing at the exasperated looks of some colleagues at the length and tone of the introduction. After answering questions from other groups, we finally got to SWWAC's second question, regarding the position of the WPS regarding Canada's new prostitution laws and what they intend to do to make sure that all sex workers are safe. Danny went on to explain that the efforts of law enforcement are now focused on what he calls "exploiters" which he defined as people who buy sexual services. The facilitator then reassured Danny that the question related to people in the sex trade or in sex work and that he would be welcomed to use this language in this setting. Danny stated that he believes that "most of the people in that [sex trade] are being exploited in one way or another". He then added that he refers to them as "exploited persons, whether they be men, women or children". Looking at the person sitting next to me, it was obvious that they were as shocked as I was by this answer: he had basically denied the very existence of people describing their experience in sex work as work, in answer to a question from a group that has the words "sex worker" in their name. My colleague sat restlessly next to me until the end of the question session, and then proceeded to go introduce themselves to him and to ask for Danny to set up a meeting with SWWAC.

As described in the vignette above, the new chief of police Danny Smythe was invited in the fall of 2017 to a community townhall and SWWAC was invited to ask two questions (see figure 4). In SWWAC meetings and casual interactions, people who are in position of power are often referred to by their first name (or by nick names). While we have never officially named this or made it a policy, it is part of the organizational culture. I think of it as a subtle way to chip away at their authority and subvert the "forced" respect that official titles infuse in relationships. I will honour that by referring to the WPS chief as Danny for the rest of this chapter.

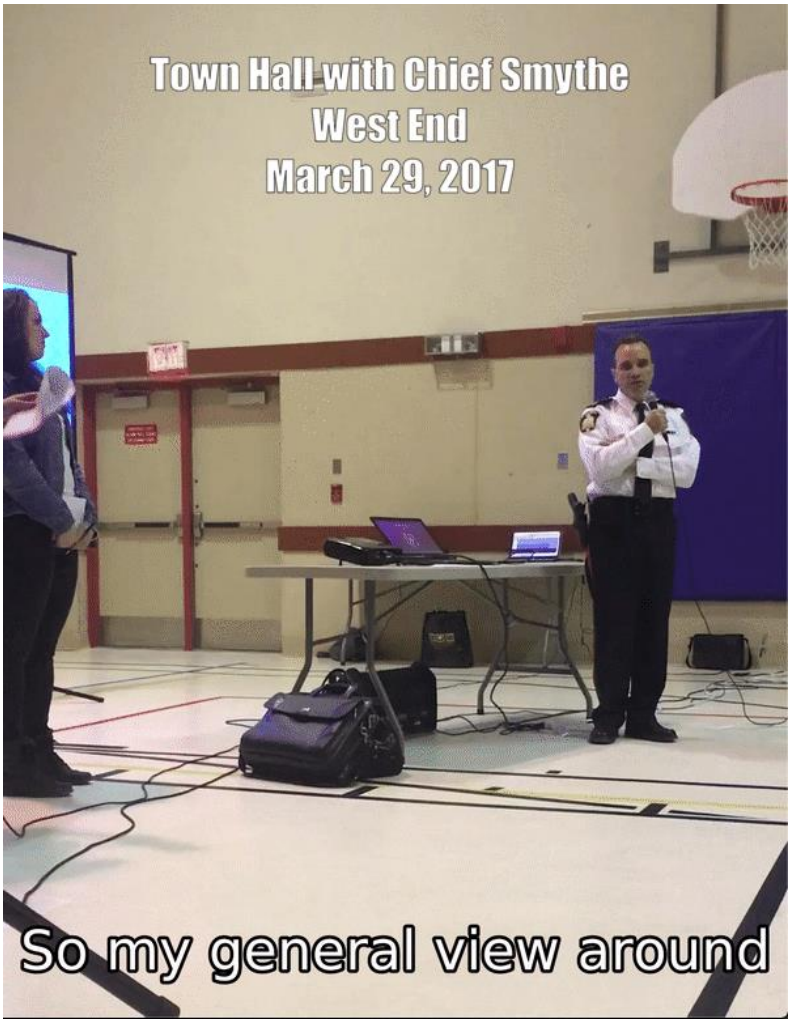


Figure 2: Still from video of Town Hall with Chief Smythe on March 29, 2017

Answering SWWAC's question on the position of the Winnipeg Police Services regarding Canada's prostitution laws and what they intend to do to make sure that all sex workers are safe, Danny made it clear that to him and to the WPS, everyone involved in the sex industry were exploited, even after the explicit invitation to consider the difference between consensual sex work and sexual exploitation. For SWWAC members who were present, that answer felt like a slap in the face. Although perhaps unsurprising coming from the Chief of Police, it remains an important example of the erasure of the experiences of sex workers and others who do not see their experience in the sex trade as exploitation. Indeed, Danny plainly stated that he doesn't think that sex workers exist. SWWAC eventually had a meeting with Danny and his colleagues, in which, among other things, SWWAC representatives made the point that refusing to use the words "sex worker" excludes people who identify with this word and portrays them as helpless victims or as ""victim-criminals" (Majic 2014a), which, in turn, reinforces stigma. Danny and his buddies made it clear that other groups had met with them to insist that they refer to the sex trade as sexual exploitation exclusively, and that they feared offending them more than they feared offending SWWAC. They were referring to different groups that are, or were at the time, closely associated with Manitoba's government strategy regarding sexual exploitation and human trafficking as well as powerful individuals who carry a lot of political weight.

Email from Counter Exploitation Unit

October 25 2016, 12:36 PM

Good day Claudyne,

My name is Andrew Smith and I am a Staff Sergeant with the Winnipeg Police Service, currently working in the Specialized Investigations Division.

Our investigations here in this Division cover Child Abuse, Sex Crimes, Missing Persons, Internet Child Exploitation, High Risk Offenders, Vulnerable Persons and Counter Exploitation among others. The focus for our Counter Exploitation Unit are issues concerning Sex Trade Workers and Human Trafficking. Sergeant Darryl Ramkissoon and Detective Sergeant Maria Koniuk are in charge of that unit and they have both been doing this work for many years.

With this in mind, after the Buying Sex is Not a Sport event at the Manitoba Legislature last Friday, Darryl Ramkisson heard an interview on CJOB radio where you were quoted in regards to this. He shared it with me and we were both intrigued by your perspective. After all, this is the work that Darryl and Maria specialize in.

We went online and found out a little more about your education/background and Darryl and I watched your TEDx Talk. We liked it.

So, bottom line, would you be interested in meeting Darryl, Maria and I so that we can find out a little more about each other? I think and hope you'll find us interesting, too.

Andrew Smith
Staff Sergeant
Specialized Investigations, Division 41
Winnipeg Police Service

I was on campus at the office of the Centre for Global Public Health when I received the email copied above from the Winnipeg Police Services. It's hard to describe the mix of emotions I felt when reading this email informing me that the Counter Exploitation Unit was "intrigued" by a perspective that I defended, and by my research. I remember how shocking it

was to me that, even though they might have heard it from me first, they could think that it was "my" perspective when the interview they referred to was done on behalf of SWWAC, a sex workers organization. Could this possibly be the first time they are hearing about the sex worker rights movement when this is the field— by their own description— that they specialize in? Their email both established their expertise in the field (a whole paragraph was devoted to listing the crimes they focus on) and seemed to list everything they could find about me online in a way that made me wonder if they were perhaps trying to intimidate me. It felt unsettling to me that a member of law enforcement wrote a very official email stating that he and a colleague looked me up online. The email stated that they were interested in my perspective, which seemed to be new to them. Of course, I do not know what their intentions were with this email.

In my work as a SWWAC member, and to speak about my research, I have done several local, provincial and national media interviews in the last 5 years. This has sometimes brought some attention on myself and on my research that I did not anticipate or plan for. One of these occasions is described in the vignette above entitled "Email from the Counter Exploitation Unit". Following this email, which focused on my research project on access to health and social services for local sex workers and was separate from my work with SWWAC, I had a few meetings with members of the CEU to exchange ideas. SWWAC has also had several meetings with the CEU and other members of the WPS over the years to discuss their work, and to give information about SWWC work and philosophy. One of those meetings is described in the vignette below.

Visiting the Counter Exploitation Unit

In 2017, I found myself sitting in the waiting room of the newly opened Downtown Police Headquarters of the Winnipeg Police Services (WPS) with three SWWAC members and one member from my research committee. We had an appointment with employees of the

Counter Exploitation Unit (CEU), as a follow up to previous communications, by email, phone and in person, regarding my research on sex work, SWWAC's work and the WPS work with people in the sex industry. There is about 15 people of all walks of life sitting around us on the plastic chairs nailed to the ground in comfortably large rows, holding their numbers in their hands and waiting to be called by the different clerks sitting at the counters facing them. The waiting room is on the ground floor and very bright, framed entirely by glass windows on the side of the visitors' seats. The police headquarters hadn't been open very long at this point and my colleagues and I commented how "nice and fancy" it all looks and joked "that it should" considering it has costs the city 214 millions and the probe into the alleged fraud and forgery its creation was already going for close to three years at that point (Barghout and Levasseur 2019). I remember that someone said it looked like a hospital, which allowed me to make references to Foucault that elicited the expected eye rolls, blank stares and knowing laughter from our little group. Even though we have an appointment with our contact from the Counter Exploitation Unit, there is a bit of confusion when we get there. You can't just *walk into* the police headquarters and we weren't provided with instructions on what to do when we got there. We end up having to take a number, wait and talk to one of the clerks, after consulting with the person at the reception. After a few minutes, our contact comes down to greet us, and he is as friendly and personable as he has been in every one one of our interactions. We follow him through long, wide, windowless hallways and go up an elevator for what seems like 5-7 minutes before we get to the CEU offices. The CEU at this point was located in a large room with ceilings so high it felt more like a factory than an office, high windows that didn't start until the several meters up the wall. It was a bright room, with clear attempts to be made more comfortable with plants and carpeting. It had a few meeting rooms on one side, and rows of cubicles organized neatly by office dividers. Andrew Smith, the staff sergeant who had reached out to me about my research several months earlier came out of one of the offices to greet us rapidly.

Our contact very kindly showed us around their office and introduced us to the employees that were there. The main purpose of the meeting was to for all of us to get to know each other better and he invited us to ask whatever questions we have about their work and organization. He went through the diverse focus of their work, which he told us focused on sexual exploitation and human trafficking, and youth in the sex trade. I often get

confused with the ways these terms are almost always used in tandem, and often interchangeably. I asked him what the difference was between those two terms and while he did answer me in great detail, I did not grasp a clear definition or distinction between the two in his reply. Perhaps I was not paying close enough attention. One of my colleagues pointed out that we have heard scary rumors and personal accounts that police are "surveilling online work" (referring to adult consensual workers who advertise online) and asked him to clarify that. He very kindly told us that they only look at advertisement if they get tips or if they suspect that someone might be exploited because of their age or because of the situation. Several questions were asked in the conversation that ensued but our contact seem reluctant to give us more details on this topic, for reasons that he did not disclose.

In terms of the application of the 2014 laws in Manitoba, the Winnipeg Police Services have been implementing a new approach since 2013 (CBC News 2015a; Winnipeg Police Services 2019), in accordance with the approach described in the Manitoban Sexual Exploitation Strategy that is aligned with the new prostitution legislation (Government of Manitoba s. d.). It means that the CEU, the dedicated WPS Unit whose self-declared priority is the "safety and wellbeing of those involved in sex trade, whether directly or indirectly", now focuses on clients, or as their website put it, echoing Danny at the Town Hall in 2017, "consumers of the sex trade", previously known as "johns" are now referred to "as Exploiters" (Winnipeg Police Services 2019). Their website also states that their investigations are "with respect, dignity, and are "victim first" driven" (Winnipeg Police Services 2019). As a response to this same page from the CEU stating that they partner "with sex trade workers themselves" to fight street prostitution, SWWAC members felt the need in May of 2019 to explicitly stated that they are not "one of those partners" and that they consider that "criminalizing and

arresting those who buy sex, as Winnipeg police currently do, puts sex workers at risk" (SWWAC 2019).

The way forward

While it remains unclear how differently the federal law is implemented in each of the provinces and municipalities[19], it is clear that it poses a threat to the security, safety and well-being of everyone involved in the sex trade (as does any criminalization of sex work, see for example Beyrer et al, 2014). In this sense, there is a broad consensus that it does not respect the recommendations made by the Supreme Court of Canada's Bedford ruling with regards to safeguarding sex workers' rights to life, security and safety.

It is on this basis that many organizations and individuals have come out against the new laws in the last 5 years. For example, a group of 300 researchers and academics came out against Bill C-36 in an open letter addressed to the Canadian government (March 2014). The Canadian HIV Legal Network has long been a supporter of decriminalization of the sex trade in Canada. As early as 2005, it published an in-depth report on criminal law, prostitution and the health and safety of sex workers in Canada that argued for the complete decriminalization of sex work in Canada based on extensive research and consultation with sex worker organizations (Canadian HIV Legal Network, 2005). Again in 2014, it published a statement rejecting Bill C-36 because of its

[19] For example, the Vancouver Police Department adopted in 2013 sex work enforcement guidelines that state that they won't criminalize sex workers or those in the sex trade and acknowledges that "where there are nuisance related complaints against survival sex workers, alternative measures and assistance must be considered with enforcement a last resort" (McCann, Akin, and Airth 2013, 3)

concerns for the safety and health outcomes of sex workers. The 2005 report made a strong case for the consideration of mounting evidence that criminalization, as well as the stigma and discrimination that sex workers face are related to their economic vulnerability and disenfranchisement and that they all increase HIV/AIDS risk (Canadian HIV Legal Network, 2005). This stigma and discrimination have been an important factor driving the development of the prostitution laws and the report urges policy makes and lawmakers to move away from moralistic assumptions and to consider the evidence backing up the need for decriminalization. They also expose the salient features of many recent studies that clearly highlight the link between the federal laws related to solicitation and how they contribute to women's risk of facing violence and, directly or indirectly, their HIV risk. This remains crucial under the new laws as they continue to criminalize solicitation for sex workers.

The Canadian Public Health Association (CPHA) published in December 2014 a position paper highlighting the possible harms of the new laws on the health, safety and well-being of sex workers (Canadian Public Health Association 2014). It called for a Canadian framework that would be based on evidence, concerns for safety and human rights, and that would consider the social determinants of health and structural violence. Based on a literature review of recent Canadian research, the position statement discussed how sex workers and their clients are at a higher risk of contracting HIV and other sexually transmitted infections due to lack of condom use, and access to health and safety services. The CPHA position statement also highlighted that many studies have shown that sex workers do not disclose their participation in the sex trade

to medical professionals due to negative past experiences after disclosure, embarrassment, fear of discrimination, judgement, and believing that it was not relevant to their visit (Canadian Public Health Association 2014). It also refers to a Vancouver-based study where an approach, similar to the Swedish adoption of asymmetrical criminalization, led to reports of increased violence among sex workers, rushed transactions and the resulting increased difficulty in negotiating condom use and other safer sex practices (Shannon, 2010). Finally, the authors also highlighted the rampant violence that characterizes certain sections of the sex trade, and how criminalization and fear of criminalization increases the risk of violence, and acts as a barrier to reporting the violence. They concluded that the current approach to managing sex work by criminalizing either the purchase or sale of sex "do not address the root causes for entry or the results of sex work" (CPHA 2014: 9). The report demands the use of a "framework of public health and business law [that] would create the conditions that enable sex workers to access necessary health services and sexual health education initiatives to promote safer sex practices." (CPHA 2014:9). Such a framework would be based in harm reduction principles and enable sex workers to have "increase control over sexual exchanges, decrease sexual exploitation and violence, and reduce the risk of disease transmission" (2014:9). It also advocates for integrated, culturally appropriate programs that address poverty, housing, and health care and other social services to help reduce the likelihood of entry into sex work and improve health and well-being for current sex workers. The Internationally renowned medical

journal, *The Lancet,* published a special series on sex work and HIV in 2014 that advised against the criminalization of the sex trade (Beyrer et al, 2014).

Even closer to the field of this research project, the Winnipeg Regional Health Authority published in 2016 a positions statement on harm reduction (Winnipeg Regional Health Authority 2016) which explicitly acknowledges the "harms caused by stigma and criminalization"(2), and how they are borne disproportionally by Indigenous peoples in Canada. The statement articulates a "client-centered, nonjudgmental, and practical applications of harm reduction to issues related to drugs, sex work, and HIV non-disclosure" (3), which includes decriminalization of sex work (6) and the adoption of what they phrased a "public health approach to sex work" (10). The statement defines such an approach as one that prioritizes the physical, social, and mental well-being of sex workers" and "promotes evidence-informed, ethical, and pragmatic approaches to supporting the health and well-being of sex workers, while addressing the structural factors that may push some individuals into sex work, like poverty, colonialism, and racism" (10). The statement goes on to highlight how the "narrow lens" of criminalization not only ignores but worsens the factors named above "due to the inequitable impact of policing and justice systems on poor, Indigenous, and racialized communities" (10).

In terms of public health management, as well as in terms of safety and protection of human rights, there is substantial evidence that an approach that decriminalizes the sex trade should be prioritized in Canada (see for example Amnesty International 2016; Beyrer et al. 2015; Decker et al. 2015; van Der Meulen and Durisin

2008; Fitzgerald, Healy, and Abel 2010; Landsberg et al. 2017). In coherence with the demands of sex worker organizations across the country, any development of laws, policies or programs must be informed and follow the voices of a diversity of women, men and transgender persons involved in the sex trade. The reports and publications quoted in this section unanimously support the idea that the input and careful consideration of sex workers' experiences and expertise is crucial to developing a Canadian strategy for sex work.

An approach that is based on evidence represents an option to move away from a framework that considers sex work solely in moralistic terms as a problem that needs to be "solved", and sex workers as a group who need to be controlled. Furthermore, the inclusion of sex workers in the discussions that surround their work is crucial to combating the stigma and the longstanding social constructions of sex workers as "deviants" who are the cause of problems.

Conclusion

This chapter attempted to highlight the ways in which the social construction of sex workers as "deviants" who threaten "proper society" continue to drive much of the discussions, and more importantly the development of programs, laws and policies regarding this form of labour. Discourses and ideologies towards the sex trade that pervaded the social purity movement of the early twentieth century continue to survive in contemporary Canada, and in Manitoba. Sex workers are discriminated against and stigmatized on the grounds that they deviant, and their agency is denied. Although the

mobilization of sex workers and sex workers' rights activist disrupt the idea that sex work is inherently and exclusively violent and coercive—laws, policies and programs have rarely been developed by taking sex workers' experiences into account. Finally, this chapter featured the work of many organizations, sex workers' rights activists and scholars who call for evidence-based, sex worker-led policy and law reform, and for complete decriminalization of the sex trade.

While there have been small, incremental changes in discourses, relationship between different agencies and organization of the sex workers communities in the years since this research has started, the official position of at the provincial level has not changed. Sex workers in Winnipeg remain in a criminalized and heavily stigmatized environment, and it remains a challenge to have the diversity of experiences in the sex trade as recognized by the general public, media and agencies. Perhaps most telling is the continued focus— if not public celebration and reification— of approaches that seek to "save" people involved in the sex trade, such as the 'John School' and the frequent "Deter and Identify" stops (DISC) conducted by WPS in collaboration with various community agencies on people involved in the sex trade (Martens 2019).

CHAPTER 3

"TO BE TREATED LIKE A PERSON AND TO UNDERSTAND THE RISKS, AS OPPOSED TO FEELING LIKE I AM THE RISK": ACCESSING HEALTH AND SOCIAL SERVICES IN WINNIPEG, TREATY ONE TERRITORY

When I started to put up posters in health and social services agencies and on my social media accounts, I wasn't sure if it would be possible for me to speak to many sex workers or if I was going to be able to speak to people in the sex trade outside the activist networks to which I was connected. Very rapidly, however, it became clear that people were interested in talking to me and I was answering calls and emails daily as my data collection began. Within a few weeks, I had to start limiting the interviews I did to try to ensure that I spoke to people from different backgrounds and with experiences across various fields of sex work. On my poster and during my first contact with everyone who wrote, called, or texted me, I explained my research project goals and informed them that I wished to ask them questions about health and social services in Winnipeg and Manitoba, learn about what was and was not working well for them, and hear about the positive and negative experiences they might have had.

It is impossible to know exactly why there was so much interest in my research, but it is clear that people were willing to share their experiences and to have their voices heard. Perhaps the opportunity to speak freely about their experience under the guise of confidentiality was appealing to the considering how rare it is for sex workers to have the opportunity to share their perspectives in a criminalized and heavily stigmatized context such as Winnipeg. Perhaps the relationships I built over the years

served as the basis for people who decided to reach out to me regarding the interviews. Once we had gone through the research consent process and I had explained the study details, I asked each one of my interlocutors why they were interested in participating. Many told me that they wanted to have their voices heard with the hopes that it might lead to better services or more compassion for their experiences. A few people told me that when they were working, as some of them had since stop working in the sex trade, they didn't realize then what they knew now; and upon reflection, they wished that they could help. I was fortunate to speak to many women who are no longer working in the sex trade but now provide support and services for people who are working and may wish to transition to other forms of work, or who are in situations of exploitation and need support. One of my interlocutors, in a situation like this, told me:

> *I like care about my sisters, so – sex-trade workers I care about, because like I know how it feels. Since I've left working the streets, I just like thought that I've always wanted to have a voice and say something, because it wasn't that easy for me to leave and it was very hard for me to get out. I just got out, but there's a lot of risks you take when you get out. And I have a lot of friends that died in the sex trade and a lot of friends that are still doing the sex trade, and I just – I really, really just want to have – like, speak instead of them, because some of them can't speak.*
>
> *(E., 60s, experiential trans woman, mostly met clients "on the street")*

I know that a few of the participants reached out to speak to me because they knew me, knew of my work or wanted to support research that they felt they could trust. Some expressed it indirectly and someone stated it clearly:

> *Yeah, and the other thing that I meant to say was that another reason that I wanted to speak with you is cause I really like you and I like really trust you and I think it's like worthwhile to work with you.*
>
> *(L., 20s, non-binary indoor worker)*

The same person also said that they were eager to participate in this research project because they felt that the lack of representation of sex trade workers in research in Winnipeg was frustrating.

> *Like in sex worker, like research or like advocacy or like whatever, in Winnipeg there's like a pretty narrow narrative about it, which is like a pretty intense like colonization street trafficking pro-criminalization model. Like it's just so bad and like when I was working at [local organization providing services to victims of exploitation], yeah, they just like that was all of their research and it like went back to like the 70's and all of their research was like twenty years old and like obviously out-dated. That's more than forty years ago. And just like climbed into this really intense like one narrative. So I mean I don't know, I don't think that that's the only research that's available but it feels like. So, yeah it feels important to be like: "That is not representative of me", allow me to be louder about it.*
>
> *(L., 20s, non-binary indoor worker)*

The people I spoke to were offered monetary compensation for the time they spent talking to me and away from their lives. As it is the case with every type of research, this may have counted as one of the reasons why people chose to meet and speak to me (Festinger et al. 2005; Grady 2001). Although it is not the norm for research usually approved by the Research Ethics Board of the Faculty of Medicine of University of Manitoba, I insisted on offering monetary compensation to my participants instead of the usual gift card and eventually was allowed to proceed this way. Of course, the amount and type of compensation offered to health research participants, especially coming from structurally disadvantaged population such as people who use drugs or

people living with HIV and AIDS, has for decades been the subject of much debate regarding when and how it may constitute coercion or undue influence capable of distorting the judgment of potential research subjects and compromising the voluntariness of their informed consent (Cheff et Canadian Electronic Library 2018; Collins et al. 2017; Grady 2001; Macklin 1981). Aside from my personal belief that it is appropriate and necessary to compensate people for their time and expertise, the specific group of people I was wishing to talk to might not be in position to use gift cards. Indeed, in the planning stages of my data collection, I was concerned that some of the people I would speak to may be in situations of homelessness or unstably housed, and that they may not be able to use the gift cards to purchase things like grocery items that they would be able to store somewhere. My questioning process echoed the recommendation of the Tri-Council policy statement on research involving humans (Government of Canada 2002) that warns all researchers to carefully weigh the use of incentives against the potential harms for participants in research. My confidence in my reasoning was somewhat shaken when two separate participants explicitly told me, when asked what made them want to participate in this project, that they needed the money. I presented the monetary compensation, usually in a sealed envelope with a thank you note, at the beginning of the interview, after we had completed the oral consent process and I had answered all their questions. I also explained, several times, that just because I ask a question it does not mean that they must answer it, and that they should feel free to end the interview at any point. One woman I met in Point

Douglas neighborhood, a health service provider, said directly that she needed the money to buy a present for her daughter's birthday.

> *Claudyne: So what made you want to participate in this research study?*
> *R.: Honestly?*
> *Claudyne: Yeah.*
> *R.: The money.*
> *Claudyne: Yeah, fair enough.*
> *R: I have a daughter and her birthday's coming up and I'm travelling again so I need extra cash.*
> *R., 30s, experiential cisgender woman, did not disclose area of work*

After this interaction, we went on to discuss the topics planned for the interview and we talked for about 40 minutes. While I was taken aback by the honesty of my interlocutor in saying that she needed the money, I went on to reflect that this was probably true of most people I spoke to and that in itself, there was nothing surprising about the money being one of the reasons, in this case the main one, that prompted people to reach out to me. Participants in research are often compensated for their time and expertise, does saying it outright undermine the quality of the informed consent they provide? This participant, like all others, was free to not answer my questions, and to leave at any point and she remained to complete the interview.

A recent survey by Toronto-based Wellesley Institute documented the current participant compensation practices of Canadian researchers found that only 4% of the researchers did not provide any type of reimbursement, compensation or token of appreciation to their participants. It showed that, among the 71 health services and social, cultural, environmental, and population health researchers surveyed, 90% reimbursed or reduced participant expenses and an equal number (65%) provided cash

compensation and gift cards averaging at about $25 per hour of participation. In addition to being the norm, there is evidence that not only is compensation critical to attracting participants, but it was seen by participants as a "transactional process through which they could challenge the underpinnings of bioethics", but also that compensation was seen as a " 'legitimate' form of support"(Collins et al. 2017). In some cases, the medicalized identities of the participants (such as living with HIV) were fundamental to justify research compensation for their expertise, when the compensations were adequate and equitable. Some research also indicated that neither amount nor type of compensation significantly impacted drug use or perceptions of coercion for participants who are people who use drugs (Festinger et al. 2005). In this sense, it seems possible that the woman who told me she needed the money for her daughter's birthday saw her participation in this research interview as a transactional process where she exchanged her expertise on the subject for adequate compensation. Additionally, the compensation was for the time she spent with me, which she might otherwise have used doing other forms of remunerated labour.

The focus of this chapter and the next is to highlight and amplify the voices and experiences of sex workers and experiential people with regards to their access to health and social services in Winnipeg and in the province. As a reminder, health and social services can describe interactions with medical services providers such as physicians, nurses and therapists, but also social workers, massage therapists,

employment insurance (EI) workers, outreach workers and anyone who works at social service agencies.

It was important to focus my interviews not exclusively on health services, but to broaden it to all interactions with health and social services that sex workers may use. This mattered because I did not wish to overemphasize the incorrect and pervasive association of sex work with STIs transmission; but also because it had been made clear to me in conversations and interactions with sex workers, and in the literature, that experiences of stigma affect every aspect of sex workers' lives and every aspect of their health and well-being. The overemphasis placed on the sexual health of sex workers, stemming from their epidemiological association with STIs transmission risk (see for example Pirkle, Soundardjee, and Stella 2007; Shannon et al. 2007 and Benoit and Shumka 2015 for details on how this is innacurate and problematic), does not only actively contribute to the stigma that they endure, but it also overshadows other important primary health concerns that they live with. Indeed, the intense preoccupation with the sexual health of sex workers in health programs, research and in the general public tends to overlook some of the other, possibly more serious health problems that they may face (Sanders 2004). It can deepen the stigma that they face because of the continuing misguided belief that sex workers are somehow “vectors of diseases” (Chan et Reidpath 2003; Fitzgerald et al. 2010; Pirkle et al. 2007). As mentioned earlier, this is of course contradicted by recent data that shows that there is no direct correlation between sex work itself and STI transmission, but instead that some sex workers are at an increased risk due to mitigating factors, most of which are

associated with outdoor sex work, including intravenous drug use or drug dependency, engaging in unprotected sex with their intimate partners, identifying as a visible minority or First Nation, Métis or Inuit in Canada[20], being coerced into having unprotected sex and/or being the victim of sexual violence, and a high number of sexual partners within a limited period of time (Benoit and Leah Shumka 2015). As a consequence, there is very limited data that focuses on the physical health and emotional and mental health of sex workers. A 2014 survey of sex workers in Canada highlighted that the main concern reported by participants was mental and emotional health (Benoit et al. 2014).

While many of my interlocutors described painful experiences of stigma and discrimination, many stated that they didn't have a lot of negative experience with service providers. However, everyone had clear strategies to manage their interactions with services providers, often mostly to ensure their safety, to protect their confidentiality, and to avoid discrimination or stigma. At the intersection of whorephobia, discrimination against substance users, racism, queerphobia and transphobia, many struggled to find and access health and social services that were not discriminatory.

This chapter is organized much like the interviews were in that it starts by exploring my interlocutors' negative experiences, then looks at the strategies they use

[20] Please note that identifying as a visible minority or First Nation, Métis or Inuit in Canada is not in itself the cause of the risk that individuals might be exposed to, but rather a marker to highlight the ways in which racism, legacies and on-going colonial violence and land theft makes these individuals the target of structural violence and may leave them more vulnerable to STBBI infections including HIV.

to manage stigma and discrimination, ideally to avoid it or avoid suffering its consequences. The next chapter focuses on the latter parts of the interviews, which revolved around experiences that felt safe and affirming to my interlocutors and the recommendations they have for service providers.

Negative experiences

Almost everyone person that I spoke to related some negative experience with health and social services, and all of them were concerned or worried that they might have one if they hadn't already. Often their experiences related to assumptions being made about their experience based on (often presumed) race, gender, whether or not they used drugs, poverty and class. My interlocutors described, often very eloquently, the stigma that they lived through and the consequences that it had on their self-esteem, lives, relationships and health seeking behaviors.

Assumptions

In the interviews, "assumptions" was a recurring theme. Services providers made assumptions about my interlocutors that seemed to shape their perceptions of sex workers and how they treated them. Sometimes, they assumed things about their patients' or clients' sexual behaviors and preferences, their knowledge of safer sex methods, or the relationships that sex workers engaged in. According to a cisgender woman who self-identified as white in her early 20s, her health care provider made

inappropriate and unfair assumptions about her desire to be pregnant, the context of her pregnancy, and her ability to care for a child:

> *I've been to the Women's Health Clinic and I went there to find out about a pregnancy that I had recently… I recently become pregnant and that wasn't really something that was very planned or like think… but it wasn't something that happened by a client, it was something that happened by my long-term partner.*
> *Because they had found out that I was a sex worker and went and assumed that I was high-risk for HIV, etc., etc., that I was not being safe at all and immediately I was discounted as a person and that my potential unborn fetus was going to be at risk. They also suggested because I was sex worker that I should have an abortion. You know, it sucks and I'd only went there to access because I knew… because of the delicacy of the situation I couldn't go to my GP. My GP always usually refuses to actually give referrals for specialists, so I have to go… I pretty much went clinic to clinic to see where I felt comfortable and after a while… Women's Health Clinic was the last clinic I tried prior to going to Nine Circles and it was…It was awful… the nurse there was very rude and disrespectful and I wanted to complain and file a complaint with the Physician's Board, but the reality is, it's nothing that's really every followed up on or anything like that, so even if they were to place surveys or if you were to file a complaint, someone might call you back, but it'll be like, "Oh, well this is how this clinic is run. We don't feel like catering to a specific marginalized part of society, so we're not going to bother putting the additional training and effort into it."*
> *Probably because the clinics are underfunded, I hope because the clinics are underfunded, but who knows because some people just bring their own personal biases into their job when they should not.*
> *(M., 20s, cisgender woman, indoor worker)*

Another person I talked to described how the family doctor that she had until recently before the interview took place seemed to have unshakeable heteronormative assumptions about sexuality and relationships that made it difficult for her to get what she needed. Because her physician made a lot of assumptions, it was challenging for example to ask for STI screenings because that would mean having to discuss the fact

that even though she was in a committed relationship, she had more than one sexual partner.

> *My old family doctor just – I don't know, she had this picture, I guess, just of who I was, maybe based on how I look, or – I don't know. And she just assumed that I was this certain type of person, without ever asking, and would just say things that made me feel uncomfortable, and, like, she was very heteronormative and yeah, definitely not, like, sex worker friendly. She didn't even seem really sex-positive either. She was just, like, be in one monogamous relationship forever and only have sex, like, once every two years and you'll be fine.*
> *Claudyne: Yeah, right, only for reproduction.*
> *H., 20s, cisgender woman, indoor worker*

Even for people who no longer are working in the sex trade, assumptions that service providers made about them continued to haunt my interlocutors in their ongoing relationships with providers. One cisgender self-identified Indigenous woman, now in her mid-30s, who hasn't worked in the sex trade in years described the continuous stigma that comes with disclosing that she previously worked in the sex trade.

> *A: I was applying for school and, they asked me, but, the questions they were going to ask me, they told me and, warned me about it. I'm going to be asked if I had any problems with drugs or, alcohol. Well, at first the questions led up to, if I've ever needed treatment or, if I will be on anything like, that. And, then, yeah, I said, "Yes."*
> *And, then, they said, the questions were going to be more intense. And, that was questions like, "Have you ever been involved in the sex trade?" And, I said, "Yeah." And, I noticed her facial expression changed. And, then, she's kind of like, because, I had so much potential in my first, like, 20 minutes telling her about myself. And, like, I didn't, I had a rough life, but, I also had a good life. I had a good mom. And, I was looking good, you know, until I told her.*
> *And, then, I told her about my addictions and, then, when that part came, I seen the expression on her face just drop. It was looking good and, then, when that part came up, I told her, it was almost, when I told her I was an addict and, I picked myself up and, I've been on a methadone program*

and, then, she went back to normal. But, when that part came again, it just dropped completely again.
Claudyne: Her face just dropped?
A: About the sex trade.
Claudyne: Once you said, sex trade.
A: Yeah.

(A, 30s, experiential cisgender woman, outdoor worker)

Forty-four years old P. eloquently described how subtle the discrimination can be and how knowing that she is experiential changes the way the service provider relates to her, how it changes their relationship instantly.

Claudyne: You've said it a little bit, you feel judged in other places. I know it's obvious and it's a hard question, what exactly happened? Can you give me an example? Was it a feeling or a look or. . .?
P: A feeling or a look or even just the way they talked. Even they could be talking professional but just their tone of voice. Once they know that you've been doing whatever, working on the streets and stuff, they just almost don't, you almost feel like they don't care for you. They're just trying to get you in and out and make their buck and have a good day. (chuckles)
Claudyne: Yeah. Was that important for you? To be able to tell them that you're working or you were working?
P: Yeah. Cuz if, say a health problem related to that situation, you needed to be open and honest about it right? To get the help or care you need to have. If I felt that I couldn't be open and honest, then I didn't wanna be there.

(P, 40s, cisgender woman, outdoor worker)

Similarly, another young Indigenous woman talked about the feeling and the reality of being "labeled" and the assumptions that came with that label. Even years after she stopped working, the fact that some paperwork still mentioned that she was involved in the sex trade as a teenager continued to shape her interactions with service providers.

R: Yeah, first of all they labelled me and to this day I'm still labelled.
Claudyne: What does that mean labelled?
R: Like "Oh, you're a prostitute"…, like right now I have three of my kids in care, but they aren't taken away from me, they were taken away from their dad. And to get them back I did programs and now she's trying to make me do another program so, I don't think it's fair because I completed everything. Because she said that was I was late one too many times or I didn't show up. I didn't show up one time because I overslept and I was on a medication well, and I just couldn't sleep. She told me that it happened three times in a row which I never miss three times in a row, but the whole part of the story is like she says that I have an addiction which I didn't have an addiction before I just recently started using. But like it says in there that I was a prostitute when I was a teenager.
Claudyne: It says that in your file?
R: Yeah, and it's written in there.
Claudyne: In your CFS file? Wow.
R: And it still says that I was a prostitute when I was a teenager and like when my mom and dad read that they were just like mad, like why is she saying that and I was like I don't know.

(R, 20s, cisgender woman, outdoor worker)

The fact that she once was involved in the sex trade continues to directly affect the way social services providers, in this case a case worker at Child and Family Services, see her and how they evaluate her abilities to parent.

For other participants, like the non-binary person in their late 30s quoted below, what they knew from experience, hearsay or from discussions with their community shaped which group they trusted and why. In their experience, some service providers make assumptions about the range of possible experiences in the sex trade for their participants. For this person, the idea of needing "*to identify with, like, being exploited to like use their services*" was unbearable and they had the distinct impression that the service providers in that program "*assess, like, your level exploitation and, like, your level of awareness about your exploitation*." To them, those assumptions were not only

simplistic and dangerous, they made them not trust the entire agency as well as all the individuals associated with it.

> *L: Now I'm like do I actually want to go places that would like out me as a sex worker in Winnipeg. I don't know. When I think about [local agency providing services to people in the sex trade] I like am like trying to remember what I know about their like policies and I'm like, ahhh, no, none of my friends go there. I'm not going there.*
> *Claudyne: Yeah, yeah, yeah, fair enough. Fair enough. So what does it mean when they have bad policies or policies that, you know, you don't identify with. Like what would it mean for you to go there? Like if you were ever to sign up at [local agency providing services to people in the sex trade] or whatever, like what -*
> *L: Oh, my God. It just makes me feel so bad to think about that. Like cause I am like, sex worker is like one of the best things that's happened in my life and they like totally demonize it and make it, it's just like putting, it would put me in this place of like enforced like victimhood and like condescension and, yeah, I think that that feels worse than just like not like then being positive about it. And I also like just don't trust those people as individuals. Like when I think of other people I work with at [local agency providing services to people in the sex trade], and like I don't trust them as individuals. I wouldn't trust them to know that I'm a sex worker and like not like blackmail me.*
>
> *(L, 30s, non-binary person, indoor worker)*

Finally, as many interlocutors made clear throughout the interviews, the assumptions made about sex work and sex workers have very real, lasting consequences in every aspect of their lives that go beyond feeling rejected. S, the woman below, wanted me to know that the discrimination, stigma and violence that she encountered went far beyond social and health services. She had called me the day before the interview and suggested that I come meet her in the small residency associated with a service provider in the North End of Winnipeg where she was staying. When I got there, I was surprised by how young she looked, certainly much younger than I would have

assumed from her voice on the phone. She would later tell me that she was 27 years old.

> *Claudyne: And the first one is like, have – you've told me a little bit already, but have you ever… Like, are there moments where you feel like you've been discriminated against or people treated you differently –….*
> *S: Maybe there's – maybe there's people in society they just throw like butts at me. They throw a whole pail of cigarette butts on me, full of water. They called me a hoe, they called me slut, they called me…*
> *Claudyne: Like, just people in the streets? Like, what…*
> *S: Yeah, even people would stop their cars and jump out and beat the shit out of you.*
> *Claudyne: Oh, shit.*
> *S: Because you're standing on the corner, and they're like, "Fuck that hoe.", "She's just a hoe." You know, "Nobody cares about her." You know…*
>
> *(S, 20s, cisgender woman, outdoor worker)*

She continued on to give me an example of what happens in certain programs where people she depends on for services may assume things about her sexuality and how "safe" it is to leave her alone with men.

> *S: If I go into a program – okay, let's say I go into a place – or let's say I met a Christian lady at church and she invited me for supper, and she has a husband. She's uncomfortable because she knows that I'm a sex-trade – I'm currently still a sex-trade worker, or I'm not a sex-trade worker anymore. She doesn't feel comfortable with me sitting there. I can get those signals. I can get that… I can feel that, you know?*
> *Claudyne: Wow. What is she afraid of?*
> *S: I've had a woman not let me actually sit in the living room with her husband. And he was on another chair; I was on the couch. Or if I were to call, like, "I'm in the hospital. I really need a ride. I need… I just… Somebody…" Let's say her husband was the only one that was available, she would end up saying, "Well, you're going to have to wait, 'cause I will come down there." You know? They don't have no… There's a lot of people, once they hear the word "sex-trade worker," they don't have trust. They don't know…*

The assumptions that are made about people when service providers know or assume that they have experience in the sex trade are informed by stereotypes, misunderstanding and harmful ideas about the sex trade. They colour and tarnish the relationship between a service provider and their client or patient. This devalued relationship between them highly affects people who become "marked" as lesser than.

Stigma and its consequences

While not all of my interlocutors used the words "stigma" or "discrimination", the vast majority described experiences of being treated in a way that they felt was different than others would be, disrespectful or rude in encounters with service providers but also in general in their lives. I am including some of their experiences of stigma even when not directly relating to service provision because they contribute to my interlocutors' overall experience and shape how they might feel about situations where they may potentially encounter stigma. This section considers the experiences of stigma with a particular focus on how it relates to barriers to access to services.

Stigma in general

As the last narrative of the previous section highlighted, my interlocutors often described encountering stigma in all aspects of their lives, and from people of all walks of life. Their experiences with stigma and discrimination in all aspects of their lives shaped their experience with service providers and their willingness to go see them.

A cisgender Métis woman, when I asked about her experiences of stigma or discrimination with health and social providers, recounts a disturbing interaction she had with a woman in the neighborhood while she was working outdoors.

> *F : Not so much with, like, stores or health care providers or anything. Just, like, for instance, that I had a bad experience actually the other day. It was during the day and [I] don't like to go out in the daytime. But I was down [in the North End] and above the store there is an apartment. And there is a woman that lives there and she has kids.*
> *And it was daytime and she came up to me and she is like, can you please move? Like, my kids, my children don't need to see this. And I respected it and I moved. And then now it was later on at night time, just around 11 o'clock at night, and she came out again and asked me to leave again. And I was like, no, I am not leaving. She is like, I have kids, they don't need to see this. Like, lady, it's 11 o'clock at night. Your kids should be in bed. They shouldn't be hanging out their window. So that's your issue, not mine. And so, if you really want me to leave, phone the police and get them to make me leave. I am not moving. But then she came out of her house and she came towards me with her dog and -*
> *Claudyne: Oh, boy.*
> *F : Yeah, I know. So, I got a little intimidated, thinking she was going to sic her dog on me. So, I moved.*
>
> *(F, 30s, cisgender woman, outdoor worker)*

Another cisgender Indigenous woman who has been working in the sex trade for over 15 years told me that the bad experiences that she's had while working, especially experiences of violence or abuse, weigh on her self-esteem and mental health. What makes it worst is that she cannot rely on support systems that people outside of sex work can, such as the police.

> *Yeah, yeah, like, for sure, my mental health. Like, because there have been some bad experiences where I have, like, experienced abuse from Johns and stalking and, like, pretty horrid things, and blackmail. Like, my experiences were pretty bad sometimes, and it's really messed with my*

mental health and my self-esteem, and it made me feel like I don't have control, when I should be the one who is in control in these situations, I feel like.
And I do everything I can to protect myself from the people that I work with. We all do, but you know, sometimes there's just a bad guy, you know. Like, most of the people are great, but there's also some shitty people, and that can really mess with your mental health, and like, desirability too is a weird thing, that I've never really had to deal with pretty much, until I got into this industry.
So yeah, so sometimes it's really good and sometimes it's really bad, my mental health, so yeah, it just depends on what I'm dealing with at the time. I didn't expect it to be so heavy when I started, but then, once I got it, I was, like, yeah, this is pretty intense stuff. And not fair, because, like, there's not many people I can go to for help in those situations, because there's so much stigma. It's like, I can't go to the cops or anything, they don't have my back, I know that. So I just go to my people, my family basically, you know, that I work with, and yeah … I couldn't do this without them, honestly, I could not. So I feel very lucky that I have support systems like I do, actually.

(B, 30s, cisgender woman, outdoor and indoor worker)

While these two experiences are not with a service provider, they highlight how constant whorephobia can be for my interlocutors and how it can affect them at any moment in their lives.

This constant need to be vigilant and to deploy strategies to avoid discrimination but also to manage the stigma when it does happen often weighed on the people I talked with. The person below was in her late twenties and self-identified as white. I met her at her home in Osborne village on a sunny summer afternoon. As we sat down to do the interview outside, it started to rain and we had to rush inside. We talked while a spectacular thunderstorm took over everything for 45 minutes and gave the interview a strangely dramatic feel that went beyond the sometimes dark experiences she shared

with me. She told me about various stigmatizing experiences that she had had with service providers and then how she wishes she didn't have to try to block them out.

> *L: When we try, you know, when we're really trying or, something, it hurts us and, it brings us down. It makes us feel like, shit. We just fall down and, we feel bad about ourselves. And, we end up going back and, feeling like, "Oh, we're not going to get anywhere. They're [health care providers] not going to listen to us."*
> *Claudyne: And, so, when, I mean, you've told me already but, like, when that happens, like, do you go back? What's your reaction when people react like, that?*
> *L: I feel bad. Like, I'm not stupid, you know. Some girls just know how to block it and, don't think about it. But, me, I'm a person that's been blocking all that stuff, like, I did that all my life. I was abused as a child and, I've done that all my life. And, I was so rebellious and, came in here [community health clinic] and, I'm done with that. Some girls will get, all the time, a hundred, at least 95% of the time, will get those looks and, attitude changes [from health and social services providers]. And, most of them are used to it, just putting it and, blocking it out. And, they don't even realize that they're blocking it but, they go back and, they don't know why, you know.*
>
> *(L, 20s, cisgender woman, indoor worker)*

Several other interlocutors who commonly, but not exclusively, worked indoors, echoed a similar sentiment by stating how tiring they find having to fight to find spaces where they aren't made to feel like there is something wrong, shameful, and inappropriate about them. It was indeed exceedingly challenging for them to find providers who would not discriminate against them. One of them, a white non-binary person in their early 30s, described how it felt to be discriminated against in healthcare settings.

> *D: Especially after they've been through a system that's treated them not like a human, just completely dehumanizing, "I already don't feel like a person and now you're telling me I have to wait even longer to try to feel like one?" I'm tired of fighting for it.*

Claudyne: I mean, I think I understand what you mean, but just to clarify when you say that you feel "like not a person" or "dehumanized," what part of it makes you feel dehumanized in the healthcare system?
D: Well, the simple fact is that they discriminated against me because of the profession that I'm in, so if I was just a child care provider and a doctor, and I could go in there and say that I need STI screening every 115 days, they would probably give me the access to it more freely without the barrier of the questions in front of it, which makes it feel like because of the profession that I do, I have to go through a little more of a rigorous system because I engage in, I guess what they consider high-risk behaviour. Yes, it's really frustrating.

(D, 30s, non-binary person, indoor worker)

Another person I spoke with told me how it made her feel whenever she encounters discrimination.

It makes me feel shameful and slut shamed and promiscuous and a lot of these circumstances were similar and worse when I was not sex trade working. Some of that alleviated actually when I started becoming a sex worker. Because it's more manageable, I'm in control now, I set the rules and the boundaries and in general people respect those boundaries.

R, 20s, cisgender woman, indoor worker

My interlocutor who we met earlier who was told that she should consider having an abortion because of her profession further discussed how that experience of blatant stigma affected her.

M: Yes, and that makes me feel sad. Sometimes it does cause a little bit like… before I was able to cope and stuff. Like I said, I went through a really huge depression after the woman told me that I should have an abortion because I was a sex workers and sex workers shouldn't have babies.
Most likely, I'll probably be infected with something; therefore, the baby will be infected with it and course of treatment won't be effective and like, what's the point if you're a sex worker, you obviously don't have the money to pay for it. Just overall, thanks for making me feel like not a person. Yes, you're right I probably should have an abortion. Yes, you're right, I probably just go lay in my room until no one cares about me and I

mine as well not be in existence in this world because that's how you see my life.
That's really, really like, especially going in such a delicate situation, it's really hard and I suffered for a depression for like three months after that. I even had to go on medication for it.
Claudyne: Wow, that's so horrible. I know it changes nothing, but I hate that that happened. I hate it.
M: No, it sucks. And there's other people who've had similar experiences that equally horrifying.
Claudyne: Yes, sure, but I mean that's pretty horrible and you have to cope with it.
M: Every day, yes. Especially considering in that particular situation I ended up having a miscarriage, so that just sort of, at that time, reinforced what this woman said. Oh, maybe this is what was supposed to happen, maybe because I was more sexually active, I forced myself into behaviours that were high-risk that forced me into this potential situation where now… I don't deserve this because I'm not a human essentially was the overall feeling that I got from that, which translated into three months of being sad.
Claudyne: That's horrible.
M: Yes, it sucks.
Claudyne: And that's not true what she said.
M: No, it's definitely not and that's not fair for anyone to feel like that.
(M, 20s, cisgender woman, indoor worker)

The young woman who shared this with me also stated that she considered making a formal complaint about the healthcare provider, but that in the end, it felt too exhausting a process to even consider. It was obvious from our conversation, and it is hinted at in the extract above that the disturbing things that were said to her and how it made her feel still heavily weighing upon her.

S, who identified as white, shared that, while in the experience healthcare providers are "professional" about her involvement in sex work, she had one discriminatory experience that she often thinks about. After an incident on the street, S came into an emergency service in order to get a preventative shot. After the shift

change in the morning, a new nurse came in who made her feel so judged and uncomfortable that she began to cry.

> *I could tell right away she is going to be one of those, right off the bat, straight open and, straight out, like, "Why are you here? Oh my goodness. What were you doing out so late?" And, when I told her, I noticed right away just like, I wanted to walk out of the hospital. Because, she was writing and, shaking her head when I had told her what happened, about my incident. That, now, that, is really… I found that unprofessional, yeah. She was an older nurse and, she'd probably been working at least ten years. And, I just, oh, like, I was just so, hurtful and, I just wanted to walk out of there. And, I don't know but, I did ask for a different nurse. And, then, she did smarten up after that.*
> *Like, I told her, I started crying. I said, "You don't have to treat me like that, you know. I'm just like, any other person that comes in here." I finally had enough, so, after a couple of hours, I finally had enough and I just told her. I started crying. I said, "Why are you treating me like, that?" I'm just like any other person that comes in here." I said, "You should just never mind about the situation and, just take care of me," I said.*
> *And, she just, she went quiet. And, I said, "Actually, you know what, I would like to ask for someone else." I said, "Who's your nurse in charge? I would like, someone else to take care of me, because, I've been through a lot.*
>
> *(S, 20s, cisgender woman, indoor worker)*

Although S was able to advocate for herself and ask for someone else to care for her, this experience was significant enough that she regularly thinks about it. Interlocutors in this study are resourceful, resilient people: indeed all of their narratives show exemplary resilience and willingness to advocate for themselves and defend themselves as much as is safe or possible to do. The experiences that they described happened in moments when they are reaching out for help and support –as everyone does when seeking health or social services—which makes their stories sometimes even harder to hear, and the shame, sadness and anger they feel even more justifiable. One of my Indigenous interlocutors, who was then in her late 40s and told me that she

doesn't work anymore, described how desperate it felt to not be able to reach out to anyone in times of great need, when she simply wanted to be listened to.

> *It makes you feel really broken, makes you want to get high more, makes you just feel hopeless, makes you want to maybe even kill yourself. It's not how I feel right now, but when I was in the problem and I was coming off of the drugs or I got raped or I was beaten and I just wanted somebody to talk to me, not necessarily to tell on who did it but just to get it out, they said, "Here's a cap slip," or "Oh, we're going to take care of you." Next thing you know, police show up. You're getting hauled into the drunk tank and left in there for like 14 hours. And all you want to do is talk to somebody, because you just want to talk it out.*
>
> *(T, 40s, transgender woman, outdoor worker)*

Another long-time worker told me that she would never report sexual assaults to the police because she doesn't trust them. Feelings ranging from mistrust to outright anger and fear of the police were expressed by 12 of my interlocutors. This 49-year-old indigenous woman expressed it very clearly.

> *Claudyne: Are there places where you won't go like in terms of health or?*
> *C: I don't know? If I got raped I'd never report it.*
> *Claudyne: Oh no?*
> *C: No.*
> *Claudyne: Can I ask you why not? I think I have an idea…*
> *C: Because I don't like the police. It's like because you're in that area they look at you like a "nobody".*
> *Claudyne: That's horrible.*
> *C: It is I don't even trust them. They've done things to the workers that not any normal person would. They just tend to degrade the workers on the street I know that.*
> *Claudyne: Do you think other people feel like that?*
> *C: I'm pretty sure, yeah. They've asked some of the workers so that they won't arrest them to show them their pussy in order to let them go. That's how some of them are. My daughter told me that one of the cops did that to her.*
> *Claudyne: That's horrible.*
> *C: Yeah it is. It's not right; they're abusing their badge.*
>
> *(C, 40s, cisgender woman, outdoor worker)*

Given these experiences, it is understandable that many of my interlocutors, and others in sex work, are concerned with being careful or avoidant of encounters with health and social service providers. As mentioned earlier, every person I spoke to, even when they had mostly neutral or positive interactions with service providers, was aware and concerned of and had strategies to manage stigma and discrimination.

Barriers to access

The prevalence of whorephobia can act in itself as a barrier for sex workers and everyone in the sex trade to access health and social services. For example, one of my interlocutors stated that sometimes just worrying about how she might be treated makes her want to cancel appointments. I had asked in what ways being a sex worker affected her health after she told me about a stressful experience where a doctor did not listen to her concerns. « It doesn't really affect it, but, you end up walking away. Like, you don't want to be, I end up like, when, if I'm going to feel like, I'm going to get upset, I'll just cancel. Yeah. Like, I'll cancel the appointment (L., 20s, cisgender woman, indoor worker).

There are many other barriers that follow more clearly what is widely documented in the literature as affecting access to health and social services for marginalized populations, such as inappropriate hours of service, lack of transportation, services confined to certain areas of the city. For example, these 22 years old white woman listed a variety of barriers that affected her at different moments in her life in ways that reflect many of my interlocutors' experiences.

L: I used to live rurally predominantly. So, it's a two-hour drive in and out, so waiting for appointments from per se Manitoba Clinic for six weeks, a two-hour drive into the city, waiting in the… so, I had an appointment for 10:00 a.m., waiting an hour before I even get in and just to have my doctor not give me the services that I specifically requested, then to go back and not… And then have to research back the information, like fighting for my rights essentially, constantly, to get access to healthcare and then it's essentially just spending time and money out of my regular day to actually get things done, even just outside of work, out of my personal life, to get things done.

I think that they usually only do appointments Monday to Friday, like business hours, like 8:00 a.m. to 4:00 p.m., which for me is at times a very high client time, so I can be working at any time and then I have to take an entire day off, not just an hour to go to an appointment. I would have to take an entire day to go actually try to fight for my rights and still not get what I required out of it.

So, compared to that, like rurally… now I live in St. Boniface and I don't go out of the city too often, just on the weekends, so Nine Circles is on Broadway, kind of like West Broadway area, so it's not too bad. It's like one or two buses or a 10 or 15-minute car ride and the Manitoba Clinic is about 10 or 15 minutes away from St. Boniface as well. The access to healthcare, I guess the physically access to it is there, except for the services aren't being given effectively.

Claudyne: So, you can show up there and they'll let you in?

L: Yes, but they're not effective. It's not an effective service I find. It just depends I guess on who you get, which I think I kind of really crappy in terms of an overall healthcare system, especially I know that Nine Circles is over-burdened. On Wednesdays they do clinic days so that they can do STI screenings and things like that, so that's one clinic that… one clinic out of probably like 100s that are across the city that does, like transparent healthcare and that's kind of sad actually to think about it.

Because if you don't live in the city or if you live far away from it and you are someone who doesn't maybe participate in full contact sex work or just in general, doesn't have the sort of budget to move around the city, it would make it very difficult even further to access healthcare. That's if they can get you in, but I find that they're pretty effective, so that's one of those things and if people feel like they're… it's kind of like a crap-shoot, like Hail Mary, then what's the point, right?

(L, 20s, cisgender woman, indoor worker)

L raises many important points in this short excerpt. Clinics that have a reputation for offering decent, respectful, specialized services to people in the sex trade

and other targeted communities are often located in certain neighborhoods of Winnipeg only, making it difficult to access for anyone not living close, or outside the city. The opening hours can make it almost impossible to schedule appointments without losing wages. These clinics also often have requirements to be able to be their clients, be it to declare that you are part of the population they are serving or to live in their catchment area. Even "if they *can* get you in" (emphasis added), then, as she explains, you still run the chance of being treated poorly, not having access to the services that you need or having to verify everything that is said to you in the appointment to make sure it is based on evidence and not on prejudice.

As described in chapter two, the community health centre Klinic was involved in some tense relationships with the sex workers' rights advocacy group SWWAC, as well as the general sex working community over their strong position that sex work is nothing but exploitation and that groups like SWWAC are "pro-prostitution"(Sheng et Chevrier 2019). While the vast majority of the people I interviewed ended up not connected to SWWAC directly, the story of what happened with Klinic had circulated far and wide and was brought up several times during the interviews. Someone who I had never met before the interview commented on the conflict:

> *E: Okay, so like, Klinic used to be one of the places where I was, like, no, I will never go there, because I know that they don't work with sex workers. So for a long – and, like, everyone I know, and people that I work with too, yeah, they were – like, people I work with, it was the same issue, which was really weird, because in a lot of other areas, they're super-awesome. But with that one point, they were just, like, why can't you see how these things intersect? Like, honestly, these different identities intersect so much – so, so much. So that was one of the places. But it sounds like things are changing, so that's good.*

Claudyne: And can I ask you, what it is that you'd heard about Klinic, or why you didn't want to go? I mean, because of their position on that?
E: Yeah, yeah, it just didn't seem like it was sex worker-friendly, based on their policies. And that's super-alienating, and it's, like, I'm going to walk in there and tell them what I do, and they're just going to shoot me dirty looks and look down on me and not want to help me, and I'm just going to have to go somewhere else anyways, and then also feel like shit.
Claudyne: Yeah.
E: And, like, I'm doing something wrong, when I'm not doing anything wrong. It's just a job, and it's totally fine. And it's my decision, I'm an adult, and I consent to it, so yeah. And it's, like, infuriating.
Claudyne: Yeah, that is infuriating. It makes no sense.
E:Yeah, and I wouldn't want to go through that, I don't want to put myself in that position, to go ask people for help who can't even look at me like I'm a person, like, I'm just working a job like anybody else, so yeah.
(E, 20s, non-binary person, indoor worker)

This excerpt is very important because it exemplifies how even the idea that a service provider might not be welcoming or respectful impacts people's decision to utilize services there or not. In a community that is stigmatized and the target of criminalization, like sex workers, individual will not take any chances with providers who are or are rumoured to be discriminatory. As SWWAC made clear during the 2016 presentation at Klinic which will be described in chapter five, the community health centre's position, and their enforcement of it by banning SWWAC created, at the time, a significant access barrier for a community that they claim to want to support and service. This barrier was extended to many in the sex trade community who heard about the banning of SWWAC. And because Winnipeg is a medium-sized city with small and closely intertwined communities, many of my interlocutors indeed heard about it.

This closeness of social networks, which also can be beneficial in sharing information to keep one's community safe from discriminatory service providers, can

also mean that confidentiality is harder to maintain. During informal conversations with sex workers' rights activists and sex workers in general, the topic of confidentiality and "outing" oneself or another person was common and very important. A few of the people I talked to during my interviews specified that sharing a healthcare provider with a family member who may not know about their work, or just knowing that they might run into their provider in a different setting was a cause of anxiety. One person expressed their envy toward bigger cities where populations were more transient and certain people seem to be able to live openly as sex workers—something they couldn't imagine in Winnipeg.

> *And like in Winnipeg that just sounds like so awful. Everyone's parents live here, like, you know, it's so different in cities where like if I'm going to keep using New York as like the comparison, I'm like, no one's from there. You can like go there and like pretty much live your life because it's like the life that you moved there to live. But here, yeah, I just don't even know. I can't actually imagine what that would be like. The consequences is just so – and I only know like one or two people who are like actually out all the time and they seem like they have normal fine lives.*
> *I mean, I can't even imagine being out to like my doctor who's like also my mom's doctor. Like, I think the thing that I want and then maybe other things to happen like maybe that could happen in like some magical world, but like the first thing that I want is just like service providers or spaces that are like sex work specific like the way the Trans Health Clinic is.*
>
> *(L, 20s, non-binary indoor worker)*

Managing discrimination and stigma

Many described using certain strategies to choose service providers when possible and to manage their interactions with them in ways that would minimize the chances of being discriminated against. People described the array of factors that they

weigh to decide whether or not they will disclose to their service provider; the constant battle to have their expertise to be taken seriously; and myriad intersecting forms of discrimination that they anticipate facing. What is at stake for sex workers or people involved in the sex trade when it comes to disclosing their work to service providers should be clearer after reading about some of the experiences in the previous sections. This section goes on to highlight some of the benefits that people have experienced when disclosing without being met by discrimination and some of the downfalls of disclosing. Finally, I discuss some strategies that people reported using to choose their healthcare providers.

To disclose or not to disclose

A very important reason why sex workers do not disclose their profession to service providers is that it simply isn't always relevant (Benoit, Smith, Jansson, Magnus, et al. 2019). Indeed, one's profession is not relevant to getting a flu shot, treating a broken arm or getting a suspicious mole checked out, to name but a few examples. Considering the potential for stigma that sex workers may encounter when they disclose, it may not, for some, be worth the risk and stress to disclose unless they are planning to build a relationship with this provider. The following excerpts from my interviews with D and O seem to echo this idea and thought that she would only disclose that she had worked in sex work when explicitly relevant.

Claudyne: So let's say you go to the hospital because you have some sort of health stuff like when you were working or whatever; is it relevant for you to say that you worked on the street?
D: No.
Claudyne: Like it's never relevant?
D: Unless I got punched out and they ask me what happened, then yeah. Like "Okay, a john just punched me out? But even I know – I'm not telling them my past. I don't know who you are.
Claudyne: Yeah, fair enough. And why won't you tell them?
D: Because it's none of their business and I probably won't see them again.

(D, 30s, cisgender woman, outdoor worker)

Not really. Like, I've really… I guess if I was to go to a different office or something for healthcare, I don't think I would tell them I'm experiential or anything, because I'm scared of that judgement. Yeah, I'm just scared they're going to be like, uh, no, like or – or people think, some people right away think, "Okay, an experienced girl or a working girl or whatever, oh, you know, she's probably got HIV or something." Just, you know, like, touch them and you'll get diseased or something. And so that's what I'm scared of – people all getting like that, so…
I don't even tell anybody. Unless it was something that had to do with that, then yeah, I would say something. But other than that, I wouldn't say anything.

(O, 20s, cisgender woman, outdoor worker)

A few of the people that I talked to had a family physician to whom they had not disclosed their profession. The Métis worker quoted below thought that it was very likely that he had gathered that her profession was based on the services she receives from him but she stated that she did not want to have that conversation with him.

Claudyne: With your doctor now, does he know about your history or about the fact that you worked?
E: I'm sure he does, he's not stupid.
Claudyne: Have you ever told him though?
E: No, I've told him lots of other stuff, but not that.
Claudyne: Oh, is there a reason why you won't tell him?
E: Well I've told him I've had unsafe sex and that with a different partner, you know? I would tell him that. I'm sure he figured it out. I don't know

how often I went there, but too many times, you know? I mean it doesn't take that much to figure that out.

(E, 30s, cisgender woman, indoor worker)

For someone else I spoke to, who was experiential, it was preferable to her to have her service provider know of her involvement in the sex trade, and receiving care at a resource centre that focuses on people in the sex trade was a suitable way for her to have that be known without having to discuss it directly.

Claudyne: For some people it's really important that they're person see the doctor or nurse practitioner or whatever that they know that they have a history in the sex trade or that they are working. Is that something that's important for you?
A: It doesn't matter to me really.
Claudyne: And did it matter to you before when you were working or is that something that changed?
A: I didn't really go and see the doctor like before, I used to be ashamed and I'm not ashamed anymore though.
Claudyne: Yeah, you have nothing to be ashamed about. Have you ever like outed yourself to a doctor or to a nurse? I mean if it was relevant or...
A: No, but I think that's why I'm more comfortable going over there because they know my history right. I'm already down there. That's how I found out about there because I – through Sage House. So.
Claudyne: Because they told you. And is there a difference between like a doctor that you see that that knows your history and just another random doctor that you can see at a walk-in clinic?
A: I'd rather have – I'd probably rather see a doctor that knows my history you know? It's more comfortable for some reason, you know what I mean? And like you know, if they know of you, you know a little bit of your history, right, they can help you better too.

(A, 20s, cisgender woman, outdoor worker)

The following vignette shares a slightly longer narrative of a woman in her early thirties who has worked in different areas of sex work in the last decade, both as an indoor worker and as an exotic dancer.

L's story

I met L. in a local pub, on a surprisingly warm September day in 2017 to do the formal interview for my doctoral work. She was coming from another "vanilla" job she has in the finance field and looked stunning in her distinctive punk-rock look. I was so pleased that she accepted to talk to me and she made sure to tell me that she did so because she knew me, the work I do with SWWAC and that she knew I would treat her story with respect. I assured her that I take every precaution when it comes to confidentiality and explained my strategies to protect my interlocutors' anonymity.

I first met L a few years ago through mutual friends. We were both starting graduate degrees in different fields. We met when I was attending a local conference discussing sex and drugs and harm reduction in a community centre where L was going to give a presentation about her work and her experience. L started working as an exotic dancer when she was 19 as a way to support herself as a student and to have more independence. She has worked on an off in the last decade, and eventually also worked as an indoor worker, offering erotic massages. She has recently started working again as a dancer. She once told me about how being a sex worker was a lot less exploitative and dehumanizing than a "vanilla" job (referring to a job outside the sex industry) she got through a temp agency for an insurance provider. She took the job at the insistence of her then-boyfriend, who was uncomfortable with her being in sex work. In a small hipster coffee shop a few years ago, she told me about how she felt disrespected by the mangers there, that she had to work long hours that "took over [her] life" for a lot less money than she made as a sex worker. "It just felt so ridiculous to me that that job was supposed to be 'less exploitative' than sex work but then it was! It was a lot more exploitative", she explained.

During the interview, L said that she has never disclosed to a healthcare provider, because she doesn't "trust any of them to be safe". Exotic dancing is a physically demanding job that requires a level of physical and emotional strength and skill that often goes underestimated. As it was relevant to what we were talking about, she told me about the demanding movements required, performed in high heels, that led to recurring back issues for her. She has sought treatment from various practioners over the years like chiropractors,

physiotherapists and massage therapists without ever being able to tell them that she is a dancer. She would have to come up with stories about how she got her injuries or be careful to be "vague but believable" in order to get what she needed and avoiding being stigmatized, judged, or hurt. She once hinted that she was a dancer to a massage therapist. I say "hinted' because what she told him that she was a dancer and was vague as to where she danced, but she got the distinct impressions that he assumed she meant an exotic dancer. She described feeling horribly uncomfortable during the duration of the massage. "*Once it ended, he was looking at me in a way that made me nervous and he made a comment about what kind of dance I do to have this specific injury and something about seeing me again. He gave me his personal phone number… it was just weird and felt off and I just left as soon as I could*". She never went back to see him again.

She had a family physician for years and, like other workers I spoke to, she never felt comfortable talking to about her work. The physician knew L 's mother and generally had an attitude around sexuality and relationship that made L feel judged for everything, and she assumed that it would be much worse if she were to mention sex work. Her physician would assume that she was in a monogamous relationship and ask for reasons to get STI testing. Eventually, her physician retired and she moved to a community health centre that other workers had recommended.

> *It was so stressful to ask for what I needed and ask questions without giving it away, without giving the big secret away. I used to have to try and do that with my family doc - my old family doctor – all the time. Until eventually, like, I just went in there one day – she'd already told me that she was retiring.*
> *And then one of my last appointments I went in – because she never wanted to give me STI tests. I'm just, like, just – you know, and I always had to be, like, well, like, I don't know, maybe my partner this or that and I don't know – like, they cheated or something, because I didn't feel safe to say I do sex work, and I'm queer and non-monogamous, right. Because I'm like, you're going to hate me if I say who I really am.*
> *So I would just, like – she would never want to do it, and then she was retiring, so I was, like, well, you know what, fuck them; the relationship is already screwed and dying, so I just went in there and I'm just, like, you know what, give me every freaking damn STI test ever in existence now. And she's like, oh – I'm like, every blood test, everything, like, give me all the information.*
> *And she sent me to go get every test and she's, like, oh, okay, like, but aren't you in a relationship. I was just, like, yes, I don't care, I don't care, I don't care.*

Send me the slip to go get the tests now. And then she finally did, and that was, like, our last interaction, and then I was, like, okay.
And then she actually called me, which she'd never done before, to tell me what my results were. Like, she would, in the past, if I finally got her to let me do it, she just said, like, well, if it's fine, then you won't hear from me, or whatever. I was, like, okay, cool.
Yeah, it wasn't that great a care, but it was something, and I didn't know what else to do, so I was, like, I need some kind of healthcare, I need to at least still keep getting, like, my birth control and my migraine pills. And this person does that, so I don't want to burn any bridges with her, so yeah.

Then she retired and I was, like, okay, this is scary, but also, I guess, it's the kick in the ass I needed to find someone else. I didn't know how to find anybody, and yeah, and then my friend started telling me that they'd got into Nine Circles and that I would be able to get in easy. And I was, like, how would I get in easy? And they were, like, well, you are this, this and this, and you do sex work. I'm just, like, oh, okay, I didn't know that this place was that great, or that I could get in there. I thought it was just, like, the door was closed to me.

But they were, like, no, go in there and talk to the social worker and, like, be honest. All the things – everything that you've been too scared to tell your other family doctor, go in there and be brutally honest and say it all to the social worker, and you'll see, it's totally different.

And so I did that, like, shaking and freaked out, yeah, and having a panic attack. But she was really, really, like, soft and gentle with me, so it made me feel – like, it was easier to just load it all out really quick, and, like, not skillfully at all. [Simultaneous talking], and she's, like, okay, yeah, well, we can help you, yes. I was, like, oh, whew, all right. You're not saying, get the hell out, so …

I reflected that her shock at being treated with basic decency was telling of how stressful getting healthcare had been up to then. She agreed and told me how frustrating it is to have to put up with so much stress just to have what she needs.

I don't want to say that I'm thankful for not being stigmatized for something I do, you know. But is does make a really big difference to not be scared when I have to see my healthcare provider. It's a whole world of a difference, to be treated like a person and to understand the risks, as opposed to feeling like I am the risk.

I asked L what exactly she was afraid of before disclosing, what was going through her mind before disclosing and she told me:

> *Well, I was just afraid that they were going to treat me badly, I guess, that they were going to – I don't know – give me dirty looks. I don't know, just, like, all these weird things I'm spiralling down the rabbit-hole, like, they're going to call me a whore or they're going to spit on me, I don't know. Or kind of kick me out, they're going to be, like, you're gross, like, why do you do this, do you have no self-respect. Or just, like, this – yeah, just anxiety of all the horrible things that someone could do to you if they don't know you.*

As with L's story, many of my interlocutors had to massage their stories to fit into "vanilla" ideas that service providers might have around work, be on guard for any sign that the provider may catch on to what their occupation is, and brace themselves for potential consequences in the form of denied healthcare, judgement, breach of confidentiality, inappropriate or dangerous behavior. Disclosing that you are a sex worker, or indeed avoiding disclosing it weighed on every interaction with healthcare provider and created a veritable minefield for them to navigate. In some cases, when workers did disclose their occupation or experience in sex work, the assumptions about what their work entails, what sex work is and their "risk" created more stress and opened up new "categories" of assumptions (such as "potential substance user", "engages in risky sexual practices", etc.) that were then left for them to decide to challenge or not.

Disputed expertise

Several workers I spoke to always or often disclosed to their healthcare providers. In several cases, they told me that it did not affect the care that they got. Some described disclosing and doing the educational work that often comes with saying

that you're a sex worker as a type of "investment" in their relationship with their physician, nurse practionner or any other service providers. Indeed, the assumptions and negative perceptions associated with sex work are so prevalent that it is rare for sex workers to be able to disclose to anyone without having to "*explain everything*": dispel myths around violence, childhood abuse, substance use, define the vast variety of sex work that exists, defend one's ability to make the best decisions for themselves, explain the legal context, and impart that they are not, in fact, ignorant about safer sex practices. Many interlocutors, especially indoor workers, would mention how exhausting it is to, even when they finally work up the courage to disclose to a provider, to be met with ignorant assumptions and uninformed advice. One person reflected on the assumptions made about sex work and how they were mirrored in the language used in different services around risk.

> *T: You're like "I have to hide and I'm not going to be able to access the care that I require because I have to be, like kind of devious." It's frustrating sometimes.*
> *Claudyne: Can you give me an example of the language?*
> *T: I went into my GP to get pregnancy tests and just basic STI screening, like regular three-month check-up, and the language that he used, like he at first suggested that I was participating in unsafe, high-risk behaviour. And that's essentially what he… sort of what he said, but it was a little more offensive. "How many partners do you have?" And you answer the question just honestly and the look on the face combined with "Well, shouldn't you be using contraceptive protection? Do you need birth control?"*
> *It's really interesting how they put it in terms of when you reveal to them, like per se suggesting that I was being unsafe as opposed to, like at Nine Circles them saying, "If you are a sex worker, that tends to be more of a high-risk profession," which is different than… it's not a judgement on me, it's truth. It is more of a high-risk profession; therefore, I would probably want to be getting tested more often, etc., etc., and I can also decline if I don't want to. Per se, if I go to my GP, he would say, "You engage in high-*

> *risk behaviour." I've heard people even say, "That's promiscuous." I've heard people suggest that I have an STI when I don't, when I came in per se for when I accessed that healthcare at... I explained that I had a pre-existing condition and they automatically just suggested that I… because I was a sex worker with high-risk behaviour that I was infected with something… which was not the case. The only person I engage with unprotected sex is my long-term partner, which… It's one of those 50/50 things, you know what I mean? Why stigmatize something when it could happen to anybody, especially when I do this as a job, that makes me feel really crappy about who I am and about my body, and especially if it's not something that I really even did myself or knowingly, like being 100% protective.*
> *I could still be exposed to something and because I went to go find out, I'm now discriminated against because I'm doing the safe thing, which is horrifying because you want people to be encouraged to do the safe thing, not to be discouraged to do it, which is from what I hear, very common and unfortunate.*
>
> *(T, 20s, cisgender woman, indoor worker)*

T went on to explain that she is extremely safe and well informed about safer sex practices, as sex workers often are (Benoit et al. 2014). Many of my interlocutors echoed feeling like they know more than their healthcare provider, but that they still have to sit through paternalistic lectures about safer sex or sometimes being given inaccurate information and having to ask other workers for evidence-based information. The worker interviewed below described harmful advice they were given by a doctor and the second one having to go to different places to get the information they need to be safe.

> *L: I had an experience with my first doctor, it was horrendous. I was masturbating with a Hitachi wand, which is a power rim device, it's pretty powerful. And I had damaged some [schemed] that got over frictioned and they swelled so it looked like I had three clitorises and I was like what's going on? So I went to the doctor and I asked him what was happening? I had to come home and figure everything out on the internet after because she didn't know. And then I put her in shock. She went*

outside, she gossiped with all the nurses and the doctors and she couldn't believe it and she came in the place with her mouth jarred at me disapprovingly four or five times going you did what, you did what to your vagina, you used what? And then she forbid me for masturbating for a whole month, that was her treatment.

Claudyne: What, are you kidding?

L: And all it was is when I got on the internet and I figured out what I was actually looking at atomically she didn't even know, she didn't even know. It was schemed glands, they're typically - they can clog, it's just like milk ducts. It's a duct system so if the secretions I guess are blocked then it's going to swell a little bit until it gets relieved. So it just takes time, it goes away, it's not a big deal.

Claudyne: No. And Dr. Google was better than your doctor.

L: That's right. So she shamed me, humiliated me, spread all my confidential information around the office to her colleagues, snickered and laughed, I could hear them outside the door talking about it and they had to explain it to her.

Yeah, so I have a family doctor that I've gone to all my life pretty much, yes, I guess my regular care provider. I'm not like honest with her about those things. She's like pretty uptight and like one time I asked her about like safe anal sex and she like totally freaked out, so you know, we don't really talk about that much. But I do go to her for regular STI tests and like she prescribes like my anti-anxiety drugs.

Yeah, she's like my regular care provider and has been like tracking me long term. And then I also go to Nine Circle sometimes I guess if I want to get an STI test like faster like within like a few days or if I have questions about things that I don't think my family doctor like would be able to answer. And even in Nine Circles like I've never been to a service provider that actually like knows the answers. I feel like, I was asking in Nine Circles I was asking them about like herpes transmission and the nurse was like, I don't really know and all my pamphlets are gone, so Google it. Wow, like I could have done that, like I did, it's very confusing. So I have, I mean I also just like ask C. things cause C. like knows the most of anybody.

(L, 20s, non-binary indoor worker)

C is another worker who has extensive experience in harm reduction services and who is very well informed. My interlocutor above was lucky to be able to have access to such a resource to answer their questions when their doctor could not. It is frustrating to have to manage the reaction of the service provider one discloses their occupation to, in addition to having to doubt the validity of the information you receive

and/or to do your own research on the health issue you are consulting for. For sex workers who already had to weigh the harms of disclosing or not disclosing, it can feel very alienating.

> *Yeah, I mean it's just so obvious, I mean being like those people at [Vancouver clinic that works only with sex workers] are like specifically here to work with sex workers. They like know how to, and you can like tell, whereas anywhere that I go in Winnipeg it's like I do not expect that they know how to work with sex workers. Or even like with queer people, or like trans or gender queer people. Yeah, Nine Circles I think is the only place where like I actually told them that I was a sex worker, and like the person like responded really well and I mean it was kind of funny. She was like oh, great, that's amazing. I'm like okay, cool it. Is it amazing? Like I think you're over compensating but I appreciate.*

As L added, in many negative experiences that sex workers had, other factors played out—like sexual orientation, gender identity, drug use and racism, which will be discussed later in this chapter.

Choosing the provider

Some would get their sexual health needs met only from certain trusted agencies or healthcare providers. They often got their recommendations on here to go from other workers. The relations of trust that they built with those agencies and service providers were always described as very precious. A cisgender woman who declined to identify her race or ethnicity learned of an agency because her mom used to attend it.

> *I don't know. . .like. . .if you went in there with a problem or something and you can just come walk in, like one time for me, I had to come in to see the nurse and she's like "what's going on?" So while I was getting high and the fucking brillo flew through the pipe and hit the back of my throat (laughs). You can laugh about it because it is funny but it hurts, I'm like, "I*

don't know if it's still stuck in there". She giggles at you but you know that they're not laughing AT you.
They're like, "oh my God, k let's check this out". You know what I mean? They're there for you, even, again, Sage House was the place I found out I was pregnant with one of my children and then they just ask you questions like, "have you been actively using? When was the last time you used?" And stuff like that because they wanna gather that information to help you the best way they can. You know? The other people it's like, "oh are you into drugs?" Just the way they say, it makes you feel like you gotta say no, you know what I mean? Whereas Sage House it's like, "yeah, you know I was getting high last night". Then, "do you have plans to quit?" "No I don't." You know what I mean? "Ok well let's get you some vitamins or something and lets try to make this the best pregnancy possible the way we can." Stuff like that. They let you know that they're there for you. I don't know if my- not that I feel that I'm special in any way- like I said, I've been around Sage House before I was even entrenched in that stuff so the workers were there a lot for me and my sister. They almost went above and beyond cuz they knew that was us. With a lot of people, they're fourteen, they grew into that stuff so that's all they know. Where with me, I never knew that stuff. They know that that's not where my endgame is I guess? (chuckles) I dunno it's just very welcoming. It's not like they're changing workers every week or something so you grow to know them and build relationships with them. Well they build them with you.

(D, 30s, cisgender woman, outdoor worker)

For others, factors like the gender of the provider, their religion or their age also played an important role in assessing or attempting to assess their views—and potential reactions—regarding sex work. The opinions and experiences of other workers played a major role when deciding where to access services for almost everyone I spoke to. The quotation below echoes this clearly.

I actually talked to a lot of other sex workers, which was very helpful. I was very, very worried about even just trying to access outside healthcare because of the fact that I had experienced so much discrimination from my current doctors that I was a little leery about that. But people told me, who are also sex workers, and people from the queer and trans community that they went there. They felt very accepted, very helped, and

so I decided that that was something that I could give a try. Yes, it was very helpful.

As mentioned by the person above, sex workers experience discrimination and stigma for other reasons than their involvement in sex work.

Racism, queerphobia, sexism or whorephobia, who's to tell?

My interlocutors, besides all being sex workers or having experience in the sex trade, were a highly diverse group in terms of age, race, gender identity, sexual orientation, socioeconomic background, views and practices surrounding substance use (some were entirely sober, some used regularly or occasionally, some stated that they lived with problematic substance use). This means that in many situations, it was unclear to them if they were being discriminated against because they were sex workers, or because of their (often assumed) race, substance use, or any other characteristic about them. In some cases, like the one shared by V. below, the discrimination was made quite clear, however.

It was really sad, because it was my first appointment with meeting a doctor. And I was all pumped up that I got a doctor. And I go in the room, and he starts asking me questions. He maybe asked me three questions, and I answered them. And he told me, "I don't help your kind of people." And then I looked at him, and I got out and I walked out, just crying. And I told my worker, my support worker. And she was furious.

(V, 30s, cisgender woman, outdoor worker)

Several workers I spoke to also revealed that it was common for service providers, and especially physicians, to assume that people in the sex trade all had problematic substance use and refused care on that basis. As one cisgender worker put

it, they think "*Oh, it's just another, in other words, you're another junkie coming in just trying to get some pills to get high or, something like, that."*

It was very common for people I spoke to feel that their queerness was a source of discrimination, or at least that they were constantly made to feel "not comfortable with [their] queerness" in their interactions with service providers. Sometimes, this served as a red flag regarding how the service provider might react to their involvement in sex work.

> *And the same with me; I was always too scared to tell my previous family doctor, yeah, because she just definitely was that person who didn't care in the first place about any of my health problems, or my pain – my chronic pain – or nothing, didn't care. And seemed very, like, heteronormative, I guess, so even, like, making all these assumptions about my orientation and, yeah, like, my relationship structures. So I already didn't feel comfortable with my queerness there. So it was, like, there's no way I can tell this person that I do sex work, like, there's no way, yeah. They might even stop seeing me.*
> *I think I've mostly kept what I do pretty secret, especially when it comes to the healthcare system because I've been too afraid to deal with the potential shaming from people, and homophobia – homophobia, and – yeah, so I've tried to read people's mannerisms and their tones when they ask me those questions, you know, and how they react when I give them the answer they want, compared to when I say something kind of off to them.*
> *Yeah, I mean it's kind of like what I'm used to and like, you know, raised as a female and like women get like bad health care and like bad treatment generally now. Like I'm gender queer and like definitely trans people get like bad treatment and bad health care and like, you know, just like I'm queer, nobody knows about queer shit, like I just kind of expect that people that everyone hates.*
>
> *(R, 30s, gender queer person, indoor worker)*

At the intersection of whorephobia, discrimination against substance users, racism, queerphobia and transphobia, it was hard to distinguish as to why my

interlocutors were being discriminated against, but the consequences on their access to services they need, and to their self-esteem, safety and well-being, was evident.

What is at stake

The previous sections of this chapter should have already made abundantly clear what is at stake for workers when they fear, strategize, and navigate the minefield of stigma and discrimination surrounding service provision. However, they told me in no uncertain terms what it meant and how it felt to them when they were treated this way and how it affected their future encounters with service providers.

One cisgender Indigenous woman who had a negative experience with a doctor who made assumptions about her life and made her feel like a "*yucky girl*", even while she wasn't working as a sex trade worker, modified her approach to healthcare providers to avoid the possibility of being made to feel that way again.

> *And the doctor treated me badly because he said, "What are you doing with yourself?" And it was- he wasn't even in the sex trade. He's like, "oh what's wrong now?" and I'm like "I got that smell again." "Well who were you with? Don't you wear a condom?" "He's my boyfriend." And this guy made me feel. And he made me feel like this was my fault. "You're the girl, you're the yucky girl. Why don't you look after-" And just like, "you're a doctor." And I was made to feel like I was a yucky girl. […]It affects your self-esteem, for sure. It also affects your self-confidence when seeing another doctor. It affects how open you would be and how honest. I was honest with this last doctor and I was made to feel like a yucky girl so why am I gonna open myself to hurt and shame again?*
> *I was definitely intimidated to go to the doctor after that when I had a case of BV. I just wouldn't say anything, I was just like, "yeah can I just get a swab(?)?" I wasn't even sick cuz I didn't even, I would know what was going on but I wouldn't wanna say because of that experience so I would just say, "can you just do the whole pelvic exam?" and have the go*

through the whole thing instead of just saying what the actual problem was.

(J, 50s, cisgender woman, indoor worker)

This experience she had early on not only shaped her future interactions with healthcare professionals, but her relationship to herself, her body, her sexuality and her self-esteem.

Because of the nature of their occupation, sex workers who engage in physical sexual services described how having access to the medical care that they need is crucial for their own health, and in this case survival, but also to keep their communities – which include people they have sexual contacts with— safe and healthy.

The first time I went to talk to my doctor about when I first started into full-service sex work, I thought I would be okay, so I sort of went in there with a brave face on and was quickly thrown in the defensive and turned around and realized that I couldn't expose myself. Then I didn't bother asking for STI testing, which then put me and everybody else that I worked with at risk when I was 25. That's very frustrating and if I would have had proper access to proper care at the time, who knows what I've been able to do with my work alone, let alone my personal life.
I should be able to across the board, disclose. It's a healthcare issue. My job boils down to, it's healthcare thing and if I don't have the proper access to healthcare, I could not only be sacrificing my health, but the heal of other people, especially with things like HIV and things that are particularly, non-reversible with medication to an extent.
I don't want to have to put someone into a situation or have to access the entire network of people that I know to let them know that they've been infected and how am I supposed to know that if I don't know that? It's really frustrating to have to worry about that sort of situation. If I could go to my GP and say, "I'm a sex worker. This is what I need" and there, done.
…
I have to go back. I have to. He's my GP unfortunately. The system is overburdened. So, I'm forced to go to my GP because I have uterine cancer. I'm stage 3, so potentially if I don't maintain my appointments with my OB/GYN and my GP, I could become terminal, which is wholly, obviously not the idea. I don't want to die, I especially don't want to die based off of the fact that someone wants to discriminate against me. So,

> *I'm forced to go and I'm forced to be discriminated against by my doctor every six weeks, sometimes more frequently than that. Then if I go to hospitals, again, I'm forced to and I don't typically disclose when I go into the hospital.*
>
> *(L, 20s, cisgender woman, indoor worker)*

Keeping herself safe and healthy, and keeping her community healthy for L. meant subjecting herself to regular discrimination. So many people I spoke to described that feeling of 'having' to subject oneself to discrimination in order to get what they needed. L also described how this made her feel.

> *Well, I feel crappy. Immediately I shrink. Immediately I shrink and immediately I have to realize that I am now on the defensive. I am now defending myself as opposed to accessing services that I need, so my doctor makes me feel really crappy. It makes me feel that I shouldn't be working in sex work. It makes me feel like every choice I've ever made since I was a teenager is invalid and it's not okay. It makes me feel crappy. I makes me feel that I couldn't… like I could not access the care that I need, therefore I get anxiety about it. I suffered from depression for quite a while because I was unable to find out whether or not I could get proper testing.*

Conclusion

> *The research is really… it's important for us, especially as sex workers because of the fact that there's such a stigma around sex work and even without sex work, it's hard to access healthcare services in the country and the city as well. Then you add the fact that there is a stigma of sex work, which makes it almost impossible.*
>
> *(D, 50s, indoor worker)*

This chapter explored the multi-layered and intersectional experiences of stigma, discrimination and its self-reported consequences on the health and well-being of sex

workers and people with experience in the sex trade. It also illuminates their attempts and strategies to keep themselves safe while accessing what they need. In order to manage the stigma and poor treatment they might encounter if they disclose their involvement in the sex trade, my interlocutors used different strategies, such as not disclosing, disclosing only to certain providers in certain cases, or avoiding certain service providers.

Recent research in Canada also highlights the thoughtful weighing that sex working people go through to deciding whether or not to reveal their occupation. Benoit and colleague (2019) found, in their analysis of 218 accounts from sex workers all over so-called Canada that their participants also had mixed feelings about disclosing to their service providers. Much like my interlocutors, their participants who chose to not disclose were fearful of negative treatment, concerned about confidentiality or did not consider it to be relevant. Interestingly, they found that those who did disclose their occupation mainly described benefits and only a minority experienced judgment, stigma and inappropriate healthcare. While they praised the work of healthcare providers with sex workers who disclosed their occupation, they highlighted the need for some providers to learn how to better care for and converse with people in the sex trade. The burden of the decision to disclose or not disclose and of assessing if the risks of disclosing might be made worthwhile by the potential access to needed help and support, the research work to decide where to attempt to access services, and the very justifiable fear and stress that surrounds the whole process is a substantial amount of work that sex workers face when accessing any services.

The conflict involved in the process of deciding to or not to disclose one's involvement in sex trade to a healthcare provider is another side of the social process that I call deliberative identities. My interlocutors discussed and deliberated within themselves but also within their communities the costs and benefits associated with disclosing. Additionally, depending on their experience and their self-identifications with the different identity labels of "sex worker", "experiential woman", "sexual exploitation survivor", another layer of deliberation was added to assess the organizations where their experience and identity would be heard and respected, and the personal views of their healthcare providers. Once again, my interlocutors were forced to wrestle with categories that seek to confine their life experiences.

As in the research quoted above, my interlocutors often described— and indeed cherished—affirming, caring and respectful interactions and relationships that they had with different service providers. The following chapter will focus more directly on what happens when sex workers receive care that they feel is adequate, safe or even just neutral.

CHAPTER 4

"I JUST WANT TO BE TREATED LIKE A HUMAN BEING"

Sex workers and people who have experience in the sex trade are constantly cast in simplistic binary categories: exploited persons or dangerous temptresses, members of a risk groups or victims of oppression, entrepreneurs or threat to marriages, symbols of empowerment or ultimate pawns of patriarchal domination. These categories are always looming over and in the background of conversations, news articles, provocative think pieces and policy reports regarding sex work. As soon as it is known or suspected that someone might have experience in the sex trade, the specter of these categories appears to color their interactions and changes the quality of their relationships. Like stigma, these categories stem from and feed on systems of oppression and thus participate in reproducing and maintaining them (Parker et Aggleton 2003). Heated controversy inflames academic, political, activist and public health arenas that attempt to confine the lived realities of people selling sex within categorical limitations. In this chapter, and throughout this thesis, I document how the lived experiences of people in the sex trade cannot be fully contained but, instead, leak out beyond these restrictive categorical boxes. Other sections of this thesis focus on the ways in which identities – that may relate to the categories mention above—are deliberatively brandished by different actors to make sense of their experiences or as tools in the enactment of moral and political projects. The previous chapter highlighted how the assumptions, misguided opinions, well-meaning advice and sometimes prejudiced and ignorant behavior affected sex workers in their attempts to seek the health and social services that they

need. The sex workers and people with experience in the sex trade that I spoke to had a lot to say about how these categories, and the various ideas associated with them, can be harmful to them.

To underscore what was described to me as the difference between what "safe" interactions look and feel like, I spend some time in the following pages presenting people's narratives. My interlocutors were very generous in their recommendations and advice for services providers on how to make the services they need more accessible, more welcoming and more relevant. I then move on to discuss the varying importance that people placed on their negative experiences with health care providers. The conclusion of the chapter then highlights some of the suggestions for services that were made during the interviews, organized under the main principles of harm reduction. Harm reduction can be defined as the "policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption" (International Harm Reduction Association 2010). As the 2016 Winnipeg Regional Health Authorities stated, its "principles can be equally applied to other stigmatized and/or criminalized practices and behaviors related to substance use and sex" (Winnipeg Regional Health Authority 2016, 3).

What does "safe" look and feel like?

While everyone I interviewed about their experiences with service providers were concerned with discrimination and stigma, and used strategies to manage or avoid

it, not all of them had negative experiences personally. I asked my interlocutors about safe and affirming experiences they may have had. For instance, I asked them how they knew, walking into a meeting with a service provider, if it was going to be a good experience, and to describe the clues or markers for that. M., a white cisgender woman in her late 20s, told me that there is no way of knowing from the start if you're walking into a safe environment or not. She then walked me through her process to assess safety and contrasted safe and unsafe experiences that she has had.

> *You don't. I don't. I expect it to be safe and that's the unfortunate thing, is I expect it be safe, I expect it to be transparent and it's not, and I have to go in there and I have to kind of give my society projected out in public me, my every day personal me and leave my profession aside and then kind of just get a feel for who the doctor is and listen to how they speak to me and just try to understand them.*
> *As I reveal what sort of services that I'm seeking, see how they respond to that and hopefully they respond positively. When I first when into Nine Circles I didn't reveal that I was a sex worker because I was still worried about how I was going to be treated. When they went through their basic questions, I just answered them and when she asked me things, I just explained to her that I…whatever, like I engage with… I'm always saying outside of my long-term partner and that I do engage in high-risk behaviour that would be considered getting prevalent to getting testing regularly, so I just wanted to see how that felt.*
> *Even when she [the nurse at her current healthcare provider] asked me to reveal how many partners I had in three months, I was weary because the last time someone did that to me, they gave me the very, very, very bad, you're a disgusting person look, and then suggested that I get an HIV test because I'm probably dirty: "That's a lot of people to have sex with in three months"…That's not something you're supposed to say. My GP said that. My female OB/GYN said that. Maybe not in… what they consider "appropriate doctor terms," I guess, but at the same time, my GP flat out said that, "That's quite a lot of people. That's what I would consider high-risk." How about "That could be high-risk"? That's all you need.*
> *(M, 20s, cisgender woman, indoor worker)*

Reminiscent of what was discussed in the last chapter, M describes how past negative experiences of judgement and stigma continue to haunt and shape her encounters with service providers. Her experience also highlights the courage that it takes for sex workers to continue to seek services—in this case sexual healthcare—while managing the risk and consequences of experiencing stigma. Later, M told me what a difference it made to receive care from a safe provider and how good it immediately felt, with her stress melting away as soon as she was able to disclose her sex worker identity without being disrespected.

> *Like, my quality of life has just, like, so much improved, and the treatment that I get there, like, just as a person too, and people listening to you, and taking you seriously and doing what you want, and not saying, stupid shit, like: "You're too young", or, "But you're in a relationship, right?", and I'm, like, well, yeah, but what the hell does that have to do with this… And then I'm like, okay, I don't feel comfortable telling you my other job, and that I'm also queer and non-monogamous too. So it's nice to be able to talk about all those things.[…]*
> *She made me feel really comfortable. And it was scary going in there and talking to complete strangers about that stuff. It's really weird to go to somebody, even a social worker, and sit in there and feel like, uh, "I need to come to your clinic, because I can't go anywhere else, because I do this thing and they don't get it, and I heard that you guys get it." Yeah, and to have them actually respond in a really supportive and warm and friendly way, and then give you all the information about what they do for people who have my job there. It was scary to do it, but then once I'd said it, and they reacted so well, like, my heart rate went down instantly, it was just, like, [sighs], exhale. It's like, okay, this is really nice.*
> *Like, I just need you to do this for me, give me these tests, give me this information. Like, remember that this is my situation and when you come in here and you talk to me, like, be careful about your language too. And yeah, just treat me like a regular human being, just like everybody else, you know.*

People sometimes looked almost apologetic when telling me that they had a good relationship with their doctor or social worker, or that they had never really

experienced outright discrimination. I would spend time assuring them that I was also looking for positive experiences[21], encouraging stories that showed that it is possible for service providers to have affirming, respectful interactions with people in the sex trade. For this reason, this chapter features quotations that describe stories of feeling "safe" with service providers and what aspects made the people I spoke to, like the woman above, feel safer: relationship building, the absence of judgement and attention paid to respect and consent.

Relationships

In M's narrative above, she emphasizes how important it was for her to be able to talk to someone who would remember her situation without making her feel ashamed or judged; someone who also would be careful in the way they speak to her. Considering emotions that may surround disclosing one's past or present involvement in sex work to service providers, once my interlocutors found a person that they felt that they could trust, they attempted to maintain that relationship and valued it greatly. The efforts of specific service providers to build relationships with their clients or patients was very much appreciated and often the reason why they kept going to see them. H, a non-binary person in her mid-30s, who self-identified her race/ethnicity as being "a mix", described how the fact that the service provider listened and took time to discuss

[21] As opposed to exclusively negative experiences with service providers. Indeed, I was interested in hearing about what was working as well as what isn't working with service provision for people involved in the sex trade.

things with her convinced her to disclose that she sold sex during their second appointment.

> *That's what the Nine Circles, the nurse practitioner did for me. When I started listening to what she was saying to me, I was more comfortable and on the second visit of being there, I just revealed to her I was a sex worker, because just in general conversation, talking, I was getting shots and stuff and general conversation, I just… She's like, "Okay, are you in healthcare?" Because I alluded to high-risk behaviour and I don't even like saying it like that, but it's just the only way to say it without being… without outing myself… it's the only way to say that without outing myself, so that's what I kept saying to her and I guess she was kind of prodding to understand a little bit more and then I was like, "No, I'm a sex worker," just flat out. She was like, "Okay." Just okay. That's it. Okay. Again, that was just a personal, casual conversation, as opposed to her trying to find out about my outside life. That was something I just revealed to her based off of feeling comfortable with her after… my first visit was 45 minutes.*
>
> *When I went in there the very first time, they went through the questionnaire. They gave me medication suggestions and then also waited outside another patient's door to access their doctor, they only have one doctor that works there, to make sure that she could drag the doctor out of the room as soon as he was there, into my room, to see me because she had concerns about my sexual health because I hadn't been taken care of for so long.*
>
> *Even that, that kind of behaviour just showed me that she was, whether she wanted to judge me or not, she cared, which was super important to me, that I was being taken care of. I felt like I was being respected and taken care of; therefore, the next time I saw her I was like, "Yes, this is what's up. I don't need to hide anything from you." As opposed to my GP, who I've been seeing for 10 years and he still doesn't know that I do that stuff, so…*
>
> *(H, 30s, non-binary, indoor worker)*

The care that the nurse practitioner showed, even though my interlocutor still had uncertainty about being judged, led them to feel that they could trust this service provider as opposed to their long-time general practitioner. Everyone I spoke to who

had what they considered to be a positive relationship with a service provider valued it. K, a cisgender woman in her 40s who self-identified as Neechi told me that she was very comfortable in one community health clinic that she visits because they address her concerns as they come up and are flexible in their procedures, which makes their clients comfortable.

> *Everything that you need – okay, like, I'm going to just use Klinic as my example. When I go there – I just went there last week – I was like, okay. I had this big ass like line – like, it was huge. And she was like right on the internet, because she didn't know what it was, right? So she's like right on the internet with me. And she's like, "Oh, it's probably this." And then I have like this boil right here. And I was like, "Okay, I need to show you this now." Like, I was totally comfortable with it. I'll just pull my pants down right here – just joking, you know? And then like for testing and stuff, it's not uncomfortable, because you get to do your swabs and stuff yourself. So you can just go in the bathroom, do it yourself. You don't have to undress and put your legs up on the thing. You just do it all yourself, so it's really comfortable and easygoing.*
>
> *(K, 40s, cisgender, outdoor and indoor worker)*

An important marker of safety in relationships built with service providers for the people I spoke to was the time spent with them, as the next excerpt details:

> *The good services yeah and they take their time to like sit down and talk with you. If there's anything --if you have any questions about symptoms with yourself and why is this happening? Blah, blah, blah you know, like just every little detail, whatever you have inside yourself that you just want to say and you have questions for them which is good.*
>
> *(Y, 20s, transgender woman, meets clients on the street)*

Taking time to talk and address the concerns of their clients, taking steps to show that their well-being was important to them, contributed to making them comfortable and to building trust for my interlocutors in their relationship with service providers.

No judgment

An important part of the affirming experiences that people described with service providers was the absence of judgment. That meant not feeling that service providers attributed a negative or even positive value to being involved in sex work but also that they did not feel like assumptions were made about them based on their experience in the sex trade.

For some, it mattered that service providers understood that life circumstances or other factors played in their involvement in the sex industry, and for others it mattered that service providers respected their judgement and their ability to make decisions for themselves. The following excerpts highlight this preference and why it mattered to my interlocutors.

> *They appreciate the fact that the girls don't choose what- the girls or the transvestites don't choose their lifestyle. They know that if mostly they're born into it. If their family doesn't have money, if they don't have money, if there's all kinds of trouble in the family. Chances are, you're not going to get a lot of help. And maybe sometimes the wrong people will misunderstand you. So they're very sympathetic.*
>
> *(N, 20s, cisgender woman, met clients in bars and on the street)*

> *Claudyne: Did you… again just because I ask questions, it doesn't mean that you have to answer. You mentioned that you had to deal with CFS for your kids, I know they can be particularly prejudiced around folks who have experience in the sex trade or whatever, did that relate in any way? Is there anything you'd like to share about that?*
>
> *B: Honestly, I don't think they ever, I don't know. I've had some pretty good workers. I think I've been lucky. I mean they made me do a lot of fucking work (chuckles). But they've never made me feel uncomfortable going, they knew what I did, it's not like I was open and honest, well not honest, I wasn't open about the situation, they just knew, the main problem was the addiction right? Cuz if I didn't have the addiction I wouldn't be on the street so that's where they based it on was the addiction.*

(B, 30s, cisgender woman, met clients on the street or on in internet)

> *Yeah, I used to come [interview location] to do my laundry and stuff. Eat, whatever, bingo. Basic needs. Yeah, for the resources that they offered. Yeah, you could come here and there's like no discrimination against you whatsoever, that's the biggest thing I liked about it. I'll give you an example like you know, because people know that I'm a hooker or I was a hooker, that I do drugs whatever and say I go to the food bank, they'll be like that's the one, blah blah blah. And they won't treat me as equal as they treat like other people you know what I mean? Like that.*
>
> *(W, 40s, cisgender woman, met clients outdoors)*

Some of my interlocutors described how they particularly appreciated going to services that are for people involved in the sex trade because they could assume that workers there understood more about their life and felt that it was an assurance that they wouldn't be judged.

> *I just liked Sage House because it was, they didn't judge you and that's what they were there for was specifically for us right? I didn't like going to hospitals and doctors and stuff. I felt like I was being judged and if I had to disclose something and they're gonna be like, you know?*
>
> *(S, 20s, cisgender woman, met clients on the street)*

> *Claudyne: You said you'd rather go to see them than to go to like a random health clinic; what are they doing that's better?*
> *K: Oh nothing; they just don't judge people. They have more respect for – they know what the street people are going through and it's a struggle like in life. And they shouldn't be judged on their mistakes or what they're doing.*
>
> *(K, 40s, cisgender woman, met clients on the street)*

Some of the services referred to in these narratives have mixed reputations with sex workers and people involved in the sex trade. Some feel like they focus on people working or who worked outdoors and that there is an underlying assumption that specific life circumstances—such as substance use or problematic substance use,

consequences of on-going colonization, racism and poverty—inevitably lead people into sex work. While this is of course true for many people involved in the sex trade industry, for my interlocutors who did not identify with these life journeys, it sometimes felt uncomfortable to have this assumption made. It felt like their experiences were not recognized, if not completely erased. For my interlocutors who felt this way, speaking to other sex workers about where to go played an important role in finding a place where they hoped not to be judged.

> *L: I actually talked to a lot of other sex workers, which was very helpful. I was very, very worried about even just trying to access outside healthcare because of the fact that I had experienced so much discrimination from my current doctors that I was a little leery about that. But people told me, who are also sex workers, and people from the queer and trans community that they went there. They felt very accepted, very helped, and so I decided that that was something that I could give a try. Yes, it was very helpful.*
> *I wasn't too sure about going anywhere else because I tried other clinics as well, that were, again, you feel very stigmatized going into there. Just even the language that they use, stuff like that when they talk to you. The difference between when you go to Nine Circles and when you go to per se, my GP, you can definitely discern that there's an emotional feeling there that you feel like you're being discriminated against, as opposed to when you go to Nine Circles.*
> *Claudyne: When you go to Nine Circles, you just feel like its…?*
> *L: Yes. They just ask you questions and they don't respond and, you know what I mean? It's very straightforward and they're very delicate with their language, especially because they deal with people who are more marginalized, so it's pretty awesome.*
>
> *(L, 20s, non-binary indoor worker)*

"Let that person. . .say what they need to say."

One of my interlocutors for the interviews was P, a wonderful trans woman community activist in her early 50s who also has been involved in many community health and advocacy services over the last 2 decades. I had known of her and her work for years,

and, as I biked over to meet her for our interview, I felt excited and nervous. I wasn't sure what she thought of my politics and my advocacy work acting as an ally to sex workers. I wasn't sure, in fact, what her views and political stance were on sex work, that's not specifically what her work is on. Of course, I was willing and excited to talk to her and hear about her experience, thoughts on the sex trade, whatever they may be. My concerns were mostly that she would be offended or angry with what she might have heard about my politics.

We discussed the weather and recent community events that happened in the week preceding our meeting for a few minutes before I introduced what my research was about and went on to describe the interview process. When writing my interview questions, I was careful not to focus my questions on topics that, while relevant to my research, might not be necessary or appropriate for me to focus on. As a Montreal-based sex worker was kind enough to explain to me years ago, "*nobody needs another research project on whether sex work is moral or feminist or not*". She was signaling to the vast amount of research projects "*by young, white M.Sc. students who have never talked to a sex worker before*" exploring why people are in sex work and how it relates, in their views, to feminism, morality and ethics. My friend was advocating for research that is meaningful and useful to sex workers, and that focuses on concerns that they have expressed. As I progressed in sex workers rights activists' circles and read more and more writings from sex workers online, I would find similar criticism of research benefiting the researcher's ego or career before the sex workers they worked with echoed endlessly. Of course, this criticism has been around for decades before I became aware of it and has also been documented in academic publications such as Nussbaum's work on what makes sex work different for some people than other work in capitalist societies (Nussbaum 1998). After considering other jobs involving selling parts of oneself and often involving the use of one's body in exchange for money, she concludes that enduring stigma seems to be the main difference with sex work and suggests that much of the feminist theory may be "insufficiently grounded in the reality of working-class lives" and that is creates an artificial separation of sexuality from people's lives "as if it could be extricated from the fabric of poor people's attempts to survive"(Nussbaum 1998: 819).

With those very clear guidelines in mind, I designed questions that were directly related to my research topic: access to health and social services. While I asked my interlocutors about the field or type of sex work they did (where they mainly met their clients,

how long – or how long ago—they have been involved in the sex trade, etc.) I did so as little as possible. If there is a research bias with focusing on the health risk of sex workers—and within this area of research with focusing on sexual health—, there also exists a bias with focusing on the reasons *why* sex workers are doing sex work. There is a strong focus in research on looking into the "causes" (Benoit, Smith, Jansson, Healey, et al. 2019a; Shaver 2019) of someone being involved in the sex trade and is can often be informed by assumptions that all of sex work is exploitative or even "violence" against women. In this logic, there has to be an explanation for someone being a sex worker or reporting enjoying their job that is more complicated than the reason to have any other source of employment.

As we sat in a quiet spot just outside a popular pizza place in a central neighborhood, P told me about the importance of creating safety for people involved in the sex trade because that can mean helping someone on their road to healing, for those who are looking to another form of income. She shared that this was her experience, and that someone asking respectful questions without being "nosey" started her on a path of mental, emotional and physical healing.

> *P: I would tell them... (long pause)…don't shame people. If it comes to light that the person- as a healthcare provider, if you see somebody and they disclose to you that they are in the sex trade and blah blah, it's like, at all costs make your office, make their visit a safe environment. Safe mentally, safe physically, safe emotionally, safe psychologically. Make a safe environment. Those times when- I wasn't even in the sex trade then. And I didn't feel safe and they just have to keep going back to that HIV. I did get tested, it was abuse and bullshit. And its' like, "oh what is it this time?" It's like, "don't you use condoms?". This was my regular sex partner. Make them feel safe if it comes to, if they disclose that they're a sex trade worker make it safe. Sometimes you are, a lot of times, I think that the healthcare provider, that's they're first foot in the door to them healing. Mentally, emotionally, that's their starting point to healing. Emotionally, mentally, physically.*
> *Claudyne- When you say "make it safe", can you tell me-*
> *P: Emotionally safe.*
> *Claudyne- What should they not do?*
> *P: Don't shame. Don't be nosey, don't ask a lot of questions. Let that person. . .say what they need to say. If they don't know what they need to say, say, "can I ask?". Always ask, ask ask. Don't ask nosey questions, but ask, "is this what you're trying to say? If not, tell me so."*
> *I think most girls, it IS their first point. I see girls that come in off the street and they're just, they look like they're piggy-backing the grim reaper. I know it because I've looked at myself in the mirror and I've seen the grim reaper on my back too. Literally at death's door. That's how close I got myself. The first*

thing they do is, "is there a nurse here? Can I go see the nurse?" That's instinct, to get help. You know, you know what I mean? That is, a lot of times, their first contact IS a nurse or a doctor. That's why it's so important to be a safe environment. And treat them with kid gloves. Really really gently.
Claudyne- That's really good advice.
P: Be happy to see them! (laughs) Because sometimes the impact, just that one person, the impact if they see them is all it takes to bridge that gap to establish that trust.

As the conversation drifted to some of the community work P had been involved in, I reflected on what she also had a negative experience with a healthcare provider that marked her so much that it shaped what she saw as possibilities for future interactions with providers. Later during our conversation, I circled back to this point and asked her to tell me more about it.

P: I didn't even trust myself going to the doctor. Cuz I had been wrong in the past, with that doctor who made me feel like an idiot. I had been wrong there so like, "oh I don't trust my judgment when it comes to healthcare providers. I don't know what I'm doing." I didn't trust my judgment as far as my healthcare provider after that. Sage House dispelled that myth.
Claudyne- Are you saying that you didn't trust yourself choosing a healthcare provider or-
P: I didn't after that. It affected my self-esteem, it affected my self-confidence. I doubted my ability to get myself healthcare because of that one lousy doctor.

The experiences and advice that P. shared with me vividly exemplify the importance of offering spaces that are as welcoming, safe and free of judgement as possible; and how not doing so can affect clients or patients of those spaces and people. For everyone describing affirming and safe interactions with service providers, a focus on respect and consent played an operative role in their interactions.

Respect and consent

When my interlocutors described feeling safe in their interactions with service providers, knowing that their consent was respected was an important part of it. They told me about appreciating being asked if and how they could be contacted, touched, what language to use to describe their bodies and experiences, and that the provider made it easy for them to express what they needed out of the interaction and respected their time. N, a 32-year-old Metis woman, described the changes, over time, in the care she received at a community health centre. She was particularly happy with their concern around consent.

> *If I was just someone who had HIV and I wanted to go to my GP and reveal I potentially might have been exposed, whether I was a sex worker or not, I would feel like I couldn't because of statements that he's made in the past. I would definitely just go over to Nine Circles and be like, "Hey, this is what's up. I'm really freaking out right now, can you help me?" They would probably calm me down and get me in a good headspace and then go through the process of testing.*
> *They're very good with consent as well. I guess they want… access is I think what they want the most, the nurse I spoke to said that… she asked me if I… she called me with test results, if I didn't answer the phone, would it be okay for her to leave non-identifying things on the thing, so everything came back negative. Can you give me a call back, so I could get the message right away and then contact her and she would review it with me on the phone?*
> *Then when I came into the clinic as well, I sat down and so, like just a redundancy system, as well. So, three times this person told me over and over again and explained to me and asked me if I had any questions and explained to me how everything is transmitted. Especially, as a sex worker, when she became aware of the fact that I was a sex worker, she became more tedious with explaining to me, that these things are transmitted in a certain way and that I don't have to… like so that I felt more comfortable that I don't have to worry about this, etc., etc.*
> *She asked me the list of questions and then she just asked me, "Is there anything else you'd like to know?" She just let me talk for like 10 minutes. I'm pretty sure I didn't talk anything about… related to healthcare. I just*

talked and she just listened to how my experiences in the system made me feel like I was not being heard and prodded and continued to ask questions.
Obviously, it maybe felt like there was something that I wasn't revealing to her, but wasn't pushy about it. "Is there anything you'd like to tell me? Are there any sexual health questions you have? This information is maybe useful to you because of the information you've revealed to me," etc., etc., then just continued the redundancy. Going over it again and again and again and again and again, so that if I do have any questions at the end of it, I probably won't and if I don't have…
My doctor would not do that. My GP wouldn't do that, they would just probably tell me that I'm dirty and send me for testing, or probably not even send me for testing, probably just prescribe me some sort of antibiotic that I don't need and then send me on my way.

(N, 30s, cisgender woman, indoor worker)

In this case, N describes how having safer sex information explained in greater details felt reassuring and that the nurse she was speaking to was interested in making her feel "more comfortable" and less worried. Earlier in our conversation that day, she had described how she has at times hated the assumptions that she lived a "risky lifestyle" because of her involvement in sex work. When I mentioned to her that she seemed to appreciate the repeated questions and the education in this situation, she explained that the context, the tone and the general feeling of her interaction was completely different. The nurse took time to listen to her and let her express concerns. Establishing an environment where she felt that her concerns were heard, her consent was respected, she didn't feel any judgment, or assumptions being made about her created a positive experience.

N's relief at being able to speak freely about her concerns and to be able to receive all the relevant health and safety information was echoed by another one of my interlocutors who had recently started going to that same community health centre.

Oh my god, it's so night and day, it's so weird, but it makes my experience so much nicer now, way less stressful. And, like, I'm not wasting my fucking time. Every time I would go to my old family doctor's office, I would be taking time off work to be there, – like, off my day job – and then she'd just like – and then at the end of it, I feel like nothing happened, like nothing got accomplished, like, I'm still freaked out, or I'm still scared about this thing. Or, like, I'm not getting anything done, like, I don't feel like I'm feeling safer about my situation.
So that sucks, so then I would book another appointment, like, the next month and be, like, okay, this time I'm really going to – you know, and then I would get in there and start to say it, and I would get, like, kind of her to say, like you said, like, the runaround, trying to get what you need without saying that I'm a sex worker.

(A, 40s, cisgender woman, meat clients on the street)

A, the Metis woman above felt, like many interlocutors, that when she could freely express that she was a sex worker and that it was received in a respectful way, she could relax and have access to the care that she needed, that she took time off from her day job to get.

What service providers should know

Like, regardless of what your personal opinion is on somebody's job or their lifestyle, or their orientation, or anything like that, it doesn't matter. This is your job, you're a fucking doctor, and you don't get to make people feel like shit about who they are and what they do.
And you're just supposed to help them and give them all the information they need, and do your best, and give a fuck. And just because someone does something that you don't approve of, or you wouldn't do yourself, that doesn't mean they don't deserve the same treatment as any other person, and the same quality of healthcare, you know, that's what I would say.
Like, then don't work in this industry, like, don't be a doctor. If you're just going to pick and choose who you approve of, or who you like, and then you're going to give them better care, then you shouldn't be a doctor. I don't know, just, like, have compassion for all types of people, because, like, you may not approve of something, but the person who's coming into the doctor's office and sitting on your chair and just chatting, is having a

> *way harder time telling you what they do, because of the stigma, and how scared they are with whatever health things they're going through, and they're coming to you for help. Like, they're having a way worse time than you.*
> *Have some fucking compassion, because you're offended by it, who they are, or what they do for a fucking living. It's a job, right, like …*
> *(K, 20s, transgender non-binary person, indoor worker)*

Towards the end of my interviews, I invited my interlocutors to make recommendations to service providers. I asked them that if they could send a message to all service providers, what would they like them to know. The statement above was made by a non-binary trans person who identified as white and black and who has been working in different areas of the sex trade industry for over 15 years. They, like many of my interlocutors, felt incredibly angry with service providers for their inability to provide comprehensive, non-judgmental care to their clients who are sex workers. They stated repeatedly, and rightfully, that healthcare providers are simply not allowed to discriminate based on occupation, just like they aren't' allowed to discriminate based on race, national or ethnic origin, color, religion, age, sex, sexual orientation, gender identity or expression, marital status, family status, disability, genetic characteristics, a conviction for which a pardon has been granted or a record suspended (Branch 2019).

While I expected my interlocutors to answer this question with relative ease, given the experiences of stigma and discrimination that sex workers are known to encounter with service providers (Benoit, Smith, Jansson, Magnus, et al. 2019; Lazarus et al. 2012), I was surprised by the passion, and the consistency, in their responses. People I spoke to wanted service providers to be more compassionate, to show more transparency, to use appropriate, careful language, to educate themselves on the varied

realities encompassed by the term “sex work” or “prostitution”, to hire more sex workers and above all, to respect their humanity.

Compassion

Among the most common responses to my question was the need for service providers to show more compassion for my interlocutors and for everyone involved in the sex trade. My interlocutors pleaded for and offered several ways to make service providers see their side and the complexity of their experiences and lives. Four people specifically requested that “compassion training”, where service providers could develop empathy and compassion for individuals with different experiences than theirs, be made mandatory for service providers. L expressed it clearly in the excerpt copied below:

> *And, I think, people that work like, with those kind of things, I think, they should get training for even how to be compassionate about that. They should start including that in anything, even welfare workers, like, EIA workers or, anybody that's going to work with anybody involved in drugs, at least for the women. Because, I think, that would be helpful and, that would be encouraging for us. Because, that's why we fall down a lot, because, we're always judged all the time and, it hurts us. (…)*
> *Well when someone comes in, when someone comes in and, says that, "I want help and, I want someone to help me, as much as possible," I want them to know that they get the run around. And, we do, I understand, we do have paperwork to do and, it does take time and, but, we need them to be more compassionate. And, try and, put themselves in our shoes and, try to imagine that it took all this courage, just to come and, try at least.*
> *(L, 30s, cisgender woman, indoor worker)*

R, a 39-years-old experiential Anishinaabe woman suggested that services providers, and in this case physicians, should imagine how they would talk to their patients if they were their children.

> *Just imagine us being, like, one of your kids. Like, how would you talk to one of your kids in that situation? You got to like feel for us, that would make things a little easier. Understanding. Try not to like judge us and make us feel uncomfortable. We're already hard on ourselves and we got it pretty hard.*
>
> *(R, 30s, cisgender woman, outdoor worker)*

Like other people I interviewed, T reminds us that services providers are in fact not supposed to let their opinion guide the quality of the care they provide to patients or clients.

> *I think compassionate care is really important. Even though they're not supposed to put their own personal preferences into things, you're still supposed to be compassionate towards your patients. I understand that everyone has learning and growing to do, which is probably why they should have an overall program to teach doctors who are not even, before they become doctors, like when they're in university there should be some sort of program put in place to teach them about trans people, about the queer community, about sex workers, about the marginalized people in society, so that they're not forcing people to hide who they are.*
>
> *(T, 20s, cisgender woman, indoor worker)*

She also raises the need to educate service providers on the realities of different groups targeted by systems of oppressions and how to treat them with respect.

Transparency

Three of my interlocutors specifically raised the issue of what they saw as a lack of transparency in their interactions with service providers. By "transparency", they

meant taking the time to understand what their concerns are and to explain, in language that everyone can understand, the reasons behind questions, treatments, suggestions and decisions. When transparency did not happen properly, they described feeling like it might be the service provider's opinion that guided the questions, treatments, suggestions and decisions.

> *Transparency is a real thing. Take your personal preferences out of things. Even just as simple as breaking things down for someone, taking the time to actually talk to someone and explain to them what's going, listening to the concerns and questions, and transparency, again, is just really, really important.*
> *Listening is probably one of the most important things to being transparent. You don't even have to say anything, all you have to do is listen, and then make a medical suggestion instead of a personal suggestion.*
> *The way that they make their… they shouldn't combine their personal suggestions with their suggestions per se, like "this is high-risk behaviour because you're a sex worker" [instead of saying] "I would suggest this type of testing because it's just important" or "I would just suggest this type of testing."*
>
> *(D, 30s, cisgender woman, outdoor worker)*

One of the ways that service providers "combine their personal suggestions" in their interactions with their clients or patients, as D. stated above, is through the language that they chose to employ.

Language

One of the most common answer to my question concerning what they would say to service providers was to be careful with the language that they used to talk to

patients and to talk about the sex industry when someone has disclosed their occupation.

> *What I would say to a doctor would be, "Watch your words." Definitely. Don't judge people, just be very aware of your vocabulary. Even if you are someone who good be judgemental or have trouble dealing with marginalized people because you have certain beliefs, which is understandable, you should still always revert to your training and if they don't have that training, then… yes, so…*
>
> *(V, 30s, cisgender woman, outdoor worker)*

Similarly, R, a white worker who meets clients on the internet, talked about how her difficult relationship with her physician would be greatly eased if he was more careful with the language he uses to describe sex work and sensitive issues.

> *Yes, the vocabulary is so important and I think with my doctor, more or less I would feel uncomfortable with him if he would just watch the way he said things to me because everything that he suggests to me is medically important, aside from his vocabulary and the way that he places his personal preferences on these tests that I should do.*
> *It may not be up to him how long it takes the tests to get back and again, listening and vocabulary is so important, probably for me, that's number one how I feel. I've been discriminated against. It's just they're either not listening to me or they're too busy judging me to listen, the way that they talk to me is… I don't like it a lot of the times.*
>
> *(R, 30s, cisgender woman, indoor worker)*

Hire more sex workers

Two of my interlocutors, who were indoor workers, mentioned that health and social services might want to consider hiring sex workers or people who have experience in sex work. In their eyes, having sex workers or experiential people on staff would convey the message that the organization is welcoming, or even safe.

> *I always want to like emphasize to people like how many people are sex workers and that they definitely know people who are sex workers and that like so many people in the health care industry and in social services are sex workers or have been sex workers. I feel like most people I know who are sex workers are also either like nurses or therapists. And so like, and I guess part of that is to say like we like see you and like have a really accurate understanding of like the quality of the health care you're providing. We're very informed, yeah.*
> *And also that like, it's funny because I'm like we have, you know, the thing that I really want is that people just hire more sex workers to be service providers and like they're probably are lots of sex workers who are service providers but like aren't out about it and like their services would be so much better if people like could be out and like could be providing the levels of here that they actually like want to provide. I feel like, yeah, it's just like the structures of like organizations and like, I don't know, like when I worked at [local organization providing services to victims of exploitation]I wasn't out because I was worried that they were going to like charge me for soliciting or something, you know. …Yeah, and like right now the only acceptable way to be out is to be like experiential and like having exited.*
>
> *(L, 20s, non-binary indoor worker)*

As L mentioned in the interview excerpt above, it is impossible to know who may be a sex worker or who has experience in the sex trade unless they share that information. The significance of sex working or experiential employees in making service providing agencies more welcoming and safer was also mentioned by experiential people, and by some of my interlocutors who identified their experience in the sex trade as being exploitative.

Education about the diversity of sex working experiences

Many of my interlocutors expressed that service providers do not appear to understand the complexity of their lived realities and that of marginalized populations in

general. They suggested that more specialized training on the realities and needs of groups marginalized by systems of oppressions was for health professionals.

> *I: Yes, it might be good to have some sort of, yes like redundancy in terms of the training and education that doctors go through. My GP is probably in his 60s or 70s, so I am pretty sure that he has not been in medical school or any sort of legitimate training for a good 20 years at least, so that just speaks to the kind of care that he provides.*
> *He hasn't had any training in terms of how society functions as opposed to how it functioned 20 years; therefore, of course he's going to treat patients the same way.*
> *Claudyne: That's what he knows, not to excuse what he…*
> *I: Yes, now there's a huge visibility for intersexual people and marginalized people, like queer and trans community is so super important and doctors who were trained 20 years ago, weren't trained like that. They weren't trained to be okay with dealing with different people, they were just… yes, it's just… it's very interesting, just even as a doctor myself, I'm like, "That's not what you're supposed to do."*
> *Claudyne: No, it's really not.*
> *I :It's definitely not what you're supposed to do at all. It sorts of makes me feel sad for the profession at times.*
> *Claudyne: That they're not doing better.*
> *I: Yes, and then there's such a high demand for healthcare professionals at this time, that even with the progressive community that we have, they're not being trained properly. In the last 10 years, they're not being trained properly, in the last 5 years, even in the last year I bet you they're still not receiving the proper training for dealing compassionately with marginalized people. That's unacceptable completely because you should be able to go somewhere and feel like you're safe, especially when you don't feel safe.*
>
> *(I, 20s, cisgender woman, "cam girl")*

It was also suggested that service providers should educate themselves specifically on the reality and the diversity of experiences existing in the sex trade. Several indoor workers expressed how exhausting and frustrating having to explain what their work entails to service providers who are both ignorant and make

assumptions can be. One person suggested that a local directory of service providers who both "*have a positive, friendly attitude and aren't crappy*" would be very useful. Two of my interlocutors also expressed the desire for a way to evaluate their interactions with service providers and send them or their agency anonymous feedback.

Respect their humanity

Over 30 of the women and non-binary people I spoke to answered the question with clear demands to be treated with respect and for their humanity to be recognized. It was difficult to be hear in interview after interview, in very similar language, that my interlocutors felt dehumanized, felt that the systems they had to interact with "*treated them not like a human, just completely dehumanizing*" (D., 30s, non-binary person, indoor worker). Several of them, like R. quoted below, indeed stated clearly that they wanted, most of all, to be treated like human beings.

> *More or less, I would like to tell them that we are human beings too. We do have our addictions. You need to learn to talk to us better, where we can understand but you guys don't do that, you just degrade us and talk to us like we are beneath you, beneath gravel level. I just want to be treated like a human being.*
>
> *(R, 30s, cisgender woman, outdoor worker)*

I met K where she lived, in West Broadway. She had called me after seeing the recruitment poster for my research at a health clinic and we had planned to meet in the afternoon. It was raining, very intensely, and I came into her basement apartment soaking wet and apologetic. We laughed at the dreadful state of my appearance and sat down in her living room to start the interview, sharing some of the snacks I brought with

me. The TV was on for most of the interview on low volume and we kept being distracted by what was on it. Our conversation felt casual, like we knew each other already. K was in her late 30s, Aboriginal[22], and lived with her sibling and was soft spoken, with a booming laughter. She told me that she had been in the sex trade for over 10 years and who worked mostly outdoors, not too far from where she lived. K has had the same doctor for 20 years and "*he knows everything about me*". She says that she gets checked for "*everything*" and that she's never had a problem with him. K goes to whatever healthcare provider she needs, and that she often discloses to them that she's a sex trade worker, when its relevant to the health issue she has. "*Like, I'm not scared*", K told me, "*I don't care what they say*". Even though she's never had experiences of discrimination she says that she hears a lot of stories from other people who also work. She told me simply that she'd like to tell service providers to "*not be jerks*". K stated:

> *Yeah. You guys, just because, we're a sex trader, sex workers, they're no different than anybody else. We're all human. Yeah. Just because, we do sex trade work or, whatever, you call it, they have to be an asshole to somebody, some people sometimes. I've seen it with two of my own eyes.*

Even someone who did not live a lot of discrimination from healthcare providers, like K, reported how dehumanizing service providers can be. E, an experiential cisgender woman in her 30s, brought up the interesting point that sometimes it is administrative staff or other employees associated with service providers that can be discriminatory and make her feel unwelcomed from the start.

[22] This is the language that K used when filling out the demographic information sheet.

> *"for me-". It starts with the receptionist also because if you walk in there and she looks like a complete bitch, sitting there with a big smug look on her face, well I ain't gonna want to go in there. I can't even imagine what the doctor's gonna be like if he's letting his receptionist sit there look like that. You know? So I always said like, "if this is where you wanna be then you gotta greet everyone with a smile, like 'hey how you doing?'" I've had midwives with my last two little guys and it was amazing because the receptionist knew OUR names, not my name, OUR names. She would sit there, "hey (child's name) how you doing, hey (child's name)". Even, she'd ask how I was doing but even if her first approach is the kids that's good to me because she's talking to my children. A lot of people see another girl with a baby. My thing was the receptionist, it has to start with them because if they're not gonna make that environment feel welcoming, you're not gonna feel welcome. When it comes to the actual professionals, them too.*

E went on to talk about how important it is for service providers to not just be "stuck up" about the needs their clients or patients may express but to try to see the complexity of their lives.

> *And like, I don't know the welfare workers, if their clients ask for something, they should like really look it up and see if they can give it to them, not just say no right away. Because you know, aren't they better to help those people, right? That's what their job is, right? And they're just being all stuck up about it, oh no, not even thinking about it like not even – the people are asking for things you know, they should at least try and help them see if you know, that's going to help them or not?*

Sex workers and other people involved in the sex trade also expressed how important community-building initiatives are to combat the sometimes-overwhelming feelings of isolation that can come from having to hide your occupation from friends and family, and service providers. They also expressed the need for legal services that would be free or affordable, and that could be knowledgeable about the specific issues facing sex workers.

My interlocutors asked for more compassion from service providers, for them to be more careful about the language that they used, but also to educate themselves regarding the diversity of experiences in the sex trade and to use an intersectional approach to look at how certain groups are targeted by systems of oppression. Creating more safety for staff members in service providing agencies to feel comfortable revealing that they are sex workers, and policies to hire more sex workers were also concrete suggestions that were made.

In excerpts from my conversation with K. shared above, there is a dynamic that was common in the narratives that were shared with me. My interlocutors, like K would often tell me that they have not encountered stigma or discrimination in their interactions with service providers, but when we discussed it further, they did describe experiences of discrimination or stigmatization. The next section explores this dynamic.

I've got 99 problems but health ain't one of them

While some of my interlocutors were very clear about what made it difficult for them to get services that were not discriminatory, many told me that they didn't have any issues accessing healthcare as sex workers. When asked more directly about experiences of discrimination, or feeling treated differently than other patients, some of my interlocutors shared such stories, but they didn't always see them as being discriminatory, or as being related to whorephobia. Indeed, for many of my

interlocutors, the way healthcare provides treated them seemed to be pretty low on their list of sources of discrimination.

My conversation with J, a young "Neechi" woman in her early 20s, was representative of that dynamic. At first, she told me that she has never had an experience of discrimination. After a while, she mentioned that she perhaps chose not to look at these experiences as discriminatory, as a way of coping.

> *Claudyne: Yeah. And you say that happens a lot. And I know that it happens in health care setting and stuff like that, but you say it's never really happened to you and that's great.*
> *J: Well maybe I just didn't want to know. I just keep on walking with my head up. Say what you want to say, what I don't know doesn't hurt my feelings. Or whatever like I'm not going to let this get to me.*
> *Claudyne: Yeah, sometimes you just have to go on with your day right?*
> *J: Turn away from it, yep.*
> *Claudyne: Yeah. And is that how you usually react to stuff like that?*
> *J: Most of the time. I won't hear it, yeah.*
>
> *(J, 20s, cisgender woman, outdoor worker)*

A recent needs assessment regarding the community-led management of violence against sex workers through a bad date list system (Mexico, Sheng and Chevrier, 2017) highlighted the overall habituation to violence and discrimination on the part of sex workers. This may have played a role in my interlocutors' sometimes' seemingly nonchalant reactions to discrimination.

In addition, as discussed in the last chapter, some sex workers and people in the sex trade encounter stigma regularly in all aspects of their lives. I had a long conversation with O at the very beginning of the summer of 2017, in her home in the North End. She was a white cisgender woman who met clients online mostly and had been a sex worker for about 5 years. We sat at her kitchen table and talked for over 2

hours. O told me, in an almost uninterrupted flow, about the issues she has had with Child and Protection Services (CFS), Employment and Income Assistance Programs (EIA), various health centres and community organizations. O had a difficult co-parenting relationship with her children's father, and eventually lost custody of her children. She also had various chronic health issues. O was a resourceful woman, who seemed to be well-informed regarding the available programs and of her rights. She also seemed to be at the end of her rope after falling in what seemed to be every crack in Manitoba's social services systems. While O told me about her experiences with various service providers, sex work almost never came up. Towards the end of the interview, this interaction occurred:

> *Claudyne: But yeah what really strikes me everything that's going on is how you talk about sex work as something that's just happening, which is kind of positive.*
> *O: That's the best thing that's happened to me because it's the only time I get any sexual release and endorphins and serotonin in my body so that I feel actually human again. And I don't feel like I want to off myself. I have nightmares all the time.*

For O, her being a sex worker was not solely a negative force in her life, one that was bound up in discrimination. Instead, it was a positive aspect of her life.

Conclusion

My interlocutors came from all fields of the sex trade and could not have been more diverse in their experiences and backgrounds. While there are overall differences in their experiences based on the field of sex work that they work in (or where they

meet clients), their difficult relationship to accessing health and social services was very similar.

The recommendations that my interlocutors made regarding their experience with the provision of health and social services are coherent with the basic principles of harm reduction (International Harm Reduction Association 2010). The notably flexible, patient-centered and non-judgemental approach, based on the idea of building respectful relationships that allow the client to define their goals, can accommodate a different type of deliberation around identities and experiences, allowing space for what otherwise leaks out of identity categories.

The insistence on the need for service providers to show more compassion towards my interlocutor's multifaceted realities, their recommendation to be careful with language being used and non-judgemental fits with the harm reduction principle of being client-centered, non-judgmental, and facilitative, rather than coercive. Of course, their demands to have their humanity, and the complexity of their lives respected also is in accordance with this principle. The focus and recognition of individual experience can act as a deterrent of the impulse to contain people's lives and identities in categories that might not fit them. Another principle of harm reduction is to "target the causes of risks and harms" (Winnipeg Regional Health Authority 2016) and the appeals of my interlocutors for service providers to have more education about the complexity and diversity of experiences with the sex industry, as well as about intersecting systems of oppression echoes this. A careful focus on what individuals define as being harmful in

their lives provides a framework to look at their experience from their point of view, to honor the complicated and sometimes contradictory nature of their lives which can almost never fit into finite identity categories.

Harm reduction is evidence-informed, practical, feasible, effective, safe, and cost-effective and many of the recommendations that my interlocutors made fits with this principle. Perhaps more importantly, having peer-led harm reduction services is well documented as an effective strategy to work with people whose lives entwined with systems of oppression (Ashford, Curtis, et Brown 2018; Greer et al. 2016; Strike et al. 2015). The fact that my interlocutors made many recommendations and shared experiences based on affirming interactions and relationships that they had with service providers shows that their recommendations are feasible. Harm reduction principles also value promoting autonomy and dignity and being transparent and accountable. Services that reflect these two principles were very eloquently demanded by many of my interlocutors when they asked for transparency, and when they shared how much they valued their consent being respected in the relationships they built with service providers. The meaningful engagement and participation of affected communities in the program and policy decisions that affect them is also a central principal of harm reduction, and echoed in my interlocutors' suggestions to make agencies safer for sex workers to work in or reveal their occupation in. The suggestion to make it possible to evaluate the services they receive is also one way for people in the sex trade to ask for more accountability. Finally, much of the efforts of the proponents of the harm reduction perspectives is centred around challenging policies and practices that

maximize harm (including criminalization, discrimination, abstinence-only services, and social inequities (International Harm Reduction Association 2010). For the people who accepted to speak to me for my research, this was reflected in their perspective in the calls for service providers to education themselves further on their lived realities. The suggestion to develop a list of safe service providers also fits with this, as an effort to bring their experience together to protect each other from harmful service providers. In a broader sense, as some sex workers I spoke to expressed, participating in my research project was an attempt to name and challenge policies and practices that maximize harms.

My interlocutors asked plainly for services providers to do better in terms of caring for them and meeting them where they are. These results highlight the need for specialized services that focus on participants' needs and realities. It also calls for general training of service providers regarding the complexity of the sex trade, the principles of harm reduction, and anti-racism. Beyond strict and sometimes mandatory categories of experiences in sex work and the sex trade, there is a need to recognize individual experiences, goals, and the harms they might identify in their lives. Services dedicated to people in the sex trade are organized around deliberative identities and their invocation, and that is sometimes part of the appeal or what stops sex workers and experiential people from going. In this sense, the flexible, patient-centered approach of harm reduction could provide a potentially more welcoming and safer space for the varied experiences for the reality of "leaking" identities surrounding selling and trading sex.

CHAPTER 5

SWWAC/ DELIBERATIVE IDENTITIES

Carol Leigh (also known as Scarlet Harlot) is credited with coining the word "sex worker" in the 1970s in attempt to "reconcile [her] feminist goals with the reality of [her] life and the lives of women [she] knew" (Leigh 1997). Her coinage sought to counter other terms that ignored what people did and purposefully obscured her "role as actor and agent in the transaction" (NSWP 2014). Since then, the term has made its way into the global parlance of international development, global public health and HIV prevention largely through sex worker rights movement in the 1980s and 1990s (Kempadoo 2003a). Indeed, with the dawn of the HIV epidemic, increased funding for prevention initiatives targeting "high risk groups" crystalized the intentional efforts of sex workers to forge an international sex worker rights movement (Kempadoo 2003a). The use of the term "sex worker" remains highly contested and using it, I insist, is instrumental in creating and shaping the material and social conditions of daily life.

This chapter focuses on the ways in which the language used to describe experiences, identities and people contributes to shaping these same individuals' experiences and identities. Specifically, by examining the activities of a local advocacy group, SWWAC, this chapter considers how the label "sex work" acts as a vital thing—that is, an identification that stirs up an array of moral projects, setting in motion particular "affective economies" (Adams et al. 2011; Lorway 2019). The emotionally charged fields that emerge around the deliberate deployment of identities and labels like "sex work" and "exploited person" not only entangle a diversity of social actors but

shapes concrete possibilities for people trading sex as they attempt to access services, resources, funding and social legitimacy. Winnipeg, in the heart of Treaty One territory, is the site of complex and overlapping interventions that deploy multiple labels for people involved in the sex trade, labels that open up a polarizing and at times challenging field that people with experience in the sex trade navigate. This discursive arena often reduces the complexity of their lives to dichotomous categories that classify them based on their assumed inherent innocence or guilt. Within this thorny and dichotomous social terrain, how does the use and contestation of the term "sex work" hold together groups of people who occupy divergent political perspectives and moral sensibilities? How does the re-articulation of sex workers' "suffering" by various interveners open new conditions and possibilities for emancipation and ruin, salvation and fallenness? How does the seemingly harmless if not helpful "soft knife" (Kleinman, Das, et Lock 1998) of policies, programs and interventions contribute to affecting the potentialities for people involved in the sex trade, alleviate or exacerbate suffering, distress, and frustration?

Guarded expressions

In Winnipeg, at the time of the creation of SWWAC in 2014, all programs catering to people in the sex trade adhered strictly to a narrative that reduces all involvement in the sex trade as exploitation, if not human trafficking. Through the work of people like then Member of Parliament Joy Smith, who is a vocal anti-sex work activist, the idea that all sex work is nothing but exploitation dominated the discourses in Manitoba and

underpinned the approach taken to all sex trade workers and sex work. Underlying this approach is the fact that Indigenous women are overrepresented in the poorest parts of the sex trade (Bruckert et Chabot 2010), a reality for which a variety of activist, political and policy responses have emerged all over the country. On Treaty 1 territory, those responses have not been focused on harm reduction— as they have in other places (see for example Muree Martin et Walia 2019; Sterling et Meulen 2018)— but on prohibitionist approaches to the sex trade, seeking to eliminate it entirely. Member of the Legislative Assembly for the New Democratic Party and long-time advocate for Indigenous women's rights and justice for MMIW Nahanni Fontaine spoke publicly regularly on the topic of prostitution and describes in its tie with colonization. In a public presentation on the legalization of the sex trade in Canada in October of 2014 at University of Manitoba, Fontaine described her views in this way:

> *When discussing prostitution, we begin from the twisted and insulting premise of prostitution as the world's oldest profession, positioning prostitution as a legitimate and longstanding human— or male— right and experience. Consequently justifying patriarchy's violence against and claim over the bodies, minds and spirits of women, men, boys and girls all over the world. Let me be unequivocally clear: in these lands, these indigenous lands, prostitution did not exist within our territories prior to contact. Prostitution was not something intrinsic to Indigenous peoples ways of living or understandings. […] The narrative of "choice" circumvents women's and girls' lack of choice and the push and pull factors from which their exploitation derives itself. The only people who exercise choice are the predators, offenders and pedophiles who make a conscious, methodical and strategic choice to prey upon and sexually assault or rape the most marginalized, disadvantaged and oppressed within our society, all the while justifying to himself with the ridiculous mythologies on why these women and girls are prostituting themselves.*

MLA Fontaine's perspective echoes the perspective of many indigenous community organizers and activists on Treaty One and all over so-called Canada. Among them is Diane Redsky, Executive Director of the Ma Mawi Wi Chi Itata Centre in Winnipeg and Project Director of the 2011-2014 Task Force on Trafficking of Women and Girls in Canada put together by the Canadian Women's Foundation[23]. In a news article with CNN in 2017, she points out the association of human trafficking (which in englobes all sexual labor) and the history of racism against indigenous Canadians feeding into the cycle of violence and exploitation against them (Newton 2017). Critical anti-trafficking studies scholar Julie Kaye, in her research on the response to human trafficking in Canada (2017), reported that, while the conflation of sex work and human trafficking happened in each of the three cities she focused on[24] – and indeed at the national level— it went a bit further in Winnipeg where all experiences of children, youth and adults were conflated under the banner of "human trafficking". The level of disciplining and silencing happening to those deviating from the dominant anti-trafficking was unique to Winnipeg where her participants reported feeling like they" can't speak openly". Furthermore, it was apparent that the strength of the dominant discourse and the single narrative it projects was such that "the actual voices of

[23] As mentioned in Chapter two, this report was later pulled from circulation because the ways it presented data was not representative of the variety of experiences in the sex trade.
[24] She conducted 56 one-on-one interviews in Vancouver, Calgary and Winnipeg in 2010-2011 with representatives involved in various levels of anti-trafficking, including frontline workers, representatives of nongovernment organization, sex workers and sex workers rights advocates, policymakers, politicians, immigration officials, judiciary, government officials, law enforcement, and some formely trafficked persons.

experiential workers and trafficked persons are silenced, whether directly or out of fear of such disciplining" (Kaye 2017: 152).

The highly guarded boundaries between the terms of "sexual exploitation" and "sex work" are in direct contrast with the fluidity with which they seemed to have entered the social field of interventions on people in the sex trade in Winnipeg and their seemingly interchangeability.

An oral history of locally contested expressions

I was lucky to spend a few hours talking to O, who has worked in health and social services in various capacities with "all sorts of people", including sex workers in the last several decades in Winnipeg and all over Manitoba. She described first hearing the term of "exploitation" associated with the sex trade in the early 2000s. Before that, she said, it was described as sex work or the sex trade or prostitution. In her view, a handful of people in important positions deliberately adopted the word, and then proceeded to get funding for past and present local projects, thus establishing the new wording as gospel.

> *Big organizations like that one with huge multimillion-dollar budgets, they can start talking that talk, pretty soon it's established. As part of the lexicon. When does that lexicon get built? Who contributes to it? So that exploitation notion, that's a by-product of that whole thing.*
>
> O, 60s

Similarly, F, who worked in the 1990s and 2000s as an outreach worker for health organizations in the city, recalls first hearing the term from the faith-based organization, Save the Children, which supported some of the outreach work. From there, the label seemed to become more and more prevalent.

> *After that we started seeing conferences being done, people coming in, doing speeches and stuff like that and these people had access to monies. And monies often run a dynamic just as they do in American politics (laughter). You know? The more that you connect to being in the media and tell people in the media what the language is because the language is very key to how you understand an issue and they're very savvy about how to manipulate the discussions and stuff like that. And so they use the terms like "exploited"*
>
> F, 50s

F described how a similar process later occurred with the term "human trafficking", which was slowly imposed as the 'right' – and even perhaps the only – way to describe complex realities.

> *There's a lot of smart dynamics that happened. I saw it gradually building at their camp and when you provide free training people will come. And so they do things like say "this is the language, you don't call them sex trade workers, you don't call them prostitutes, you call them trafficked". Which is a term again which is wide, broad and it doesn't really define people. It's too wide of a brush so when they talk about people that are trafficked, they could be talking about farm workers, they could be talking about the person that served you coffee you know? But they won't tell you that those stats include those people but they'll be talking maybe about the sex trade and they'll say, "this many people are trafficked" and where are those stats coming from? […] The terminology started to change and they weren't telling people that would say "well you know my experience with prostitution", they go "oh they don't call it prostitution" and they'd be shamed. People would be shamed into using terminologies that don't fit*

> *what they want it to be. And that's the way they control a conversation and that's the way they control media.*
>
> F, 50s

I spoke to L who worked for one of the organizations that O. described as playing an instrumental role in making "sexual exploitation" the powerful identifier it has become today. L told me that the focus on exploitation naturally presented itself as necessary or inevitable because of the social and political need to hear the voices of Indigenous women and girls who go missing.

> *Just when you see any kind of movement for change, and women who are pushing for change or black community- it's just all quite typical of people who have been oppressed and how they need to move forward to make change. And here in Manitoba because we have the largest urban indigenous population per capita in Canada, that's been the voice that's gotten really loud so that's what people think of when they think of exploitation. It's just, aboriginal.*

A, who also worked for one of the organizations identified by O and several others as being very influential in the province, identified the importance of funders in the use of language, in this case "human trafficking". She also described the emergence of the term in her work.

> *First of all, there was not even any trafficking, there was no talk about trafficking at one time. Drug trafficking but not sex trafficking. That's a whole new phenomenon. I think that came in around, more international forces and things that were happening in Thailand, the Philippines, all that across the border trafficking. And then it kind of came down to more social service organizations and governments, locally which. . .we started using different language gradually. Government picked up on it and*

> *started developing trafficking laws and then you're dealing with (inaudible) around funding issues. And then you gotta use the word trafficking because that's gonna get you the money. And funders like [Canadian Funder]? Say the word "trafficking" and you're in. If you say "exploitation" it's not bad but you add trafficking and it's like "whoooooa" (laughter).*
>
> A, 60s

In a similar way, community-builder and outreach worker N highlighted how individuals adopting the language and ideology underpinning what he calls the "sex work is sexual exploitation" narrative come from very different places on the political spectrum and that it gives light to unexpected alliances, even between elected politicians who would otherwise fundamentally disagree with each other.

> *I think what makes the Manitoba [discussion regarding sex work] really fascinating is that you'll have people from both left and right who believe. So, like typically the sex work is exploitation thing – the conversation that happens is generally something that the right takes up, but in Manitoba the left is really onboard with that too.*
> *So, that really makes it a fascinating like… it makes for strange bedfellows. So, you have folks like [Member of Legislative Assembly of Manitoba] Nahanni Fontaine who are actively working with [former Member of Parliament] Joy Smith when it's what – it makes it super fascinating because both of those women are super influential in their political arenas. And so, people will buy-in to that without actually questioning it as people do with any type of campaign.*
> *So, I think that's why – and then I don't want to say voices of reason, but any kind of reasonable discussion that typically can happen around sex work become really muted because it's like both sides can be like well, this must be the way it is because we both agree on this and if you guys are talking about it like this you guys are obviously in the wrong.*
>
> N, 30s

The roles played by individuals in deployment of the identifier "sexual exploitation" and, more recently, "human trafficking", are not the focus of this section.

Instead, it is interesting to focus on how their deployments is part of moral projects that serve varying goals for social actors, social movements and policy makers. The deliberations surrounding the use of terms like "sexual exploitation" and "sex worker" are perhaps, most evident in the often-aggressive boundary work that comes with their defence.

Aggressive boundary work

Klinic Community Health: "Just care. For everyone."

That day Klinic kicked SWWAC out

I just got off a call on the suicide and crisis line I volunteer at every Monday morning and my shift supervisor tells me that there is someone on the line for me. This has never happened; I didn't even know that I could get phone calls here! I walk to the other room to answer the phone, pushing away panicked thoughts about what sort of emergency would make someone try to reach me at this moment. To my surprise, the voice on the line is an administrative staff from the organization I am volunteering for and I am abruptly asked to confirm that I am a member of the Winnipeg Working Group for Sex Workers Rights (later renamed the Sex Workers of Winnipeg Action Coalition or SWWAC). After I answer, the staff person tells me that, as a "pro-prostitution group", we are "not welcomed" to use their space. With my heart pounding uncomfortably and my voice shaking more than I would like it to, I start to explain that SWWAC is a "sex worker-led advocacy group" that focuses on harm reduction and that banning us would send the message to our sex working members and to all local sex workers who see themselves as neither being exploited nor looking to change jobs that they are not welcomed to use their services. Before I could finish, the administrator tells me to "not get started with that stuff" and that they take their leadership from Indigenous women, who access programs which offers services to folks wanting to "exit the sex trade".

Klinic community health centre that hosts the line is very vocal about its feminist values and celebrated for its inclusivity, I really thought we were safe there. As I walk

back to my desk to finish my shift, I can hardly believe this conversation actually happened, and I start listing in my head which SWWAC member I will tell first, and how to let local sex workers know that another health centre has to be considered unsafe for sex workers.

The group of sex workers, researchers, healthcare people and other allies that make up the Sex Workers of Winnipeg Action Coalition (SWWAC) came together in 2014 to fight, under the umbrella of the Canadian Alliance for Sex Work Law Reform, against then Bill C-36 (now passed into law as the Protection of Communities and Exploited Persons Act), which introduced asymmetrical criminalization in Canada (Sheng et Chevrier 2019). We first met on a warm spring evening in a room we reserved under the pretenses of talking about harm reduction in the basement of a community clinic – the same clinic from which SWWAC would eventually be banned. I remember vividly the cautious expressions on everyone's faces and how nervous people looked that someone there could be part of the "antis" (i.e., person or group that holds anti-sex work positions). Everyone who was present, whether they were sex workers or allies, felt the intense anticipation of a potential confrontation if someone convinced that people selling sex are exploited showed up. Of course, the stakes were considerably higher for sex workers who chose to disclose that they were workers at that meeting. I was eventually to learn that everyone in the room had experience having interactions that ranged from uncomfortable discussions to traumatic confrontations, including sex workers being outed to their friends and families by someone convinced that the worker was brainwashed or exploited. Since that meeting, SWWAC has grown into a well-known advocacy group that was the first and remains one of the only groups in

Winnipeg to openly and very vocally support the full decriminalization of sex work (UM Today 2019).

We chose to hold our first meeting at Klinic Community Health because of its commitment to inclusivity, and its reputation as being a feminist, radical and "cool" service provider (Community Health 2015). Its slogan reads: "Just care. For everyone"—what could go wrong? This centre is linked to public health structure of the province and it was through the contact of a SWWAC member that we were able to reserve rooms in their conveniently located centre for several months, officially to discuss harm reduction in the context of sex work. As described in the vignette above and in greater detail elsewhere (Sheng et Chevrier 2019; University of Manitoba 2014), SWWAC was banned from using that space for over two years. The months following my conversation with the administrative staff saw the development of an increasingly acrimonious situation where some SWWAC members' employment was directly threatened as a result of the intervention of Klinic employees and associates. While the focus was ostensibly on how the rooms were reserved in an improper way, it was a clear attempt to silence anyone who might have the audacity to even talk of sex work as anything but exploitation and violence. They proved unable to get any of SWWAC's members fired, but they certainly succeeded in creating an immense amount of stress, anxiety and fear in the membership and the broader community. For close to two years after that, SWWAC members and friends advised everyone to be very careful in their interactions with Klinic because of their anti-sex work policies. In a medium-sized city like Winnipeg, where community centres that uphold feminist and social justice ideals do not abound, this

was a disheartening affair. As a sex worker who had heard of SWWAC's warnings told me during an interview:

> *It's not like there's no chance of being stigmatized if I go into that place at any point, but if I KNOW that they excluded a group [like SWWAC] … and you know you won't get anywhere even if you complained.*
>
> *(L, 30s, cisgender white woman)*

Two years later, thanks to the extensive personal networks of SWWAC members and allies, several SWWAC members were invited to give a talk about health, rights and sex work at Klinic (Sheng et Chevrier 2019). As I sat with my friends, some of whom had very courageously volunteered to speak about their experience as sex workers, facing a potentially hostile audience full of health care providers, in the very room where SWWAC had held its very first meeting years ago, I remember having to focus on taking deep calming breaths to steady my trembling hands and voice. I was terrified for the consequences in my friends and colleagues' personal lives, their "day" jobs and their access to health services. While they certainly did not need me to point out the tremendous risks associated with speaking up— they understand it in a way I never could—, it didn't stop me from worrying about the potential consequences of advocating for their community. One presenter introduced themselves as a sex worker and proceeded to describe the importance of the Klinic Community Health for the 2SLGBTQQIA (two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersexual and asexual) community, which they described as being very prominent in sex work in their experience.

> *Your clinic hosts the only dedicated trans health clinic in the province. Trans people and especially trans people of color are overrepresented in sex work because that is often one of the only forms of work accessible to us. If this place isn't safe for my community, you are just not respecting your own mandate.*
>
> *C, 30s*

We presented to Klinic staff and volunteers the research that backs the demands of sex workers for approaches based on harm reduction, inclusivity and full decriminalization (Amnesty International 2016; Baratosy et Wendt 2017; Beyrer et al. 2015; Shannon et al. 2015; The Lancet 2015; Winnipeg Regional Health Authority 2016). While explaining about barriers to access to health and social services, I used the banning of SWWAC from using their space as a barrier to access for local sex workers. I described what happened very similarly than I did in the vignette, and added that I, along with other SWWAC members, have been warning the sex working community, and their allies, that Klinic wasn't safe or welcoming to sex workers. My colleagues and I highlighted what it means to the sex working community, as well as to the myriad of other marginalized identities that intersect with certain sex workers in need of care. To SWWAC members'—and the broader sex working community's—immense relief, this marked a turning point in our relationship with this health centre, which made some effort to become more inclusive in its programs, policies and staff.

SWWAC's experience with Klinic highlights an important dynamic playing out in sex worker activism, and across the wider discursive battleground waged on Treaty One territory. In sex workers rights activism, as a push back against a rich history of experts speaking for and about sex workers, representability is extremely important. The slogan "Nothing about us without us" coming from disability activism in the 1990s resonates

loud and clear in rallies and in the sex work "Twittersphere" (Grant 2014; van der Meulen 2012; Van der Meulen et al. 2013b). It is also reiterated in everyday life with vigorous demands for representations in public discussions. This makes my positionality very complicated, as I have spoken publicly about sex work in an effort to give visibility to positions that can't be represented by sex workers who cannot say publicly that they are currently selling or trading sex. The tremendous amount of stigma associated with sex work makes identifying yourself publicly as a current sex worker, "outing" oneself, extremely difficult and dangerous. It has been described by a sex working SWWAC member as in the realm "*jumping off a cliff*" in terms of risks and unpredictable consequences. Indeed, the stigma that is attached to sex work, and with it the constant threat of its manifestation as direct physical, psychological, verbal and economic violence, can act as a powerful controlling mechanism for sex workers. It is rooted in social beliefs about the impurity of mixing commerce with intimate acts in specific ways that challenge the heteronormative ideology and procreative norm of womanhood (Bahri 2019).

To again complicate further, not all experiences in sex work are considered to be the same, equivalent or "representative". In Winnipeg, where there is a large proportion of workers who are Indigenous[25], and where the majority of experiential people who will speak publicly about their experiences are Indigenous and share the position that all

[25] There are no definitive numbers available regarding the overall number of people involved in the sex trade, the demographic information or in what field of sex work participants work in. However, research consistently reports an overrepresentation of Indigenous women in outdoor sex work (Canadian Public Health Association 2014).

sex work is exploitative, representability is a painful point of contention with different groups claiming that other groups cannot be representative if they do not have a person with certain experiences or characteristics speaking on their behalf. Alternatively, this requirement for representability can be used as a way to silence certain voices because of the immense difficulty to find a diversity of people willing to publicly identify themselves as sex workers. As Amy Lebovitch so aptly reminded us in the quote at the beginning of my thesis: "there are no "representative" sex workers" (Ferris 2015). In this sense, it can be seen as tracing the borders of who is allowed to speak publicly for sex workers.

"Joy Smith just called us Madams on commercial radio!"

In October of 2016, I gave an interview on the radio station CJOB during which I spoke on SWWAC's behalf about the group's criticism of the campaign *Buying Sex is Not a Sport*, funded by the provincial government and the Joy Smith Foundation. The campaign promoted for the second year in a row the widely debunked idea that there are increases in sex trafficking, sexual exploitation and sex work surrounding large sporting events (Bahri, 2019). SWWAC insisted, based on available research and their members' sex working expertise, that these campaigns are erroneous, wasteful and allow further surveillance of sex workers and other marginalized populations, especially sex workers who are already targeted by police and state surveillance (Ham 2011). SWWAC also pointed out, in 2015 and 2016 that this campaign uses sexual exploitation of children, human trafficking and "prostitution" interchangeably, when they refer to

very different realities (Sheng 2015, SWWAC 2016). Joy Smith, in a follow-up interview at the request of the Joy Smith foundation at the same radio station the following week, defended the campaign and dismissed SWWAC's concerns that indicating that individuals defending the view that sex work can be anything other than exploitation are misguided. She stated during the interview that the "*sex industry has tried to brainwash people in saying that the exploitation and the human trafficking of women is not harmful and is empowerment. It's not empowerment at all.*" She also insisted that "Prostitution is violence against women, it really is. And in this day and age, what's really happening is underage."

When the radio interviewer asked Ms. Smith if she would be willing to speak to people holding the views defended by SWWAC she stated that "these people" are often exploiters themselves.

> *I don't think it's that simplistic. I'd be glad to talk to anybody, but I've done that in the past and it's like [talking to] a brick wall. And usually when I look at the background afterwards, we find out that a lot of these are Madams that make a lot of money controlling a bunch of girls.*
>
> Joy Smith, October 2016

Ms. Smith assertion that individuals defending positions like SWWAC's "*are Madams that make a lot of money controlling a bunch of girls*" can be seen as a way to discredit SWWAC and to position its members as needing to be ignored and silenced. Far from being the victims that need protecting, like beneficiaries of the programs and policies she supports, SWWAC members are portrayed as exploiters who may conceal a threatening hidden agenda. In this case, I – and the positions I presented on behalf of

SWWAC—was not only non-representative but she portrayed me as ill-intended and dangerous. This strategy echoes well-used tactics by anti-sex work activists internationally who sometimes refer to sex workers rights movement as being, or being funded by a "pimp lobby", referring to an imagined powerful and organized group of "pimps" who would secretively be controlling and financially supporting the ideas put forth by sex worker rights advocates. Reducing sex worker's fight to improve their working conditions by reference to "racialized and stereotypical language and fear-laden tropes about the sex industry", in this case the trope being of a "racialized and unruly male", understood to be controlling if not abusive and cruel (Clamen 2018). Jenn Clamen, heading the Canadian Alliance for Sex Work Law Reform writes about this trope that "with this disdain in mind, the movement for sex workers' rights and decriminalization is often falsely accuses of being a "pimp lobby" – a movement that promotes prostitution" in the "interests of pimps and profiteers", and thus of being "marionettes that parrot the words and interests of third parties"(Clamen, 2018:xi). This language frames sex work as inherently dangerous and exploitative and is use to silence sex workers rights activists by reducing them to the roles of victims or gullible accomplices.

SWWAC has used a vast array of strategies to inform services providers and the general public about the difference between sex work and sexual exploitation, but also to invite and demand that the term sex work be used or included. For SWWAC members who are sex workers, this matters greatly because the refusal of using the term sex work is emblematic of the efforts to erase their identity and silence their experience. While

we have gotten several agencies to revise their language and local journalists now know to use sex work when describing SWWAC members and work, the battle is far from being over. As described in the vignette included at the beginning of this section, SWWAC was banned from using the space in a community health clinic because of the position that the group holds, based on the language that is used. The use of the word "sex worker" was enough to justify excluding an entire group of individuals deemed unworthy of inclusion in the community clinic.

Simply uttering this term in closed meetings has led to the banning of SWWAC members from a community clinic and use of its public services. The use of language surrounding the sex trade in public speech, and in certain spaces is intensely guarded and defended. Not only does it matter that exactly the right expression be used, but efforts go into ensuring that certain identities and the perspective they represent are prohibited. Whatever the intentions of the individuals and groups that introduced and enforced the use of these deliberative identities, their use shapes the concrete possibilities for sex workers and others in the industry, both as individuals and when they attempt to organize collectively. Undeniably, the attempts of using or claiming the deliberative identity of sex worker open up new conditions and possibilities for emancipation and ruin, by shaping what resources individuals and groups have access to and what kinds of social visibility or invisibility they can assume. Similarly, the use of other identity labels, such as "trafficked" or "sexually exploited" open up possibilities to develop and participate in programs, to receive funding, to be heard, to have undisturbed access to certain spaces and to care.

Conclusion

The necessary rescue

Against a background marked by a long history of interventions and management of racialized and otherwise structurally oppressed marginalized population, Manitoba's Sexual Exploitation Strategy reinforces a moral project that portrays people involved in the sex trade as exploited or trafficked, and always as victims. Until very recently, it defined all exchange of sexualized intimacy and sex as exploitative, regardless of the context or age of the individuals involved. The logic it follows echoes that of the humanitarian interventions that conflate moral imperatives and political arguments, aiming to save lives at any costs, in what Fassin and Pandolfi named "states of emergency" (Fassin et Pandolfi 2013). Peoples' stories, endlessly complex lives, desires, hopes, identities and experiences are reduced and packaged into descriptive categories necessary to justify interventions. For people in the sex trade in Winnipeg, the majority of existing programs need them to be blameless, innocent victims that can and wish to be "rescued". As Miriam Ticktin tells us, innocence is an ahistorical and apolitical "space of purity" and its borders are constantly drawn and redrawn to accommodate a search for a "truly" innocent victim (Ticktin 2017). In Winnipeg, these borders, and the resources (monetary, symbolic and social) that they hide, are heavily guarded.

While I argue that terms like "sex worker" or "sexual exploitation" both represent deliberative identities, it is important to note that they do not come with the

same weight, nor are they mirrored in the current local policies and interventions regarding the sex trade. Policy makers, politicians and others who participate in creating and maintaining the strict analysis portraying the sex trade as nothing but sexual exploitation are invested, whether consciously or not, in maintaining all sex workers as innocent victims, and not as human beings with complex lives and agency.

As the results show, these terms are used, and defended. The discursive field around public health programs and interventions on the sex trade is characterized by the militant guarding of the monopoly of the depiction of suffering and representability of people selling or trading sex. The use of the label "sex work" is argued against, people who use it are excluded from spaces, from resources, for health care. If we are to look at this from a boundary work perspective, what matters about a concept like "sex worker" is "how its borders and territories are flexibly and discursively mapped out" (Gieryn 1999:23) rather than how it is precisely defined. In this sense, what seems to matter overall it that "sex worker" is kept from being used, from being adopted by new people, indeed from being uttered publicly. This helps to explain the surprising flexibility and sweeping encompassments of the terms "sexual exploitation" and "human trafficking" that occur at the same time as such tremendous energy goes into forbidding the term "sex work". The boundary work at play here is based more on excluding the use of the deliberative identity "sex worker" (and foreclosing conversation on its political implications) than on defining precisely what the terms mean.

Deliberative identities

The assertion of multiple labels, often by a class of individuals speaking on behalf of others involved in the sex trade, open up a highly divisive field in which people with experience in the sex trade have to navigate in order to get what they need to be safe and well. Certain terms anchor individuals in certain places and positions, like the flexible and evolving use of terms that seem to unlock the purses of funders. Terms can serve as entry points to spaces or relationships, for example by giving access to conference and per diems, but also an advocacy group like SWWAC. Terms can also be vehicles for moral projects for a world of potentiality where sex workers' labor and human rights might become respected (Jackson 2016) or where prostitution is abolished (Jackson et al. 2017).

The deliberate and deliberative use of "sex worker" by SWWAC and others is meant to carve out space to exist for a community, to challenge and change the conversations regarding sex work by branding and brandishing a well thought through, well documented, political term that reflects not how sex workers' are currently seen, but how they want to be seen, how they know their community to be. At the beginning of SWWAC, the need to be heard, to be seen, to be respected, to exist and be allowed to exist was pouring out of our members, pouring out of the plans we made for activities. We spent the first two years responding to, getting angry at and plotting to challenge the then-overwhelming forces that maintained a tight discursive hold on what the sex trade was, and what was a "representative experience" in it. Out of fear for our members' safety, we worried about keeping our membership secret and monitoring

who can come to our meetings, about who knows about our group. Once SWWAC was banned from Klinic, it became inevitable that we were going to have to push back differently. While, SWWAC's message about sex work being work, about the possibility and need to support sex workers and to fight exploitation simultaneously was always consistent, it wasn't clear how challenging it could be until a publicly funded feminist community health centre banned us from it. At this point, it became clear that the very existence, even behind closed doors, of people deliberatively using the term sex worker— or indeed simply not using "sexual exploitation"— was challenging, it was an action.

As a collective, SWWAC's deliberate attempts to push for the recognition of the label of "sex worker" is more than simply trying to enter the fray of contestation; rather they are driven by the desire to transform and diffuse the polarizing character of the milieu altogether. Individually, the assertion of one's identity as a sex worker is an attempt to project oneself in a way that resonates with one's experience. I argue that the use of a carefully created, debated and chosen term is their attempt to escape, to carve out space for their lives out of the strong and suffocating oppositions of innocence and guilt, of blameless victims and "victim-criminals" (Majic 2014a), to simply be something that resonates with their experience. This is reminiscent of the work of Danya Fast in Vancouver, Canada (Fast et Cunningham 2018) and Dar Es Salaam, Tanzania (Fast et Moyer 2018) focusing on granular examination of the new forms of life and harm experienced by young people in the margins, and their imagined futures.

The invocation of the deliberative identity of sex worker, by its ability to shape the potentialities of employment, access to space, care, community and safety becomes a vital thing. In Winnipeg, in the heart of Treaty One territory, the use and contestation of the label of sex worker goes beyond public health's notions of an identity grouping individuals classified for their shared risk of contracting sexually transmitted infections, instead it serves to assemble forms of lived experiences that hold together groups of people.

DISCUSSION AND CONCLUSION

In this thesis, I attempt to distance my analysis from restrictive academic and political discourses regarding the sex trade, discourses that reduce and confine people's complex lives to simplistic categories and labels. To do so, I have documented the intricate power relationships and political and affective fields that emerge with and around an array of linguistic deployments referring to those in the sex trade in the medium-sized city of Winnipeg, Manitoba, on Treaty one territory. I chronicle the ways that these discursive dynamics play out in public arenas, in the organization and delivery of health and social services, but also in the lived experiences of sex workers and people in the sex trade. Far from being only a discursive or symbolic exercise, I argue that the processes surrounding what I called deliberative identities continually (re)shapes concrete access to resources and social and political support networks for people involved in the sex trade, and the positioning of social actors invested in its management.

Processing Deliberative Identities

The concept of deliberative identities has been a valuable tool to make sense of how various intensities and identity politics have come to surround the lives of people selling sex whom I interviewed and interacted with in Winnipeg, Treaty one. Deliberative identities refer to the social practice of intentionally using identifiers to signify what one's experience is, in this case with the sex trade, in order to create, maintain, challenge or unsettle claims to identity, spaces belonging, and moral

boundaries. They can open space for individuals and groups to recognize themselves in common experiences; they can maintain distance between one's experience and other experiences being described or morally projected; they can be used to reinforce relations of domination over what type of identity can stand as the "correct" one and maintain a moral monopoly of one identity over another; they can challenge and disrupt reigning representations so that people can reimagine themselves as they wish they could be; and they can be used to express one's reality and experiences of suffering, pain, distress but also of joy, agency, and solidarity.

Deliberative identities also refer to the field of contestations that surround the sex trade in Winnipeg. It refers to the intense—and often mandatory – process of having to "declare" one's identities in order to gain access to certain services, be accepted in certain spaces, have one's experience be recognized, and to receive support and share solidarity. Using the "wrong" identifier in a situation can result in being excluded from certain spaces, resources, services, thereby magnifying the experiences of stigma and discrimination already associated with the sex trade.

The findings that I presented in chapters two to five were collected during five years of ethnographic field research in Winnipeg during which time I chronicled the changing discourses and relationships between individuals and agencies that are part of the sex trade, support those in it, or are invested in its management. My engagement with the Sex Workers of Winnipeg Action Coalition (SWWAC) since its very inception in 2014 has provided me an entry point to witness, document and to some extent experience the intense power dynamics and agitating linguistic deployments that colour

the sex trade. In order to attach my analysis more closely to the experiences of sex workers and people involved in the sex trade, I conducted 39 interviews with them, and an additional 12 with chosen social actors. I also conducted document review research. My complex positionality as a non-sex worker, and a white Franco-settler on Treaty one territory, as well as my engaged involvement as an actor in sex workers' rights activism with SWWAC has further colored the research design, data collection and my analysis, as I described in chapter one.

In this concluding chapter, I focus on summarizing what I see as the three main findings of my research: 1) the continual framing of sex work as a social problem needing to be fixed, and the making of "innocent" people within the sex trade as needing to be rescued, 2) how these deliberative identities are used to shape and reshape access to services, care, social and political support networks , and 3) the ways in which needed health and social services are difficult to access and can become spaces of discrimination for the individuals I spoke with. The chapter ends on a discussion of how these findings might be useful to local communities and of the broader relevance for sex workers rights activists, researchers of sex work and social and health service providers.

Different words, same strategies

In chapter two, I posed the following question: it seems clear that various labels and identities have been brandished by all sides in the contested arena of sex work—but how do they change and what do they achieve? Narratives from service providers,

community-builders, bureaucrats and activists who have been involved with relevant agencies and groups in the last three decades illustrate the emergence of "new language" that describes similar and much older realities and intervention histories. Interlocutors insisted that the hotly debated language surrounding the management of the sex industry has changed considerably. However, the intentions and consequences remain strikingly similar—that is, to confine the sex industry and those within it to a *social problems framework*, where selling sex is a treated as problem (Brock 2009) that requires *continual* intervention. As we have seen with the term sexual exploitation, now almost entirely replaced by human trafficking, these terms are only used as long as they can offer social, political, financial and moral purchase. If more funding, more power, more prestige can be gained by using the term "human trafficking", or if one person or organization can establish and maintain their role as a savior in a more efficacious way by using a new term, it will be employed. From the tacit establishment of a red light district in Point Douglas in the early 1900s to contain and regulate the perceived immorality of the sex trade to the strict definition of sex trade workers as "exploited persons" used by the Winnipeg Police Services in 2017, continued linguistic deployments feed into and out from interventions that seek to govern the sex trade in the name of protection, security and social betterment. Interventions today, as they have done historically, frame and reframe the sex industry as endangering (mostly) women who—as supposed agentless and "innocent" victims—urgently require rescue.

The persistence in Winnipeg of repeating and reinforcing longstanding colonial dynamics through the enactment of different policies and projects has been argued to

be “exacerbated by the regressive tendencies of the city’s neoliberal orientation” (Wilt 2019). David Hugill and Owen Toews argue that the controversy surrounding the allocation of public funds to the evangelical Christian group Youth for Christ (YFC) to build a youth complex in Winnipeg North End—an urban neighborhood with a large Indigenous population—continues patterns of disregard of the needs and aspirations of Indigenous peoples. Indeed, the approval of the multi-million dollar youth recreation complex in the midst of impressive mobilization by community organizations already established in the same community was described as the “reinstituting and state sanctifying another more contemporary, altered form of the Residential School experience, mentality and practice all under the guise of helping at-risk Aboriginal youth” (City of Winnipeg 2010 in Hugill et Toews 2014). The geographical location and focus on Indigenous youth of this revamped attempt to “Christianize” Aboriginal children, as it was called by activists opposing it, in Winnipeg’s North End reinforces the Hugill and Toews’ argument that the neoliberal strategies of governance at play “enshrine redistribution, austerity, and privatization in the name of progress” at the exclusion of Indigenous peoples. More recent example of neoliberal tendencies that continue and maintain colonial dynamics in Winnipeg are around the “safety measures” increasingly put in place since 2018, including the recent calls for more policing to “reduce panhandling” (Kusch 12:12:00 CST) and “increase safety” in Winnipeg’s downtown, the draconian safety measures at the Millennium library (CBC News 2019b) and the ever increasing measures to stop the alleged wave of liquor store thefts (Wilt 2019). Near-constant media coverage of what the CEO of a security company has called

"the darkest time in Winnipeg history" for local businesses (CBC News 2019a) has led to the ramping up of securitization of the city's stores in recent months, including hiring police officers as security guards, back checks and bottle locks, and recently the mandatory identification of everyone entering the province's alcohol vendors (Wilt 2019) . Based on very little evidence aside from the dramatic mediatic coverage and vigilante-style mobilization by private citizens[26], the responses based on "racist, ineffective, and costly "law and order" agenda" only feeds into a carceral system that will only see more Indigenous people incarcerated and homes destroyed (Wilt 2019).

Governance logics that seek to "increase safety" also base interventions that seek to increase surveillance and control of people involved in the sex trade, under the guise of helping them. Much like the policies, programs and projects developed by settler Canadians, which often are deeply invested in reinforcing colonial narratives, and power relations that uphold the Canadian state, interventions that target the sex trade continue to frame prostitution as a problem to be solved (Brock 2009) and people involved in the sex trade as victims needing to be rescued. Indeed, this is even more heightened in relation to the involvement of Indigenous peoples in the sex trade. Focusing on the words, labels and identities that are used, deliberated and defended in public and private discussions of the sex trade offer a vivid window into the workings of these power dynamics.

[26] organized posting of photos and videos of alleged thieves on social media, direct action by co-called 'citizen arrests' (Wilt 2019)

Sex work, boundary work

In chapter 5, I recount the short but tumultuous recent history of sex work activism in Winnipeg through the activities of SWWAC and their interactions with other social and political actors engaged in discussions, services and programs surrounding the sex trade. The intense boundary work that is constantly performed surrounding deliberative identities in Winnipeg was emphasized. The boundary work refers both to the vigilante-type of policing and sometimes social retribution faced by individuals and activists using the wrong words, and also to SWWAC's efforts to press agencies to include "sex worker" as one of the identities of people they serve and to define it appropriately. Both of these examples highlight the deliberative and affective process enacted through discourses surrounding the sex trade in Winnipeg. Deliberative identities maintain boundaries but also challenge, unsettle, interrupt and undo them. In the current context in Winnipeg, using the word "sexually exploited" can establish and delimitate a state of being, casting oneself or an organization in a certain light and role. Conversely, the term "sex worker" can also challenge, push back and blur boundaries between innocent and knowing victims, between vulnerability and agency, but also between saving and coercion. As we have seen with the examples of the radio interviews that Joy Smith and I gave to CJOB regarding the Buying Sex is Not a Sport campaign, the introduction of the term "sex work" and the need to differentiate it from other terms used interchangeably was challenging enough to warrant doing a counter-interview on the subject. Of course, it is the political and affective fields that the term stirs up around agency, sexuality and human rights that had to be responded to and

discredited. The history of the term "sex work" is inseparable from the struggle for labor and human rights waged by the global sex workers rights movement, but also from the acrimonious arguments around violence and exploitation in the sex trade in activist, feminist and political arenas. The political and affective fields, and moral projects that are conjured with the terms "sexual exploitation" and "human trafficking"[27] are sustained by casting "women and girls" in the sex trade in limited roles as innocent victims, or eventually as "survivors". These roles fit the lived experiences of many and they are not in themselves problematic, nor are they solely imagined. It is their imposition in a monopoly of representability that is at stake here. This social and discursive enforcement and power dynamics are part of the process that I call deliberative identities. Including the term "sex worker" in the list of possible experiences in the sex trade disrupts this monopoly of representation and challenges the category of "innocent victim", which in turn challenges the role of the savior.

Deliberative identities shape the way a person or an organization might re-envision themselves, might project themselves in the future and in the world. It also shapes how others perceive and construct their idea of "that person" or organization. It also, as it does in the case of health, create and shape access to health and social services, this can shape someone's life trajectory.

The invocation of deliberative identities like "sex worker" directly shapes the experience of participants, it gives them access to certain spaces, to certain care, while restricting their access to other spaces, both on an individual level and in their attempts

[27] As they were used interchangeably in this interview.

to collectively ask for their identities to be honoured. Deliberative identities embody how people represent themselves while it also serves as a vehicle to make sense of and navigate a thorny social terrain. Considering the intense stigmatization and the myriad of interlocking consequences that brandishing the deliberative identity of "sex worker" can activate, my interlocutors and SWWAC members who insist on using it do so as a way to urgently carve out a space for them to exist in a ways that feels less suffocating, that feels more representative of what they aspire toward.

Access and experiences with health and social services

For the cisgender, transgender and non-binary sex workers and people with experience in the sex trade that I spoke with during the summer and fall of 2017, accessing health and social services is often a complicated necessity. They described encountering multilayered and intersectional forms of stigma that often reduced the complexity and vibrance of their experience to risk groups, uninformed assumptions and rigidly assigned identity labels. My interlocutors, like many members of groups marginalized by systems of oppression, used strategies to keep themselves safe and get the care that they needed. Faced with weighing the risk and benefits of disclosing one's occupation to service providers, sex workers and people in the sex trade often feared judgment, stigma and inappropriate healthcare if they "outed" themselves. Others feared that that their experience wouldn't be respected, and that service providers may insist to provide them with unnecessary "safer sex education" or make assumptions about potential substance use, childhood trauma, personal ethics or sexual behavior.

When it comes to health, the process of deliberative identities refers to the intense pondering, weighing and concern poured into deciding whether or not to declare oneself as a sex worker to a healthcare provider. This practice of self-deliberation involves weighing concerns for safety—what are the consequences of disclosure in terms of potential discrimination, shame, and in having your health and social services needs met? What lies in the balance is quite literally whether or not service providers will see you, treat you, and make you feel fully human.

While I heard stories of discrimination, judgment and inappropriate health care at the hands of social and health service providers, the positive relationships and experiences were also shared with me. These stories, and the explanations of what "safety" can look and feel like were the centre of chapter four. Considering the narratives shared in chapter three, it seems impossible to consider that health and social services are adequately adapted to sex working communities. Nonetheless, it matters to discuss not only how cherished these positive relationships and experiences often were to my interlocutors, but also to highlight that their existence proves what is possible—and feasible—in terms of affirming and empathetic relationships. It should be noted that these stories do not represent the majority of stories shared, nor do they suggest that entirely adequate care was provided. Indeed, in some cases, my interlocutors felt that their experience was "positive" even though they didn't disclose their occupation despite wanting to or feeling that it would be more appropriate for their care. My interlocutors also shared advice and suggestions regarding how services providers could improve both their access to their services but also their experiences

when they come. They valued respectful, compassionate, client-centered care with service providers who they felt care for them and avoided judging them. The individuals I spoke to also demanded that service providers receive better training—both in educational institutions and through professional associations and workplaces—on the complex realities of people marginalized by systems of oppressions[28], and how to treat them with compassion. Echoing the harm reduction principle of meaningful engagement and participation of affected communities in the program and policy decisions that affect them, it was suggested that more representation of their peers, be that of current sex workers or experiential people, in agencies would make them more welcoming and potentially safer. This works as long as the agency is also willing to follow other harm reduction principles regarding being client-centered and can work with participants who may have experiences in the sex trade that does not reflect that of their sex working or experiential staff.

The examination of the individual, socio-cultural and structural factors that influence sex workers' access to and utilization of social and health services that was offered in this research highlighted the short comings of the current offering of specialized services for this population, as well as the pervasive stigma and discrimination that they continue to endure while accessing general health and social services. It also identified practices that sex workers and people in the sex trade see as safe and affirming and documented their advice and suggestions. Perhaps more

[28] such as sex workers, but also racialized people, Indigenous peoples, members of 2SLGBTTQI communities, low-income people, people with disabilities.

importantly, the narratives that they shared with me stressed the urgency to address whorephobia in health and social services, and the dehumanization of patients and clients that is it allowing. Considering the gravity of the widespread human rights violations facing people involved in the sex trade (Decker et al., 2014), a better understanding of how the punitive contemporary socio-legal climate influences sex workers' access to and utilization of social and health services is warranted to create effective, inclusive and safe service offering.

Drawbacks and limitations

As mentioned in Chapter One, there are several drawbacks and limitations to my study. The stigma and criminalization of the sex trade makes recruitment of participants to any study challenging. While I employed a recruitment strategy for the interviews that sought to reach outside of the networks and relationships I had created in my ethnographic fieldwork and activism, it is likely that my sample could have been even more diversified than it was. The potential that their involvement or past experience in the sex trade may be disclosed (even only to me during the interview) may have caused many potential participants to refrain from contacting me to participate in the interviews, despite the many safeguards put in place to protect their confidentiality. Indeed, the same factors that make access to health and social services incredibly challenging for people involved in the sex trade (including stigma) may have contributed to shaping the sample of interlocutors for my interviews. The fact that I had to restrict the number of interviews I conducted because of monetary and time constraints also

limits the diversity of my sample as people with different experiences may have come forward had I been able to interview them. As extensively mentioned in Chapter One, my positionality also undoubtedly played a role in who chose to speak to me and who did not.

The methodology employed in this research study restricts the possibility of claiming any representativity of the sample of people I spoke with to the general or local population of sex workers and people involved in the sex trade. It was a convenient sample which presented a diversity in terms of race, gender, age, field of work in the sex trade and experience within the sex trade, but in the absence of a picture of the overall population of people in the sex trade, it is impossible to know if it is representative or not. It remains important to note that it is rare for a qualitative study to present the experiences of participants that work indoors, outdoors and online in such high numbers.

While it is impossible to know exactly why this research project garnered such active and diverse participation, it is likely related to the years of trust and relationship building with individuals and agencies. However, this long— and, in my view, essential— process also highlights a drawback to ethnographic research. It is very time-intensive and demanding personally, which leads to longer time to completion of research and study programs that can negatively affect professional outcomes.

The limitations and drawbacks of this study are not uncommon for ethnographic research focusing on a stigmatized and criminalized population such as sex workers and people in the sex trade (Shaver 2005). As the sex trade and its participants become less

stigmatized, it is possible to imagine that limitations regarding access and recruitment will be mitigated.

Why this matters

The results presented in my thesis make contributions in three main areas: 1) the improvement of health and social services for sex workers and those involved in the sex trade, 2) the conceptual and analytical possibilities offered by the concept of deliberative identities in medical anthropology and scholarships looking at social movements and health, and 3) the on-going documentation of recent sex worker rights activism in Winnipeg.

The documentation of the current services offering in Winnipeg, Treaty One territory, and how it is experienced by local communities of sex trade workers sheds light on the historical and ideological trends that shape and reshape them, and how it affects access to and experience with those services. Far from being a simple program design exercise, based on identified health and social needs in an amoral vacuum, the services that are offered take place, as documented throughout this thesis, in a complex and emotionally charged social field. My thesis seeks to document how ideas about the sex trade and people who participate in it affects the services that are offered or not offered and who has access to them. It is crucial for policy makers, service providers and decisions makers to consider the experience of people in the sex trade with these services. More generally, the results contributes to a broader body of literature that

documents the experiences of sex workers and other stigmatized populations with regards to health and social services in Canada (Benoit et al. 2014, 2017, 2016; Benoit, Smith, Jansson, Magnus, et al. 2019; Fast et al. 2010; Landsberg et al. 2017; Shannon et al. 2007; Shaver 2019; Shaver, Lewis, et Maticka-Tyndale 2011). This project also contributes to the documentation of patterns of vulnerability and organization of services in medium sized cities such as Winnipeg, which is still scarce in Canada (with notable exceptions such as Orchard 2019).

Based on the results presented in this thesis, current and future service offering endeavors in Winnipeg should seek to follow the principles of harm reduction (International Harm Reduction Association 2010), especially that of being client-centered, non-judgmental, and facilitative, rather than coercive, and to use evidence-based strategies. Programs based on moralistic views of the sex trade are not evidence-based. Indeed, the well-researched Winnipeg Regional Health Authorities position statement on Harm Reduction could serve as the basis to plan and evaluate programs and services pertaining to the sex trade. Service providers, including health professionals, should have access to basic and continuous training on the complex and varied realities existing in the sex trade, as well as how to show compassion towards their clients in the sex trade. Based on the suggestion of sex workers I spoke to, the development of a database of service providers of all fields who have received such a training, or as my interlocutor stated "*aren't crappy*", could support sex workers and others in the sex trade to navigate services they need more safely. Similarly, the

development of an anonymous and safe evaluation system for sex workers may be an important resource to consider developing.

The concept of deliberative identities developed throughout my thesis offers a fresh attempt to engage with questions of selfhood and subjectivity as it relates to health. Building on the larger body of literature that pertains to health identities, this concept represents a departure from considering identity as tied to individual desires and individuals to locate it more broadly in a social field. Seeking to look beyond identity politics, deliberative identities situates the power struggles between typologies of sex work (such as those commonly deployed in public health and global public health) and social movements such as the sex workers rights movement. This concept may offer avenues to look into how certain health-based labels and categories, such as "sex worker", that are structurally imposed on groups of people do not define them but are deliberately used and shaped by them in processes that go beyond individual actions and desires. In my fieldwork in Winnipeg, this concept allowed me to shift the onus from the individual desires of people in the sex trade (and specifically sex workers) to the arenas of interventions, social movements and activism. It may be useful in other contexts where groups of people attempt to confront discrimination and stigma.

The documentation of the recent wave of sex workers rights activism in Winnipeg that this thesis offers through the birth and work of the Sex Workers of Winnipeg Action Coalition is a valuable addition to the long and rich history of sex worker rights activism

in what is currently known as Canada. The fact that every legal change, challenge to stigmatizing and moralistic policies, and development of welcoming, non-judgmental services has come through the tireless work of generations of activists did not escape my mind for one moment during the data collection, analysis and writing of this research project. It is important to offer details of how sex worker rights activists organize themselves to offer example to other groups, and perhaps even to inspire. It also matters to shed light on the activist work that happens behind policy, political and social changes, especially when this work is done by stigmatized individuals whose voices are ignored and silenced. In a context like Winnipeg, where is it widely accepted that people involved in the sex trade are simply victims of exploitation without much agency or power, it also mattered to document the work of a group of sex workers who come together to demand changes to their situation, who are highly capable of making decisions about their own lives and well-being. My thesis seeks to humbly contribute to the recent flow of publication of important works documenting the recent history of the Canadian sex worker rights movement in Canada such as, among others, *Luttes XXX: Inspirations du movement des travailleuses du sexe* (Nengeh, Thiboutot, et Toupin 2012), *Red Light Labour: Sex Work, Regulation, Agency, and Resistance* (Durisin et al. 2018), *Selling Sex: Experience, Advocacy, and Research on Sex Work in Canada* (Van der Meulen et al. 2013b) and *Sex Work Activism in Canada: Speaking Out, Standing Up* (Lebovitch et Ferris 2019). Particularly, my research contributes the account of the first few years of a small group of dedicated sex workers and allies in an often-hostile environment in a medium sized, conservative city such as Winnipeg.

REFERENCES

Abawi, Zuhra. 2018. « Factors and Processes of Racialization in the Canadian Academe ». *Canadian Journal for New Scholars in Education/ Revue Canadienne Des Jeunes Chercheures et Chercheurs En Éducation* 9(1).

Abrams, Laura S. 2010. « Sampling 'Hard to Reach' Populations in Qualitative Research: The Case of Incarcerated Youth ». *Qualitative Social Work* 9(4):536-50.

Adams, Vincanne, Sharon R. Kaufman, Taslim van Hattum, et Sandra Moody. 2011. « Aging Disaster: Mortality, Vulnerability, and Long-Term Recovery among Katrina Survivors ». *Medical Anthropology* 30(3):247-70.

Agustín, Laura María. 2007. *Sex at the Margins: Migration, Labour Markets and the Rescue Industry*. Zed Books.

Ahmed, Sara. 2019. « A Complaint Biography ». *Biography* 42(3):514-23.

Amnesty International. 2016. *AMNESTY INTERNATIONAL POLICY ON STATE OBLIGATIONS TO RESPECT, PROTECT AND FULFIL THE HUMAN RIGHTS OF SEX WORKERS.*

Anderson, Warwick. 2006. *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines*. Duke University Press.

Aral, Sevgi O., Janet S. St. Lawrence, Lilia Tikhonova, Emma Safarova, Kathleen A. Parker, Anna Shakarishvili, et Caroline A. Ryan. 2003. « The Social Organization of Commercial Sex Work in Moscow, Russia ». *Sexually Transmitted Diseases* 30(1):39.

Argento, Elena, Sushena Reza-Paul, Robert Lorway, Jinendra Jain, M. Bhagya, Mary Fathima, S. V. Sreeram, Rahman Syed Hafeezur, et John O'Neil. 2011. « Confronting structural violence in sex work: lessons from a community-led HIV prevention project in Mysore, India ». *AIDS Care* 23(1):69-74.

Ashford, Robert D., Brenda Curtis, et Austin M. Brown. 2018. « Peer-delivered harm reduction and recovery support services: initial evaluation from a hybrid recovery community drop-in center and syringe exchange program ». *Harm Reduction Journal* 15.

Audrey, Smeldley, George Armelagos, Michael Blakey, C. Loring Brace, Alan Goodman, Faye Harrison, Jonathan Marks, Yolanda Moses, et Carol Mukhopadhyay. 1998. « AAA Statement on Race - Connect with AAA ». Consulté 12 décembre 2019 (https://www.americananthro.org/ConnectWithAAA/Content.aspx?ItemNumber=2583).

Bahri, Jacenta. 2017. « Stigmatized in stilettos: an ethnographic study of stigma in exotic dancers' lives ».

Bahri, Jacenta. 2019. « Boyfriends, lovers, and "peeler pounders": experiences of interpersonal violence and stigma in exotic dancers' romantic relationships ». *Sexual and Relationship Therapy* 0(0):1-20.

Baratosy, Roxana, et Sarah Wendt. 2017. « "Outdated Laws, Outspoken Whores": Exploring sex work in a criminalised setting ». *Women's Studies International Forum* 62:34-42.

Beaud, Stéphane, et Florence Weber. 2017. *Guide de l'enquête de terrain: produire et analyser des données ethnographiques*. La découverte.

Bennett, Darcie. 2013. « Sex Work Groups from the DTES Ready to Intervene at SCC ». *Pivot Legal Society*. Consulté 12 juillet 2020 (https://www.pivotlegal.org/sex_work_groups_from_the_dtes_ready_to_intervene_at_scc).

Benoit, Cecilia, Chris Atchinson, Lauren Casey, Mikael Jansson, Bill McCarthy, Rachel Phillips, Bill Reimer, Dan Reist, et Frances Shaver. 2014. *A "working paper" prepared as background to Building on the Evidence: An International Symposium on the Sex Industry in Canada*.

Benoit, Cecilia, Mikael Jansson, Alison Millar, et Rachel Phillips. 2005. « Community-Academic Research on Hard-to-Reach Populations: Benefits and Challenges ». *Qualitative Health Research* 15(2):263-82.

Benoit, Cecilia, Mikael Jansson, Michaela Smith, et Jackson Flagg. 2017. « "Well, It Should Be Changed for One, Because It's Our Bodies": Sex Workers' Views on Canada's Punitive Approach towards Sex Work ». *Social Sciences* 6(2):52.

Benoit, Cecilia, Nadia Ouellet, et Mikael Jansson. 2016. « Unmet Health Care Needs among Sex Workers in Five Census Metropolitan Areas of Canada ». *Canadian Journal of Public Health* 107(3):e266-71.

Benoit, Cecilia, Michaela Smith, Mikael Jansson, Priscilla Healey, et Doug Magnuson. 2019a. « "The Prostitution Problem": Claims, Evidence, and Policy Outcomes ». *Archives of Sexual Behavior* 48(7):1905-23.

Benoit, Cecilia, Michaela Smith, Mikael Jansson, Priscilla Healey, et Doug Magnuson. 2019b. « "The Prostitution Problem": Claims, Evidence, and Policy Outcomes ». *Archives of Sexual Behavior* 48(7):1905-23.

Benoit, Cecilia, Michaela Smith, Mikael Jansson, Samantha Magnus, Jackson Flagg, et Renay Maurice. 2018. « Sex work and three dimensions of self-esteem: self-worth, authenticity and self-efficacy ». *Culture, Health & Sexuality* 20(1):69-83.

Benoit, Cecilia, Michaela Smith, Mikael Jansson, Samantha Magnus, Renay Maurice, Jackson Flagg, et Dan Reist. 2019. « Canadian Sex Workers Weigh the Costs and Benefits of Disclosing Their Occupational Status to Health Providers ». *Sexuality Research and Social Policy* 16(3):329-41.

Bernstein, Mary. 2005. « Identity Politics ». *Annual Review of Sociology* 31(1):47-74.

Beyrer, Chris, Anna-Louise Crago, Linda-Gail Bekker, Jenny Butler, Kate Shannon, Deanna Kerrigan, Michele R. Decker, Stefan D. Baral, Tonia Poteat, Andrea L. Wirtz, Brian W. Weir, Françoise Barré-Sinoussi, Michel Kazatchkine, Michel Sidibé, Karl-Lorenz Dehne, Marie-Claude Boily, et Steffanie A. Strathdee. 2015. « An action agenda for HIV and sex workers ». *The Lancet* 385(9964):287-301.

Biehl, João, et Peter Locke. 2010. « Deleuze and the Anthropology of Becoming ». *Current Anthropology* 51(3):317-51.

Biehl, João, et Peter Locke. 2017. *Unfinished: The Anthropology of Becoming*. Duke University Press.

Branch, Legislative Services. 2019. *Consolidated Federal Laws of Canada, Canadian Human Rights Act*.

Brock, Deborah R. 2009. *Making Work, Making Trouble: The Social Regulation of Sexual Labour*. 2nd ed. Toronto ; University of Toronto Press.

Bruckert, et Frédérique Chabot. 2010. *Challenges: Ottawa area sex workers speak out*. Ottawa/Gatineau: POWER (Prostitutes of Ottawa/Gatineau Work, Educate and Resist.

Bruckert, Chris, Anna-Aude Caouette, Jen Clamen, Kara Gillies, Sheri Kiselback, Émilie Laliberté, Tara Santini, Keisha Scott, et Emily Symons. 2013. « Language Matters: Talking about sex work ».

Bruckert, Chris, et Stacey Hannem. 2013. « Rethinking the Prostitution Debates: Transcending Structural Stigma in Systemic Responses to Sex Work ». *Canadian Journal of Law & Society* 28(1):43-64.

Bruckert, Chris, et Colette Parent. 2018. *Getting Past « the Pimp »: Management in the Sex Industry*. University of Toronto Press.

Bruckert, Chris, Emily Van der Meulen, et Elya M. Durisin. 2018. *Red Light Labour: Sex Work Regulation, Agency, and Resistance*. Vancouver [British Columbia] ; UBC Press.

Butterfield, Jeremy ButterfieldJeremy. 2015. « Deliberative ». in *Fowler's Concise Dictionary of Modern English Usage*, édité par J. Butterfield. Oxford University Press.

Canada (Attorney General) v. Downtown Eastside Sex Workers United Against Violence Society. 2012. *Canada (Attorney General) v. Downtown Eastside Sex Workers United Against Violence Society*. Vol. [2012] 2 SCR 524.

Canadian Alliance for Sex Work Law Reform. 2017. « Member Groups ». *Canadian Alliance for Sex Work Law Refom*. Consulté 13 décembre 2019 (https://sexworklawreform.com/about-us/member-groups/).

Canadian Public Health Association. 2014. *Sex Work in Canada: The Public Health Perspective*. Ottawa: Canadian Public Health Association.

Canadian Women's Foundation. 2017. « Canadian Women's Foundation | Sector Resources | Anti-Trafficking ». *Canadian Women's Foundation*. Consulté 17 décembre 2019 (https://canadianwomen.org/our-work/sector-resources/).

Castro, Arachu, et Paul Farmer. 2005. « Understanding and Addressing AIDS-Related Stigma: From Anthropological Theory to Clinical Practice in Haiti ». *American Journal of Public Health; Washington* 95(1):53-59.

CBC News. 2015a. « 26 Men Charged with Buying Sex in Winnipeg, Oldest Age 77 | CBC News ». *CBC*, août 27.

CBC News. 2015b. « Manitoba Launches Campaign to Curb Sex Exploitation at Grey Cup | CBC News ». *CBC*, octobre 29.

CBC News. 2019a. « Retailers Face "darkest Time in Winnipeg History" as Theft Rates Surge, Security Firm CEO Says | CBC News ». *CBC*, octobre 30.

CBC News. 2019b. « Security to Remain at Millennium Library, despite "shush-in," Protest | CBC News ». *CBC*, septembre 9.

Cecilia Benoit, et Leah Shumka. 2015. « Sex Work in Canada ».

Chan, Kit Yee, et Daniel D. Reidpath. 2003. « "Typhoid Mary" and "HIV Jane": Responsibility, Agency and Disease Prevention ». *Reproductive Health Matters* 11(22):40-50.

Cheff, Rebecca, et Canadian Electronic Library. 2018. *Compensating Research Participants: A Survey of Current Practices in Toronto*. Toronto, ON, CA: Wellesley Institute.

Chevrier, Claudyne, Shamshad Khan, Sushena Reza-Paul, et Robert Lorway. 2016. « 'No one was there to care for us': Ashodaya Samithi's community-led care and support for people living with HIV in Mysore, India ». *Global Public Health* 11(4):423-36.

City of Winnipeg. 2010. « Council of the City of Winnipeg Hansard, Wednesday, February 24 ».

Clamen, Jen. 2018. « Foreword ». in *Getting Past « the Pimp ». Management in the Sex Industry*. Toronto: University of Toronto Press.

Collins, Alexandra B., Carol Strike, Adrian Guta, Rosalind Baltzer Turje, Patrick McDougall, Surita Parashar, et Ryan McNeil. 2017. « "We're Giving You Something so We Get Something in Return": Perspectives on Research Participation and Compensation among People Living with HIV Who Use Drugs ». *International Journal of Drug Policy* 39:92-98.

Community Health, Klinic. 2015. « History ». *Klinic Community Health*. Consulté 17 décembre 2019 (http://klinic.mb.ca/about-klinic/history/).

Constable, Nicole. 2009. « The Commodification of Intimacy: Marriage, Sex, and Reproductive Labor ». *Annual Review of Anthropology* 38(1):49–64.

Conti, Joseph A., et Moira O'Neil. 2007. « Studying Power: Qualitative Methods and the Global Elite ». *Qualitative Research* 7(1):63-82.

Cornish, Flora. 2006. « Challenging the stigma of sex work in India: material context and symbolic change ». *Journal of Community & Applied Social Psychology* 16(6):462-71.

Daniel McIntyre St. Matthews Community Association. s. d. « OUR PLACE SAFE SPACE ». *DMSMCA*. Consulté 4 septembre 2019 (https://www.dmsmca.ca/24-hr-safe-space).

Das, Veena, et Erving Goffman. 2013. « Stigma , Contagion , Defect : Issues in the Anthropology of Public Health ».

Decker, Michele R., Anna-Louise Crago, Sandra K. H. Chu, Susan G. Sherman, Meena S. Seshu, Kholi Buthelezi, Mandeep Dhaliwal, et Chris Beyrer. 2015. « Human rights violations against sex workers: burden and effect on HIV ». *The Lancet* 385(9963):186-99.

Department of Justice. 2014. *Government Bill (House of Commons) C-36 (41-2) - Royal Assent - Protection of Communities and Exploited Persons Act - Parliament of Canada*.

van Der Meulen, Emily. 2011. « Action Research with Sex Workers: Dismantling Barriers and Building Bridges ». *Action Research* 9(4):370–384.

van Der Meulen, Emily, et Elya Durisin. 2008. « Why Decriminalize? How Canada's Municipal and Federal Regulations Increase Sex Workers' Vulnerability ». *Canadian Journal of Women and the Law* 20(2):289-311.

Dixon, Vanessa. 2009. « Enabling Environments Promote Access and Uptake of Clinical Services at an HIV Prevention Project for Sex Workers in Mysore, India ». Thesis, Simon Fraser University.

Dixon, Vanessa, Sushena Reza-Paul, Fathima Mary D'Souza, John O'Neil, Nadia O'Brien, et Robert Lorway. 2012. « Increasing access and ownership of clinical services at an HIV prevention project for sex workers in Mysore, India ». *Global Public Health* 7(7):779-91.

Durisin, Elya M., Emily van der Meulen, et Chris Bruckert. 2018. *Red Light Labour: Sex Work Regulation, Agency, and Resistance*. UBC Press.

Farley, Melissa. 2004. « "Bad for the Body, Bad for the Heart": Prostitution Harms Women Even If Legalized or Decriminalized ». *Violence Against Women* 10(10):1087-1125.

Fassin, Didier, et Mariella Pandolfi. 2013. *Contemporary States of Emergency. The Politics of Military and Humanitarian Interventions*. Zone Books.

Fast, Danya, et David Cunningham. 2018. « "We Don't Belong There": New Geographies of Homelessness, Addiction, and Social Control in Vancouver's Inner City ». *City & Society* 30(2):237-62.

Fast, Danya, et Eileen Moyer. 2018. « Becoming and Coming Undone on the Streets of Dar Es Salaam ». *Africa Today* 64(3):2-26.

Fast, Danya, Jean Shoveller, Kate Shannon, et Thomas Kerr. 2010. « Safety and danger in downtown Vancouver: Understandings of place among young people entrenched in an urban drug scene ». *Health & Place* 16(1):51-60.

Ferris, Shawna. 2015. *Street Sex Work and Canadian Cities: Resisting a Dangerous Order*. Edmonton, Alberta, Canada: The University of Alberta Press.

Festinger, David S., Douglas B. Marlowe, Jason R. Croft, Karen L. Dugosh, Nicole K. Mastro, Patricia A. Lee, David S. DeMatteo, et Nicholas S. Patapis. 2005. « Do Research Payments Precipitate Drug Use or Coerce Participation? » *Drug and Alcohol Dependence* 78(3):275-81.

Fitzgerald, Lisa, Catherine Healy, et Gillian Abel. 2010. *Taking the Crime out of Sex Work: New Zealand Sex Workers' Fight for Decriminalisation*. Bristol, UK: Policy Press.

Galloway, Gloria. 2015. « 70 per cent of murdered aboriginal women killed by indigenous men: RCMP ». *The Globe and Mail*, avril 9.

Garro, Linda Young. 1982. « Introduction: The ethnography of health care decisions ». *Social Science & Medicine* 16(16):1451-52.

Ghimire, Laxmi, W. Cairns S. Smith, et Edwin R. van Teijlingen. 2011. « Utilisation of sexual health services by female sex workers in Nepal ». *BMC Health Services Research* 11(1):79.

Gieryn, Thomas F. 1999. *Cultural Boundaries of Science: Credibility on the Line*. University of Chicago Press.

Goffman, Erving. 1963. *Stigma; Notes on the Management of Spoiled Identity*. Englewood Cliffs, N.J: Prentice-Hall.

Government of Canada, Public Services and Procurement Canada. 2002. « Tri-Council Policy Statement - Ethical Conduct for Research Involving Humans / Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada.: MR21-18/2010E-PDF - Government of Canada Publications - Canada.Ca ». Consulté 4 novembre 2019 (http://publications.gc.ca/site/eng/381622/publication.html).

Government of Manitoba. s. d. « Tracia's Trust: Manitoba's Sexual Exploitation Strategy ». *Province of Manitoba - Department of Families*. Consulté 4 juin 2019 (https://www.gov.mb.ca/fs/).

Grady, Christine. 2001. « Money for Research Participation: Does It Jeopardize Informed Consent? » *The American Journal of Bioethics* 1(2):40-44.

Grant, Melissa Gira. 2014. *Playing the Whore: The Work of Sex Work*. Verso Books.

Gray, James Henry. 1974. *Red Lights on the Prairies*. Toronto: Macmillan of Canada.

Greer, Alissa M., Serena A. Luchenski, Ashraf A. Amlani, Katie Lacroix, Charlene Burmeister, et Jane A. Buxton. 2016. « Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada ». *BMC Public Health* 16.

Ham, Julie. 2011. *What's the Cost of a Rumour? A guide to sorting out the myths and the facts about sporting events and trafficking - The Global Alliance Against Traffic in Women (GAATW)*. Bangkok: Global Alliance Against Traffic in Women.

Hodzic, Sandra, et Robert Chrismas. 2018. « Taking Back the Power: The Link between Poverty and Canada's Sex Industry ». *Journal of Community Safety and Well-Being* 3(2):34-37.

Hugill, David. 2010. *Missing Women, Missing News: Covering Crisis in Vancouver's Downtown Eastside*. Halifax [N.S: Fernwood.

Hugill, David, et Owen Toews. 2014. « Born Again Urbanism: New Missionary Incursions, Aboriginal Resistance and Barriers to Rebuilding Relationships in Winnipeg's North End ». *Human Geography* 7(1):69-84.

Hunt, Sarah. 2006. *Violence in the Lives of Sexually Exploited Youth and Adult Sex Workers in BC Provincial Research: Final Report, 2006*. New Westminster, B.C: Justice Institute of British Columbia, Centre for Leadership and Community Learning.

Hunt, Sarah. 2015. « Representing Colonial Violence: Trafficking, Sex Work, and the Violence of Law ». *Atlantis: Critical Studies in Gender, Culture & Social Justice* 37(2):25-39.

Hunt, Sarah. 2017. « Foreword ». P. ix-xv in *Responding to human trafficking: dispossession, colonial violence, and resistance among Indigenous and racialized women*. Toronto: University of Toronto Press.

Indigenous Sex Sovereignty Collective. 2015a. « Indigenous Sex Sovereignty Collective ». Consulté 12 juillet 2020 (https://indigenoussexsovereignty.tumblr.com).

International Harm Reduction Association. 2010. *What is Harm Reduction? A position statement from the International Harm Reduction Association*. London, UK: International Harm Reduction Association.

Jackson, Crystal A. 2016. « Framing Sex Worker Rights: How U.S. Sex Worker Rights Activists Perceive and Respond to Mainstream Anti–Sex Trafficking Advocacy ». *Sociological Perspectives* 59(1):27-45.

Jackson, Crystal A., Jennifer J. Reed, Barbara G. Brents, Jennifer J. Reed, et Barbara G. Brents. 2017. « Strange Confluences : Radical Feminism and Evangelical Christianity as Drivers of US Neo-Abolitionism ». *Feminism, Prostitution and the State*. Consulté 10 novembre 2018 (https://www.taylorfrancis.com/).

Janes, Craig R., et Kitty K. Corbett. 2009. « Anthropology and Global Health ». *Annual Review of Anthropology* 38(1):167-83.

Jones, Esyllt Wynne. 2007. *Influenza 1918: Disease, Death and Struggle in Winnipeg*. Toronto: University of Toronto Press.

Kady, O'Malley. 2014. « Prostitution Bill Should Be about Sex Work and Not Trafficking, MPs Told | CBC News ». *CBC*, juillet 10.

Kaye, Julie. 2017. *Responding to Human Trafficking: Dispossession, Colonial Violence, and Resistance among Indigenous and Racialized Women*. Toronto [Ontario] ; University of Toronto Press.

Kempadoo, Kamala. 2003a. « Globalizing Sex Workers' Rights ». *CANADIAN WOMAN STUDIESILES CAHIERS DE LA FEMME* 22(3-4):143-50.

Kempadoo, Kamala. 2003b. « Globalizing Sex Workers' Rights ». *Canadian Woman Studies* 22(3/4):143-50.

Kleinman, Arthur, Veena Das, et Margaret M. Lock. 1998. *Social Suffering*. Delhi ; Oxford University Press.

Klingbeil, Cailynn. 2016. « Canadian Universities Require Indigenous Studies: "It Feels Good to Learn Our History" ». *The Guardian*, août 25.

Klinic. s. d. « Dream Catchers ». *Klinic Community Health*. Consulté 13 décembre 2019 (http://klinic.mb.ca/wellness-support-groups/dream-catchers/).

Klinic's Social Justice Committee. 2017. « Klinic Community Health's Statement on Sexual Exploitation ».

Kotiswaran, Prabha. 2011. *Dangerous Sex, Invisible Labor: Sex Work and the Law in India*. Princeton: University Press.

Krüsi, Andrea, Thomas Kerr, Christina Taylor, Tim Rhodes, et Kate Shannon. 2016. « 'They won't change it back in their heads that we're trash': the intersection of sex work-related stigma and evolving policing strategies ». *Sociology of Health & Illness* 38(7):1137–1150.

Kunimoto, Erica Mika. 2018. « A Critical Analysis of Canada's Sex Work Legislation ». *Stream: Interdisciplinary Journal of Communication* 10(2):27-36.

Kurtz, Steven, Hilary L. Surratt, James A. Inciardi, et Marion Kiley. 2005. « Violent Victimization of Street Sex Workers ». *In Her Own Words: Women Offenders' Views on Crime and Victimization* 149-58.

Kusch, Larry. 12:12:00 CST. « More patrols, less panhandling among 27 downtown-safety recommendations ». *Winnipeg Free Press*.

Kutcher, Linda, Ellen Olfert, et John Schellenberg. 1998. « History ». *Nine Circles Community Health Centre | History*. Consulté 17 décembre 2019 (https://ninecircles.ca/about/history/).

Lambert, Steve. 2014. « Wife of Winnipeg mayoral candidate apologizes for 'drunken native' remarks ». *The Globe and Mail*, août 8.

Landsberg, Adina, Kate Shannon, Andrea Krüsi, Kora DeBeck, M. J. Milloy, Ekaterina Nosova, Thomas Kerr, et Kanna Hayashi. 2017. « Criminalizing Sex Work Clients and Rushed Negotiations among Sex Workers Who Use Drugs in a Canadian Setting ». *Journal of Urban Health* 94(4):563-71.

Lazarus, Lisa, Kathleen N. Deering, Rose Nabess, Kate Gibson, Mark W. Tyndall, et Kate Shannon. 2012. « Occupational stigma as a primary barrier to health care for street-based sex workers in Canada ». *Culture, Health & Sexuality* 14(2):139-50.

Lebovitch, Amy, et Shawna Ferris, éd. 2019. *Sex Work Activism in Canada: Speaking Out, Standing Up*. ARP Books.

LeCompte, Margaret Diane, et Jean J. Schensul. 1999. *Designing and Conducting Ethnographic Research*. Rowman Altamira.

Leigh, Carol. 1997. « Inventing Sex Work ». P. 223-31 in *Whores And Other Feminists*, édité par J. Nagle. London: Routledge.

Levin, Ben, Jane Gaskell, et Katina Pollock. 2007. « What Shapes Inner-City Education Policy? » *Canadian Journal of Educational Administration and Policy* 0(61).

Link, Bruce G., et Jo C. Phelan. 2001. « CONCEPTUALIZING STIGMA ». *Annual Review of Sociology* 363.

Lisa Lazarus MPH, BA, BSW, MBBS Sushena Reza-Paul DrPH MPH, Akram Pasha, BA Seema Jairam MSW PGDHRM, BA Syed Hafeez Ur Rahman MSW, BA John O'Neil PhD MA, et BA Robert Lorway PhD MA. 2012. « Exploring the Role of Community-Based Peer Support in Improving Access to Care and Antiretroviral Treatment for Sex Workers in Mysore, India ». *Journal of HIV/AIDS & Social Services* 11(2):152-68.

Logie, Carmen H., LLana James, Wangari Tharao, et Mona R. Loutfy. 2011. « HIV, Gender, Race, Sexual Orientation, and Sex Work: A Qualitative Study of

Intersectional Stigma Experienced by HIV-Positive Women in Ontario, Canada ». *PLOS Medicine* 8(11):e1001124.

Lorway, Robert. 2019. « 'MSM' as a 'doing thing' An ethnographic genealogy of sexual alterity and the emergence of global health in Postcolonial Namibia ». *Medicine Anthropology Theory*, décembre 16.

Machat, Sylvia, Kate Shannon, Melissa Braschel, Sarah Moreheart, et Shira M. Goldenberg. 2019. « Sex Workers' Experiences and Occupational Conditions Post-Implementation of End-Demand Criminalization in Metro Vancouver, Canada ». *Canadian Journal of Public Health* 110(5):575-83.

Macklin, R. 1981. « On Paying Money to Research Subjects: "Due" and "Undue" Inducements ». *IRB: Ethics & Human Research* 3(5):1–6.

Majic, Samantha. 2014a. « Beyond "Victim-Criminals": Sex Workers, Nonprofit Organizations, and Gender Ideologies ». *Gender & Society* 28(3):463-85.

Majic, Samantha. 2014b. *Sex Work Politics: From Protest to Service Provision*. University of Pennsylvania Press.

Martens, Kathleen. 2019. « Winnipeg Police Clarify Information on Not Naming 'Johns' - APTN NewsAPTN News ». *APTN News*, septembre 29.

Maynard, Robyn. 2010. « Sex Work, Migration and Anti-Trafficking ». *Briarpatch Magazine*, juillet 1.

Maynard, Robyn. 2012. « Carceral Feminism: The Failure of Sex Work Prohibition ». *FUSE Magazine*.

Maynard, Robyn. 2015. « Fighting Wrongs with Wrongs? How Canadian Anti-Trafficking Crusades Have Failed Sex Workers, Migrants, and Indigenous Communities. » *Atlantis: Critical Studies in Gender, Culture & Social Justice* 37(2):40-56.

McCann, Kristie, Richard Akin, et Cita Airth. 2013. « Sex Work Enforcement Guidelines ».

McClelland, Alexander. 2017. « Epistemological violence ». *Ethics & the construction of people labelled as criminal into "cases" for academic inquiry*. Consulté 12 décembre 2019

(https://www.concordia.ca/content/shared/en/news/offices/vprgs/sgs/public-scholars/2017/06/28/epistemological-violence.html).

McDonald, Nancy. 2015. « Welcome to Winnipeg, where Canada's racism problem is at its worst ». *Maclean's*, janvier 22.

McIntosh, Emma. 2019. « We Fact-Checked a Viral Claim about Who's Killing MMIWG. It Was Wrong. » *National Observer*, juin 7.

van der Meulen, Emily. 2012. « When Sex is Work: Organizing for Labour Rights and Protections ». *Labour / Le Travail* 69:147-67.

Mexico, Jonny, Anlina Sheng, et Claudyne Chevrier. 2017. *Needs assessment regarding Winnipeg's bad date list among sex workers and experiential persons*. *for Winnipeg Regional Health Authorities*. Sex Workers of Winnipeg Action Coalition.

Miriam, Kathy. 2005. « Stopping the Traffic in Women: Power, Agency and Abolition in Feminist Debates over Sex-Trafficking ». *Journal of Social Philosophy* 36(1):1–17.

Mount Carmel Clinic. s. d. « Sage House ». *Mount Carmel Clinic*. Consulté 2 août 2019 (https://www.mountcarmel.ca/health_service/sage-house/).

Muree Martin, Carol, et Harsha Walia. 2019. *RED WOMEN RISING.Indigenous Women Survivors in Vancouver's Downtown Eastside*. Downtown Eastside Women's Centre and Sex Workers United Against Violence.

Native Women's Association of Canada. 2010. *What Their Stories Tell Us Research findings from the Sisters In Spirit initiative*. Ottawa: Native Women's Association of Canada.

Native Women's Association of Canada. 2012. *Understanding NWAC's Position on Prostitution November 2012*. Ottawa.

Native Women's Association of Canada. s. d. « About • Native Women's Association of Canada ». *Native Women's Association of Canada*. Consulté 18 mars 2020 (https://www.nwac.ca/about/).

Nengeh, Mensah Maria, Claire Thiboutot, et Louise Toupin. 2012. « Luttes XXX. Inspirations du mouvement des travailleuses du sexe ». *Genre, sexualité & sociéte* 8.

New Directions. 2018. « TERF (Transition, Education & Resources for Females) ». *New Directions*. Consulté 4 septembre 2019 (https://newdirections.mb.ca/training-education-programs/terf-transition-education-resources-for-females/).

Newton, Paula. 2017. « Sex traffickers target indigenous Canadians ». *CNN*, février 23.

Nichter, Mark. 2008. *Global Health: Why Cultural Perceptions, Social Representations, and Biopolitics Matter*. University of Arizona Press.

Nikiforuk, Clay. 2014. « Sex workers demand rights and respect, not draconian legislation ». *Ricochet*, décembre 17.

Nine Circles Community Health Centre. 2019. « Home ». *Nine Circles Community Health Centre*. Consulté 17 décembre 2019 (https://ninecircles.ca/).

NSWP. 2014. « Carol Leigh Coins the Term "Sex Work" ». *Global Network of Sex Work Projects*. Consulté 26 novembre 2018 (http://www.nswp.org/timeline/event/carol-leigh-coins-the-term-sex-work).

NSWP. s. d. « Where Our Members Work ». *Global Network of Sex Work Projects*. Consulté 13 décembre 2019 (https://www.nswp.org/members).

Nussbaum, Martha C. 1998. « Whether from Reason or Prejudice: Taking Money for Bodily Services Social Norms, Social Meaning, and the Economic Analysis of Law ». *Journal of Legal Studies* 27(2-Part 2):693-724.

O'Brien, Nadia Christine. 2009. « Moving From Paradigm to Practice: The Ashodaya Sex Worker Empowerment Project in Mysore India and Its Promise for HIV/AIDS Prevention ». Thesis, Faculty of Health Sciences - Simon Fraser University.

Orchard, Treena. 2019. « Pretty Vacant: Stolen Girls and Girlhoods in Anti-Trafficking Discourses ». P. 298-315 in *The SAGE Handbook of Human Trafficking and Modern Day Slavery*. 1 Oliver's Yard, 55 City Road London EC1Y 1SP: SAGE Publications Ltd.

PACE Society. 2019b. « Media Toolkit ». *PACE Society*. Consulté 17 octobre 2019 (https://www.pace-society.org/resources/media-toolkit/).

Parker, Richard, et Peter Aggleton. 2003. « HIV and AIDS-Related Stigma and Discrimination: A Conceptual Framework and Implications for Action ». *Social Science & Medicine* 57(1):13-24.

Pheterson, Gail. 1993. « The Whore Stigma: Female Dishonor and Male Unworthiness ». *Social Text* (37):39–64.

Phrasisombath, Ketkesone, Sarah Thomsen, Vanphanom Sychareun, et Elisabeth Faxelid. 2012. « Care seeking behaviour and barriers to accessing services for sexually transmitted infections among female sex workers in Laos: a cross-sectional study ». *BMC Health Services Research* 12(1):37.

Pirkle, Catherine, Riswana Soundardjee, et Artuso Stella. 2007. « Female Sex Workers in China: Vectors of Disease? » *Sexually Transmitted Diseases* 34(9):695.

Razack, Sherene H. 2000. « Gendered Racial Violence and Spatialized Justice: The Murder Pamela George ». *Canadian Journal of Law & Society / La Revue Canadienne Droit et Société* 15(2):91-130.

Reza-Paul, Sushena, Tara Beattie, Hafeez Ur Rahman Syed, Koppal T. Venukumar, Mysore S. Venugopal, Mary P. Fathima, H. R. Raghavendra, Pasha Akram, Ramaiah Manjula, M. Lakshmi, Shajy Isac, Banadakoppa M. Ramesh, Reynold Washington, Sangameshwar B. Mahagaonkar, Judith R. Glynn, James F. Blanchard, et Stephen Moses. 2008. « Declines in Risk Behaviour and Sexually Transmitted Infection Prevalence Following a Community-Led HIV Preventive Intervention among Female Sex Workers in Mysore, India ». *AIDS* 22:S91.

Reza-Paul, Sushena, Rob Lorway, Nadia O'Brien, Lisa Lazarus, Jinendra Jain, M. Bhagya, Mary P. Fathima, KT Venukumar, K. N. Raviprakash, James Baer, et Richard Steen. 2012. « Sex worker-led structural interventions in India: a case study on addressing violence in HIV prevention through the Ashodaya Samithi collective in Mysore ». *The Indian Journal of Medical Research* 135(1):98-106.

Robertson, Mildred H. B., et Joyceen S. Boyle. 1984. « Ethnography: Contributions to Nursing Research ». *Journal of Advanced Nursing* 9(1):43-49.

Sanders, Teela. 2004. « A Continuum of Risk? The Management of Health, Physical and Emotional Risks by Female Sex Workers ». *Sociology of Health & Illness* 26(5):557-74.

Sangaramoorthy, T., et A. Benton. 2012. « Enumeration, Identity, and Health ». *Medical Anthropology: Cross Cultural Studies in Health and Illness* 31(4):287-91.

Sayer, Andrew. 2009. « Who's Afraid of Critical Social Science? » *Current Sociology* 57(6):767-86.

Sayers, Naomi. 2015. « Testifying In Vain ». *Tits and Sass*. Consulté 3 mars 2019 (http://titsandsass.com/testifying-in-vain/).

Scambler, Graham. 2007. « Sex Work Stigma: Opportunist Migrants in London ». *Sociology* 41(6):1079–1096.

Scambler, Graham, et Frederique Paoli. 2008. « Health Work, Female Sex Workers and HIV/AIDS: Global and Local Dimensions of Stigma and Deviance as Barriers to Effective Interventions ». *Social Science & Medicine* 66(8):1848–1862.

Scorgie, Fiona, Katie Vasey, Eric Harper, Marlise Richter, Prince Nare, Sian Maseko, et Matthew F. Chersich. 2013. « Human rights abuses and collective resilience among sex workers in four African countries: a qualitative study ». *Globalization and Health* 9(1):33.

Scott, Valerie. 2019. « WHOREISTORY: Time Capsules of Toronto Sex Work Activism, 1983-1998 ». in *Sex Work Activism in Canada: Speaking Out, Standing Up*. Winnipeg, Manitoba: ARP.

Sex Workers of Winnipeg Action Coalition. s. d. « Terminology – SWWAC ». *Sex Work Winnipeg*. Consulté 15 juin 2019 (http://sexworkwinnipeg.com/about-us/terminology/).

Sex Workers United Against Violence Society. 2017. « About Us ». *SWUAV's Mission Statement*. Consulté 13 juillet 2020 (https://swuav.wordpress.com/about-us/).

Shannon, Kate, Vicki Bright, Kate Gibson, et Mark W. Tyndall. 2007. « Sexual and Drug-Related Vulnerabilities for HIV Infection Among Women Engaged in Survival Sex Work in Vancouver, Canada ». *Canadian Journal of Public Health* 98(6):465-69.

Shannon, Kate, Steffanie A. Strathdee, Shira M. Goldenberg, Putu Duff, Peninah Mwangi, Maia Rusakova, Sushena Reza-Paul, Joseph Lau, Kathleen Deering, Michael R. Pickles, et Marie-Claude Boily. 2015. « Global epidemiology of HIV among female sex workers: influence of structural determinants ». *The Lancet* 385(9962):55-71.

Shaver, Frances, Jacqueline Lewis, et Eleanor Maticka-Tyndale. 2011. « Rising to the Challenge: Addressing the Concerns of People Working in the Sex Industry ». *The Canadian Review of Sociology* 47.

Shaver, Frances M. 2005. « Sex Work Research: Methodological and Ethical Challenges ». *Journal of Interpersonal Violence* 20(3):296-319.

Shaver, Frances M. 2019. « "The Prostitution Problem": Why Isn't Evidence Used to Inform Policy Initiatives? » *Archives of Sexual Behavior* 48(7):1955-59.

Sheng, Anlina. 2015. « Nov 2015: Sporting events don't attract exploitation and Grey Cup campaign stigmatizes sex workers ». *Winnipeg Free Press*, novembre 13.

Sheng, Anlina, et Claudyne Chevrier. 2019. « Changing the Conversation: The Sex Workers of Winnipeg Action Coalition ». P. 440 in *Sex Work Activism in Canada. Speaking Out, Standing Up.* ARP Books.

Sikka, Annette. 2009. *Trafficking of Aboriginal Women and Girls in Canada*. Institute on Governance.

Silver, Jim. 2010. « Winnipeg's North End Yesterday and Today ». *Canadian Dimension*, janvier 7.

Silver, Jim. 2016. *Solving Poverty: Innovative Strategies from Winnipeg's Inner City*. Halifax ; Fernwood Publishing.

Spittal, P. M., J. Bruneau, K. J. P. Craib, C. Miller, F. Lamothe, A. E. Weber, K. Li, M. W. Tyndall, M. V. O'Shaughnessy, et M. T. Schechter. 2003. « Surviving the sex trade: A comparison of HIV risk behaviours among street-involved women in two Canadian cities who inject drugs ». *AIDS Care* 15(2):187-95.

Sprankle, Eric, Katie Bloomquist, Cody Butcher, Neil Gleason, et Zoe Schaefer. 2018. « The Role of Sex Work Stigma in Victim Blaming and Empathy of Sexual Assault Survivors ». *Sexuality Research and Social Policy* 15(3):242-48.

Sterling, Andrea, et Emily van der Meulen. 2018. « "We Are Not Criminals": Sex Work Clients in Canada and the Constitution of Risk Knowledge ». *Canadian Journal of Law & Society / La Revue Canadienne Droit et Société* 33(3):291-308.

Strike, C., TM Watson, H. Gohil, M. Miskovic, S. Robinson, et C. Arkell. 2015. *Best Practice Recommendations 2 for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and are at Risk for HIV, HCV, and*

Other Harms. Working Group on Best Practices for Harm Reduction Programs in Canada.

Stryker, Susan, et Victor Silverman. 2005. *Screaming Queens: The Riot at Compton's Cafeteria*.

SWWAC. 2018.« History of Sex Worker Rights Movement », Winnipeg.

SWWAC. 2019. « SWWAC Supports Sex Workers, Not Winnipeg Police – SWWAC ». *Sex Work Winnipeg*. Consulté 18 décembre 2019 (http://sexworkwinnipeg.com/2019/05/17/swwac-supports-sexworkers/).

The Lancet. 2015. « Keeping sex workers safe ». *The Lancet* 386(9993):504.

Ticktin, Miriam. 2017a. « A World without Innocence ». *American Ethnologist* 44(4):577-90.

Ticktin, Miriam. 2017b. « A World without Innocence ». *American Ethnologist* 44(4):577-90.

Todd, Zoe. 2015. « 'Academia Has Its Own Set of Rules': Jenny Davis on Language Revitalization and Indigenous Gender and Sexuality in North America | Savage Minds ». *Savage Minds*. Consulté 12 décembre 2019 (/2015/06/02/academia-has-its-own-set-of-rules-jenny-davis-on-language-revitalization-and-indigenous-gender-and-sexuality-in-north-america/).

Tracia's Trust: Manitoba's Strategy to Prevent Sexual Exploitation and Sex Trafficking. 2019. *Collaboration and Best Practices on Ending Sexual Exploitation and Sex Trafficking in Manitoba,*. Manitoba Families, Child and Family Services Division, Sexual Exploitation Unit,Government of Manitoba.

UM Today. 2015. « Indigenizing the Curriculum ». Consulté 12 décembre 2019 (https://news.umanitoba.ca/indigenizing-the-curriculum).

UM Today. 2019. « Showcasing Inter-Professional Collaboration ». *UM Today*. Consulté 20 juin 2019 (https://news.umanitoba.ca/inter-professional-collaboration).

University of Manitoba. 2014. *Visionary Conversations: Giving the Red Light the Green Light*. Winnipeg, Manitoba.

Valverde, Mariana. 1991. *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925*. Toronto: McClelland & Stewart.

Van Der Meulen, Emily. 2012. « When Sex Is Work: Organizing for Labour Rights and Protections.(Essay) ». *Labour/Le Travail* (69):147.

Van der Meulen, Emily, Elya M. Durisin, et Victoria Love. 2013a. *Selling Sex: Experience, Advocacy, and Research on Sex Work in Canada*. Vancouver: UBC Press.

Van der Meulen, Emily, Elya M. Durisin, et Victoria Love. 2013b. *Selling Sex: Experience, Advocacy, and Research on Sex Work in Canada*. UBC Press.

Vernooij, Eva. 2017. « Navigating multipositionality in 'insider' ethnography ». *Medicine Anthropology Theory | An open-access journal in the anthropology of health, illness, and medicine* 4(2):34.

Whyte, Susan Reynolds. 2009. « Health Identities and Subjectivities »: *Medical Anthropology Quarterly* 23(1):6-15.

Wilt, James. 2019. « Winnipeg's Media Are Stoking a Racist Frenzy with Coverage of Alleged Liquor Store Thefts ». *Canadian Dimension*.

Winnipeg Police Services. 2019. « Counter Exploitation Unit - Winnipeg Police Service ». Consulté 18 décembre 2019 (https://winnipeg.ca/police/ceu/default.stm).

Winnipeg Regional Health Authority. 2016. *Position Statement on Harm Reduction*. Winnipeg Regional Health Authority.

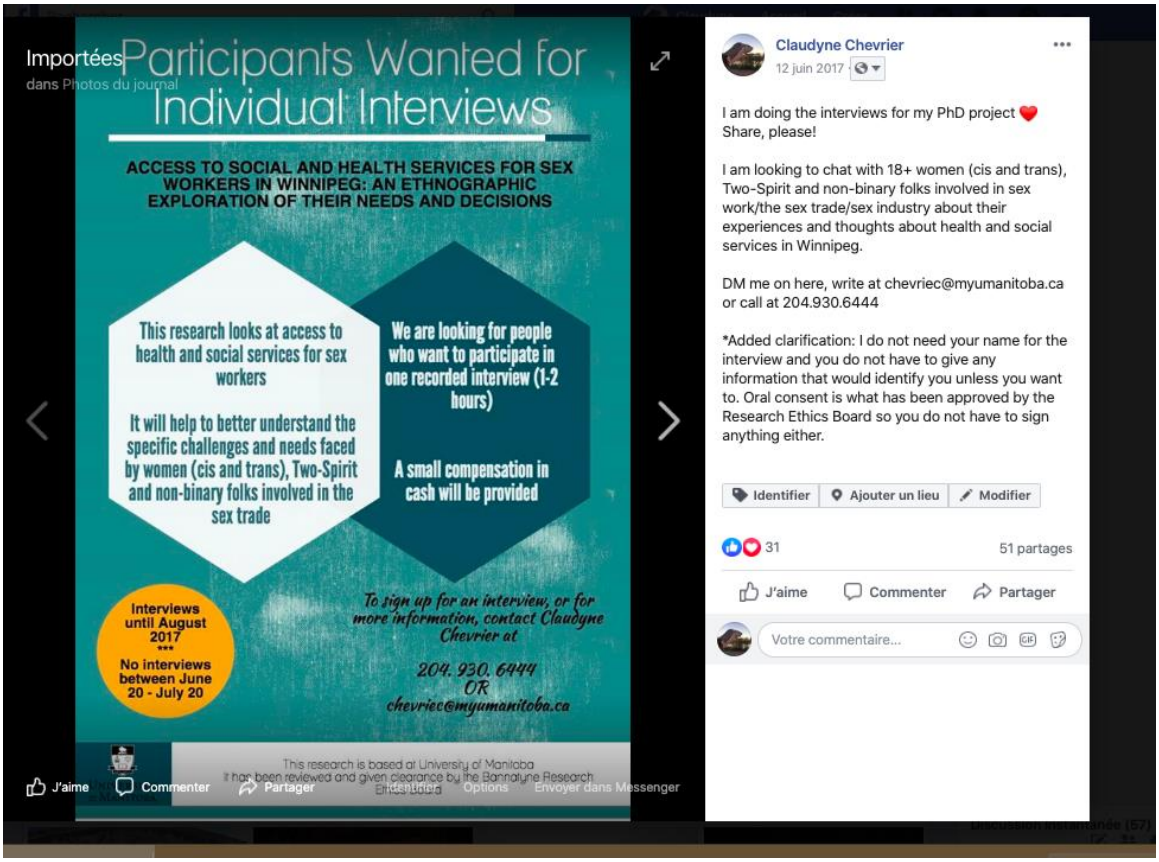
Wood, Jessica, Colleen Hele, et Naomi Sayers. 2015. « What's Missing from the Conversation On Missing and Murdered Indigenous Women and Girls - The Toast ». *The Toast*, septembre 14.

World Health Organization. 2002. *SEX WORKERS : PART OF THE SOLUTION An analysis of HIV prevention programming to prevent HIV transmission during commercial sex in developing countries*. World Health Organization.

APPENDIX 1: RECRUITMENT MATERIALS

Poster

Screen capture of social media posts with accompanying text



APPENDIX 2: RESEARCH INFORMATION AND CONSENT FORM- SEX WORKERS

UNIVERSITY OF MANITOBA
Faculty of Health Sciences
Department of Community Health Sciences

Centre for Global Public Health
University of Manitoba
R070 Med Rehab Bldg
771 McDermot Avenue
Winnipeg, Manitoba
R3E 0T6, Canada
Tel: (204) 272-3123
Fax: (204) 789-3718

Research Information and Consent Form- Sex Workers

Title of Study: Access To Social And Health Services For Sex Workers In Winnipeg: An Ethnographic Exploration Of Their Needs And Decisions

Principal Investigator: Claudyne Chevrier, R070 Medical Rehabilitation Building, 771 McDermot Street, Winnipeg, Manitoba, R3E 0T6, [redacted]

You are being asked to participate in a research study. Please listen to this consent statement and discuss any questions you may have with the interviewer. This consent statement may contain words that you do not understand. Please ask the interviewer to explain any words or information that you do not clearly understand.

Please note that if you decide at any time to not participate in the study, your medical care will **not** be affected in any way.

Purpose of Study. The purpose of this research project is to understand what influences the access to health and social services for women involved in the sex trade in Winnipeg, and what their main needs are. A total of 50 participants will participate in this study.

Study procedures. If you take part in this study, you will participate in one individual interview with Claudyne Chevrier. Participation in the study will be for the duration of the interview, which will last 1 or 2 hours. The interview will be audio recorded.

You can stop participating at any time, without any consequences.

Once the data collection is done and the data analyzed, Claudyne Chevrier will produce a summary report and will hold a community forum to present the main results.

Risks and Discomforts. The risks associated with this research should be minimal. It is possible, however, that speaking about discrimination and bias may raise issues for participants. You may contact the Klinic Crisis Line at 204-786-8686.

Benefits. There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit other people involved in sex work in the future.

Costs. Your participation in this study will not represent any costs to you.

Payment for participation. You will be given a cash honorarium of $25 ~~gift certificate~~ for your participation in this study.

Confidentiality. Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. All study related documents will either use a pseudonym or bear only your participant code. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only Claudyne Chevrier will have access to them. They will not leave the Centre for Global Public Health at University of Manitoba and they will be destroyed after 5 years.

Voluntary Participation/Withdrawal from the Study. Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your care at any health or social centre.

Questions. You are free to ask any questions that you may have about your treatment and your rights as a research participant. If any questions come up during or after the study, contact Claudyne Chevrier at[redacted]

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

<u>Do not agree to participate unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.</u>

Statement of Consent. This consent form has been read to you by Claudyne Chevrier and you have had the opportunity to discuss this research study with her. Your questions should have been answered by her in language that you understand. The risks and benefits have been explained. You should agree that you have not been unduly influenced by any study team member, or anyone else, to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) that you may have with the study team should not affect your decision to participate. You will be given a copy of this consent form afterwards. Your participation in this study is voluntary and you may choose to withdraw at any time. You continue participation in the interview means that you freely agree to participate in this research study.

The information regarding your personal identity will be kept confidential, but that confidentiality is not guaranteed. For quality assurance purposes, the University of Manitoba Research Ethics Board, may inspection of any of the records that relate to this study.

By agreeing to this consent statement, you have not waived any of the legal rights that I have as a participant in a research study.

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: __Claudyne Chevrier____ **Date** **_____**

(day/month/year)

Signature: _____

Role in the study: Principal Investigator

APPENDIX 3: RESEARCH INFORMATION AND CONSENT FORM- SOCIAL ACTORS

UNIVERSITY OF MANITOBA
Faculty of Health Sciences
Department of Community Health Sciences

Centre for Global Public Health
University of Manitoba
R070 Med Rehab Bldg
771 McDermot Avenue
Winnipeg, Manitoba
R3E 0T6, Canada
Tel: (204) 272-3123
Fax: (204) 789-3718

Research Information and Consent Form- Social Actors

Title of Study: Access To Social And Health Services For Sex Workers In Winnipeg: An Ethnographic Exploration Of Their Needs And Decisions

Principal Investigator: Claudyne Chevrier, R070 Medical Rehabilitation Building, 771 McDermot Street, Winnipeg, Manitoba, R3E 0T6, [redacted]

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the interviewer. This consent form may contain words that you do not understand. Please ask the interviewer to explain any words or information that you do not clearly understand.

Please note that if you decide at any time to not participate in the study, your medical care will **not** be affected in any way.

Purpose of Study. The purpose of this research project is to understand what influences the access to health and social services for women involved in the sex trade in Winnipeg, and what their main needs are. A total of 50 participants will participate in this study.

Study procedures. If you take part in this study, you will participate in one individual interview with Claudyne Chevrier. Participation in the study will be for the duration of the interview, which will last 1 or 2 hours. The interview will be audio recorded.

You can stop participating at any time, without any consequences.

Once the data collection is done and the data analyzed, Claudyne Chevrier will produce a summary report and will hold a community forum to present the main results.

Risks and Discomforts. The risks associated with this research should be minimal. It is possible, however, that speaking about discrimination and bias may raise issues for participants. You may contact the Klinic Crisis Line at 204-786-8686.

Benefits. There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will benefit people involved in sex work in the future.

Costs. Your participation in this study will not represent any costs to you.

Payment for participation. You will be given a 20$ gift certificate for you participation in this study.

Confidentiality. Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. All study related documents will either use a pseudonym or bear only your participant code. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law.

The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area and only Claudyne Chevrier will have access to them. They will not leave the Centre for Global Public Health at University of Manitoba and they will be destroyed after 5 years.

Voluntary Participation/Withdrawal from the Study. Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your care at any health or social centre.

Questions. You are free to ask any questions that you may have about your treatment and your rights as a research participant. If any questions come up during or after the study, contact Claudyne Chevrier at[redacted]

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

<u>Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.</u>

Statement of Consent. I have read this consent form. I have had the opportunity to discuss this research study with Claudyne Chevrier. I have had my questions answered by her in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant signature_____ **Date**

_____

(day/month/year)

Participant printed name: _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Printed Name: __Claudyne Chevrier____ **Date**

_____

(day/month/year)

Signature: _____

Role in the study: Principal Investigator

APPENDIX 4: INTERVIEW GUIDE- SEX WORKERS

Interview Guide- Sex workers

1. What made you want to participate in this research project?
2. How long have you been trading sexual services for compensation?
3. Where do you usually meet clients?
4. Do you think that your involvement in the sex trade relates to your health? How so?

Health and social services utilization

5. Do you think that your involvement in the sex trade relates to your health services utilization? How so?
6. Do you think that your involvement in the sex trade relates to your social services utilization? How so?
7. What type of health and social services do you use?
8. Are there places that you won't go? Why?
9. Do you have a family doctor? Why or why not?
    a. How did you find them?
    b. Level of satisfaction with doctor?
    c. Should you want to get another doctor, how do you go about getting a new one?
    d. Are you out to your doctor? If you are not, what do you do? Do you go to specific clinics?
        i. Are you satisfied with this system?
        ii. Does anything stands out?
10. Is the clinic/main healthcare provider that you visit close to where you live?
11. Generally, do you disclose to your health or social services provider that you do or have in the past traded sexual services for compensation?
    a. Why or why not?
    b. How does it go?
12. If you disclose to a your health or social services provider, how do they usually react?

Navigating the system

13. How do you decide where you will and won't go?

14. Do you feel welcome in the health care and social services settings that you visit?/What would make you feel safe and welcome in the healthcare settings that you visit ?

Discrimination and whorephobia

15. What are your experiences (if any) with whorephobia or discrimination on the basis of your involvement in the sex trade?
16. What is your reaction to discrimination?
    a. What impact does it have on you?
    b. Do you return to a healthcare or social services provider/ that has acted in a discriminatory manner towards you?
    c. Do you have any strategies to deal with the system?

17. What advice would you give to health care and social services providers to better answer your needs/make you feel safer and more welcomed?
18. Is there anything else you'd like to talk about?

APPENDIX 5: INTERVIEW GUIDE- SOCIAL ACTOR

Interview Guide- Chosen social actors

1. What made you want to participate in this research project?
2. What is your experience with people trading sexual services for compensation?

Services

3. What kind of health and social services are offered in Winnipeg for people trading sexual services for compensation?
    a. How do they vary between people who trade sexual services in-doors and out-doors?
    b. What is positive about the services offered?
    c. What is negative about them?
4. Who are the main organizations and programs providing services exclusively or in priority to people trading sexual services for compensation?
5. How do these different organizations and programs relate to the concept of harm reduction, as you understand it?
6. How have they changed since your have been involved with people trading sexual services for compensation?
7. In your opinion, why have the services evolved to be the way they are?
    a. What is positive about it?
    b. What is negative about it?
8. In your opinion, how would the services need to be in order to best serve people trading sexual services for compensation?
    a. How does that vary between people who trade sexual services in-doors and out-doors?