Sex workers in Canada face unequal access to healthcare

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Map the System 2022

Table of Contents

The Issue

Despite Canada's universal health system, sex workers across the country face an alarmingly high number of barriers when they seek to access healthcare.

Access to care is a key determinant of health for all humans (Socias et al., 2016) and sex workers are **almost three times more likely** than the general Canadian population to not have access to the healthcare services they require (Benoit et al., 2016). This **results in unmet healthcare needs and substantially poorer health outcomes for sex workers.**

Background

What is a sex worker?

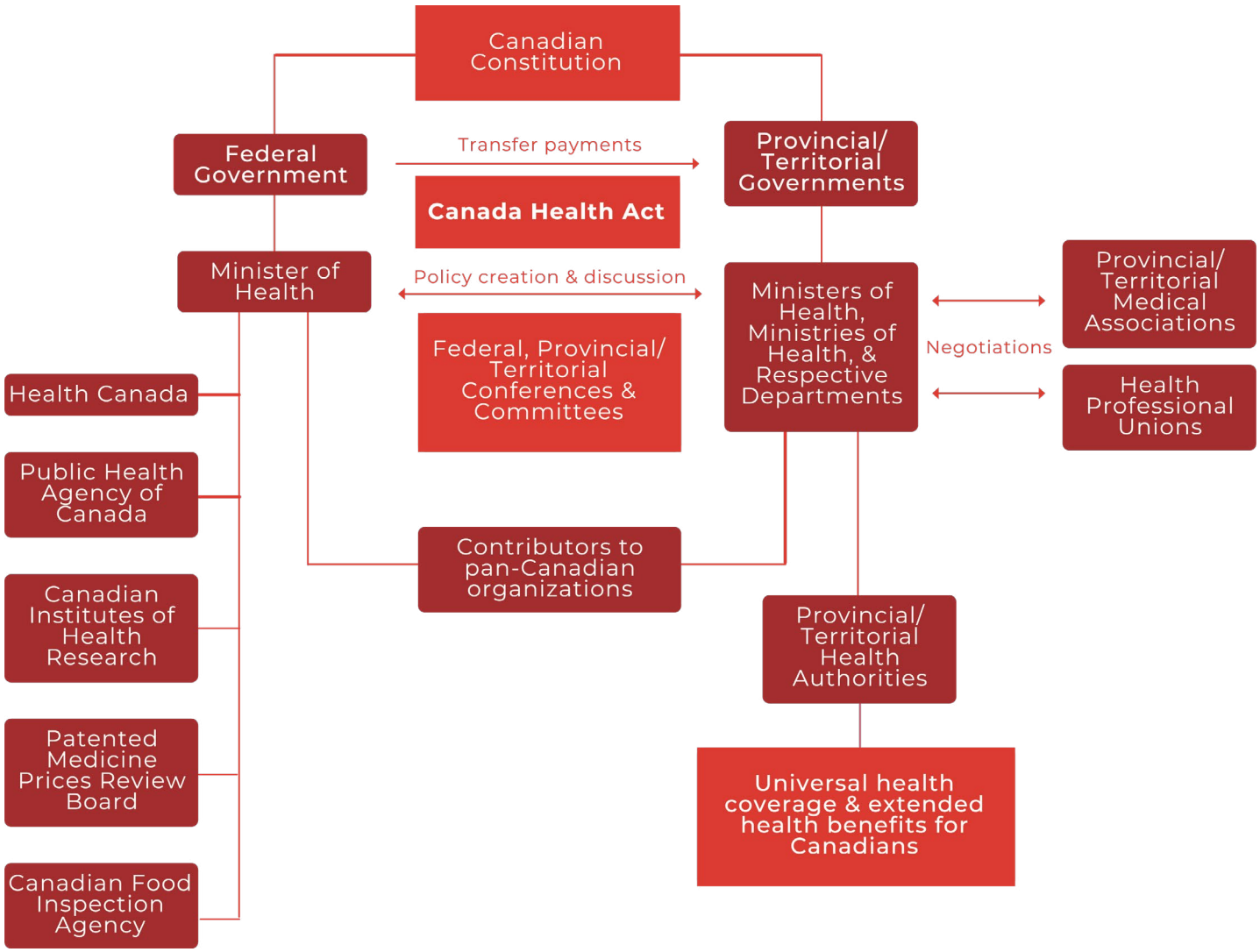
Sex work is an umbrella term that defines those involved as **adults who exchange sexual services for money or material benefit** (Benoit & Shumka, 2021). Sex workers encompass a diverse population, including people of all genders, races, and ages. This breadth is mirrored in the work environments that comprise the sex industry; including, but not limited to, indoor and outdoor spaces, brothels, commercial venues (e.g., escorts, erotic massages, exotic dancers), and online (e.g., porn, camming, phone sex operators). The sex industry is complex and ever evolving along with broader technological, legal, and socio-cultural changes.

The Canadian healthcare system

Canada has a universal, publicly-funded healthcare system. The federal government creates the national principles for the system under the *Canada Health Act* and provides financial support to provinces and territories (Health Canada, 2019). The *Canada Health Act* establishes criteria for health insurance policies that must be met by provincial healthcare plans. The Act upholds five principles of healthcare: publicly administered, comprehensive, universal, accessible, and portable across provinces (Health Canada, 2019).

Each province/territory administers their own public healthcare system, including financing, organizing, and delivery of services and providers, which covers treatments deemed "medically necessary" (Tikkanen et al., 2020). Although many healthcare services and treatments come at little or no cost to the patient, services considered to be "secondary" are not covered by public health insurance, including prescription medications, dental care, physiotherapy, counseling/therapy, homecare, therapeutic massage, ambulance services, and optical care (Government of Canada, 2021-a).

Organization of the Canadian Healthcare System



Boundaries of the analysis

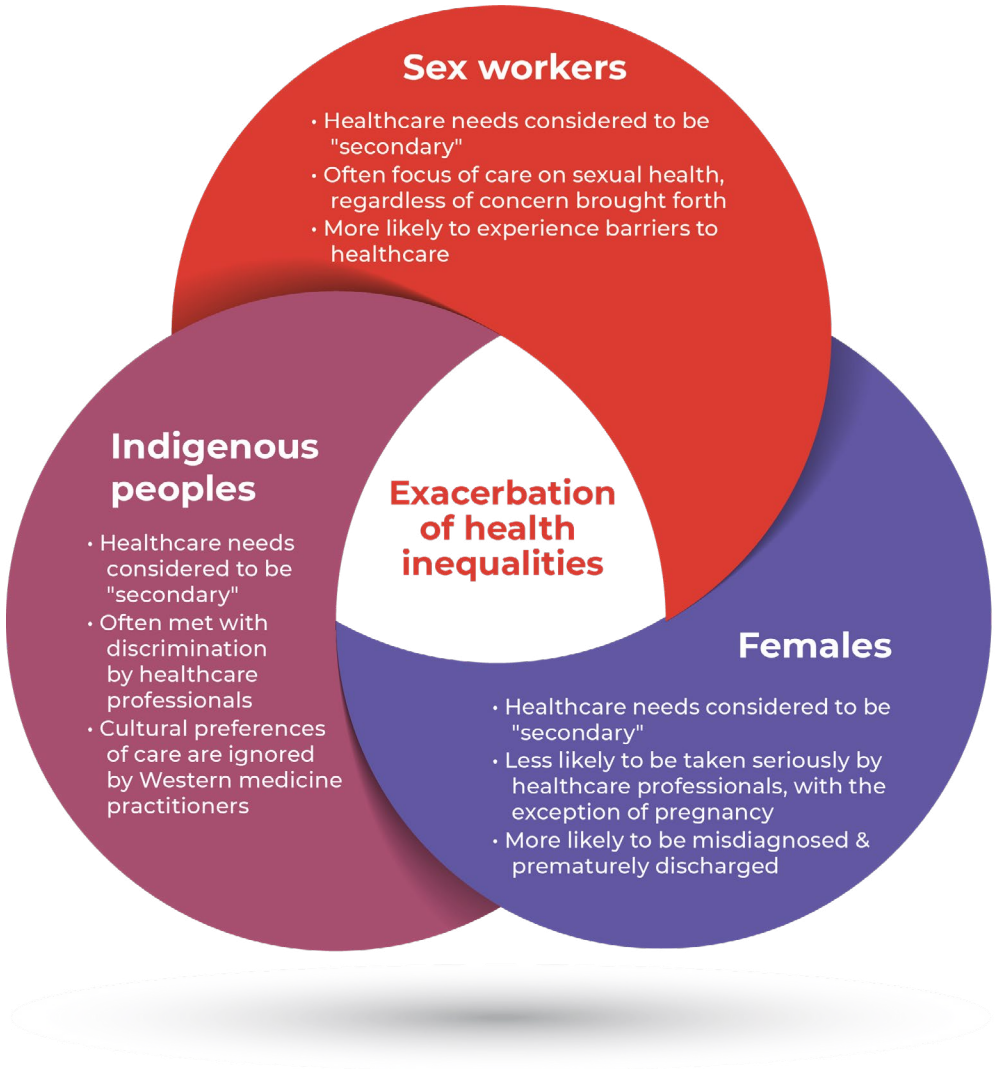
As an industry, sex workers face some similar barriers to accessing healthcare services; although, it is important to recognize that as individuals they will experience various barriers uniquely. Due to the complexity of the sex industry and the research available, this **systems analysis focuses on sex workers who engage in direct physical contact with clients** (i.e., street-based, indoor supervised or independent), as they are the sex worker population most susceptible to stigma and barriers to accessing services (Sawicki et al., 2019).

Why does this matter?

Healthcare should be accessible for all. The universal healthcare system in Canada holds the basic values of fairness and equity (Health Canada, 2019). There is an expectation Canadians receive quality care when required from a team of knowledgeable healthcare professionals at little or no cost. This is not the experience of many sex workers when they attempt to receive care. Instead, in many circumstances they are met with judgement, profiling, and inadequate care (Orchard et al., 2019).

"Often the true magnitude of harms that are experienced by those most vulnerable are invisible or outright ignored" (Bristowe, 2020, p. 12). This is a reality for many sex workers when trying to access healthcare, as a vast majority of Canadians are rarely confronted with the realities of this preventable problem (Farmer et al., 2006).

Furthermore, the **women and Indigenous peoples are the main groups facing these barriers.** Current research indicates that an overwhelming majority of sex workers **identify as female,** estimated to be **around 75%** (Benoit & Millar, 2001). Due to the effects of colonization that have marginalized Indigenous peoples socially and economically, as well as prevalent racist perceptions, there is a disproportionate representation of Indigenous peoples in street-level sex work, as it may be their only option for survival (Bingham, 2014; Maynard, 2015). It is estimated **15 to 20%** are **Indigenous women** (Phillips et al., 2011). Both of these groups already have decreased access to healthcare before the added barriers associated with sex work (Halseth, 2013; Kiesel, 2017).



Problem Landscape

Sex workers face various social and physical barriers when trying to access healthcare. A study based in Vancouver, British Columbia (BC) by Socias et al. (2016) found that **70% of the sex workers surveyed experienced barriers to healthcare.** These results were **three times higher than the estimated difficulty of accessing care among the general Canadian population** (Socias et al., 2016).

Stakeholder analysis

Barriers to healthcare

The main barriers sex workers face are **i) stigma, ii) criminalization, iii) accessibility** (e.g., location, availability, transportation), and **iv) cost of healthcare.** While cost and accessibility are similarly identified by other Canadians, they are significantly larger barriers for sex workers (Benoit et al., 2016). The barriers unique to sex work are stigma and criminalization; both of which surface as avoidance, dislike, and/or fear of medical professionals.

Mental model - Stigma

Stigma is multifaceted and the largest barrier that sex workers face. The consequences of stigma are far-reaching and apply to the whole industry at varying levels. Sex workers are often denied equal access to quality healthcare services due to stigma. Stigma reduces an individual's ability to be socially accepted and lessens them from a whole person to a tainted, discounted one (Benoit et al., 2015). Stigma is produced through perceived, enacted, and internalized forms. Perceived stigma is when a person's fear of discrimination leads them to consciously or unconsciously change how they think and act (Gray, 2001). For sex workers, this may lead to avoidance of social situations where they fear they will be treated differently if their occupation is revealed. Enacted stigma is when someone is actively treated poorly because of negative societal beliefs held about them (Gray, 2001). This can involve labelling, stereotyping, separating, status loss, or discrimination. Internalized stigma is the acceptance and application of stigma to oneself (Kane et al., 2019).

Stigma influences the perceptions of sex workers that society holds and reinforces the discrimination they face in everyday life (Goldenberg et al., 2021).

The stigma of sex work stems from **otherization, paternalism, and moralism/faith-based beliefs.** These mental models see those working in service roles as "second-class citizens" and associates sex work with three types of taint: physical from contact with bodily fluids and bodies, social from engaging in service work and association with other stigmatized groups, and moral from having their work perceived as "sinful" (Benoit et al., 2019). Together, these forms of taint contribute to the incorrect assumptions and blame placed on sex workers. Examples include: **the breakdown of the traditional family, being vectors of disease, escalating crime, the subversion of youth, and the transgression of gender norms and entrenched beliefs of what sexuality should be** (Bristowe, 2020; Lazarus et al., 2012).

MEDIA PORTRAYAL
Incorrect depictions and stigmatization

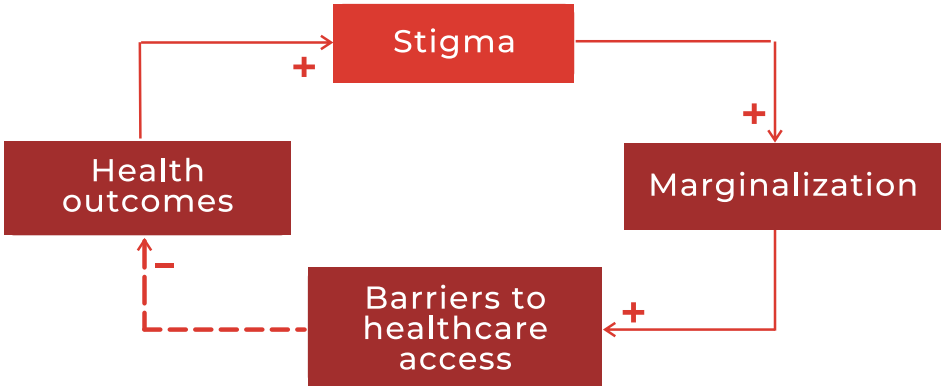
Mainstream media often depicts sex workers as street-based. In Canada, outdoor sex work only makes up about 20% of all sex work (Bungay et al., 2013). The majority (about half) of sex work occurs in the indoor independent category (Bristowe, 2020).

This portrayal, as it is often in a negative light, leads to further objectification and stigmatization of sex workers (Lee, 2016; Sullivan, 2017).

Sex workers often have intersecting stigmas (e.g., assumed substance use, gender identity, mental illness, HIV status, ethnicity, sexual orientation, socioeconomic status), meaning when a person falls into multiple of these categories, the barriers they face are significantly increased (Goldenberg et al., 2021; Lazarus et al., 2012). Stigmatization is also linked to poor physical and mental health, and negatively associated with quality of life (Benoit et al., 2015).

Intersecting stigmas — **Additive effect**

Examples:
- HIV & STI status
- Substance use
- Sexual orientation
- Migration status
- Gender identity
- Ethnicity
- Mental illness
- Socioeconomic status



Criminalization

THE CRIMINAL CODE OF CANADA

The *Criminal Code* of Canada is a federal statute. Under the Canadian Constitution the federal government has the exclusive power to define criminal offenses and update the Criminal Code (Government of Canada, 2021-b).

Figure 1. Comparison of the various forms of legislation regarding sex work (Benoit et al., 2015; Bristowe, 2020).

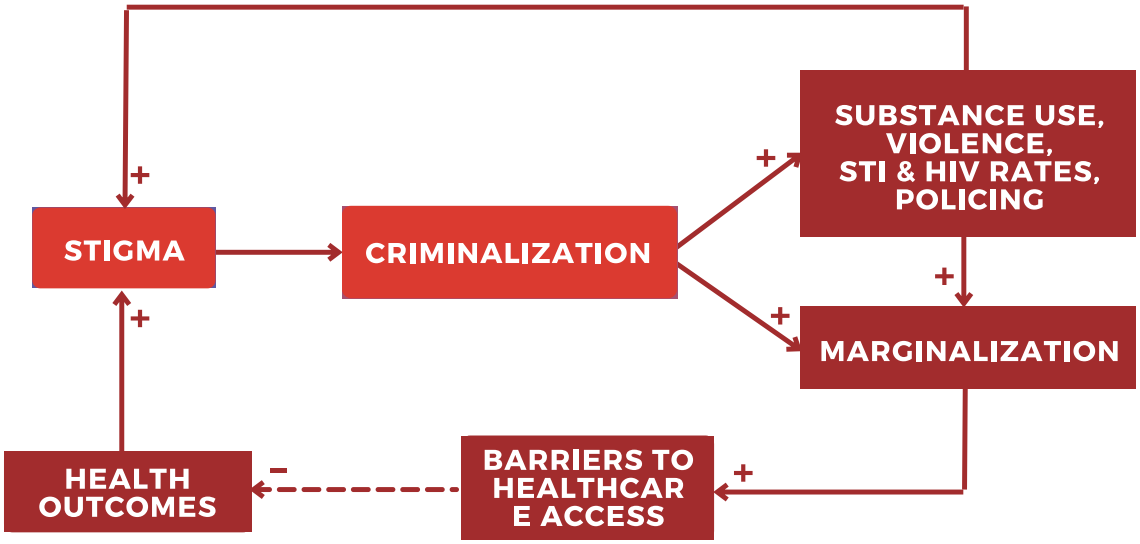
In 2014, the Canadian federal government implemented the *Protection of Communities and Exploited Persons Act* (PCEPA). It was introduced in response to Canada v Bedford (2013), wherein the Canadian Supreme Court ruled that the laws pertaining to the sex industry put workers at risk (Maynard, 2015). The PCEPA aimed to:

> Protect those who sell their own sexual services; protect communities, and especially children, from the harms caused by prostitution; and reduce the demand for prostitution and its incidence (Department of Justice, 2018, para 1).

The PCEPA is categorized as **partial criminalization** (see Figure 1). It legalizes the sale of sex, but criminalizes certain aspects of sex work, including purchasing services, receiving material benefits from another person's sex work, and procuring clients (e.g., publishing advertisements using newspapers or websites) (Argento et al., 2020).

The legislation treats sex work as a form of sexual exploitation, frames sex workers as "victims", and equates sex work with human trafficking. **Criminalization has trapped sex workers in the dualities of both criminality and victimization** (Chu et al., 2019).

The criminalization of sex work **undermines the health and human rights of sex workers.** It perpetuates stigma and marginalization; increases rates of drug use, violence, sexually transmitted infections (STIs), and human immunodeficiency virus (HIV); and decreases access to healthcare services (Anderson et al., 2016; Chu et al., 2019; Velz & Audet, 2019).



A recent study compared the rates of health-care access for sex workers prior to and after the creation of the PCEPA (Argento et al, 2020). **Despite one of the legislation's explicit goals being to increase access to services and supports for sex workers, the study found access significantly decreased** (see Figure 2) (Argento et al., 2020). The PCEPA instead endangers the very community it was created to protect from exploitation. It is apparent that **changing the law is not enough, when that law still holds the values associated with the stigma of sex work.**

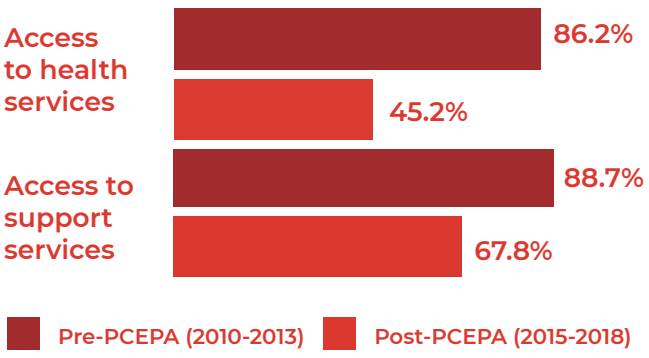


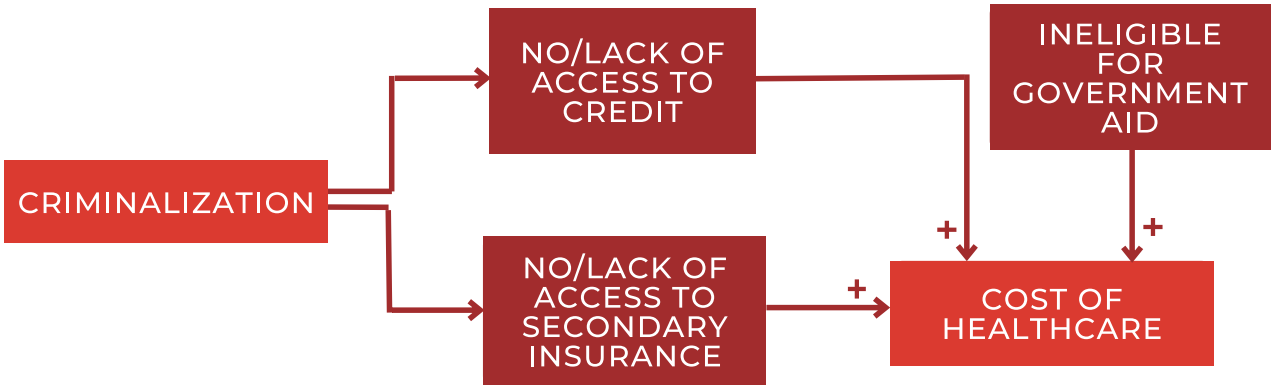
Figure 3. Comparison of sex workers' access to health and support services pre and post implementation of the PCEPA (2010-2013 and 2015-2018, respectively); adjusted for type of work, age, ethnicity, years in sex industry, and drug use. Data from Argento et al. (2019).

Access to care

Access to care includes the **location of services and treatment, service availability, and personal considerations,** such as transportation.

The **most prevalent accessibility barrier that sex workers face is service availability** (e.g., long wait times, limited hours of operation) (Socias et al., 2016). Work circumstances, particularly when working in an indoor supervised situation (i.e., restrictions from management) and personal responsibilities may limit a sex worker's ability to seek care when needed, especially if healthcare services are a distance from their home or place of work.

Outdoor-based sex workers often work on strolls. Strolls are strips of road where outdoor sex workers regularly solicit clients and are most often located in impoverished areas of cities (Benoit & Shumka, 2021; Goldenberg et al., 2021). Such areas have serious health and safety concerns, as well as a lack of access to health services (Bristowe, 2020). Furthermore, without a physical address, many medical centers will refuse to treat a patient, even if they are in possession of a provincial health insurance card.



THE FOREST LAWN STROLL
Case study: Calgary, Alberta

The prominent outdoor sex work market in Calgary is located in the southeast quadrant of the city. This area, Forest Lawn, is far from where health services are concentrated downtown, such as the Sheldon M. Chumir Centre. The centre is an important hub for vulnerable communities, as it houses the Safeworks Harm Reduction program. The **stigma of sex work, combined with a lack of accessible health services, has led to an environment that disallows sex workers to receive the healthcare they need.**

Cost of healthcare

On average, sex workers are more likely to identify cost as a barrier to healthcare than the general Canadian population (Benoit et al., 2016). A reason for this is that sex workers do not have access to secondary health insurance through work benefits like other professions and many cannot afford private insurance (Silliker, 2017). **Without coverage, many treatments and services can be too expensive to receive.**

Another source of barriers is a result of the criminalization of sex work. The current legislation in Canada does not recognize sex work as a legitimate occupation, and subsequently, **sex workers have reduced access to credit** (Benoit et al., 2016). They may earn a high wage, but without credit they are deterred from purchasing items, such as a house, bank loan, or accessing secondary insurance.

Some services not covered by public insurance are available to low-income Canadians through provincial income assistance programs. For example, in Alberta, the government insurance aid program requires an individual to make less than $16,580 annually and not be the beneficiary of any other government program (e.g., income support) (Government of Alberta, n.d.). Many sex workers are ineligible for such services meant to aid those in need of secondary insurance (Shumka & Benoit, 2007).

Consequences of the issue

Unmet healthcare needs

The unmet healthcare needs of sex workers are significantly greater than that of the general Canadian population.

40% of sex workers in Canada reported having unmet healthcare needs, whereas of the **general population only 14.9%** reported the same thing (Benoit et al., 2016).

Decreased quality of care

A reoccurring theme in current research and storytelling from the field is that **judgement and inadequate care is being received by sex workers from healthcare professionals** (Bungay et al., 2021; Lazarus et al., 2012; Orchard et al., 2019; Socias et al., 2016).

42% of sex workers in a cross-Canada study experienced a **negative response after disclosing their occupation** to a healthcare professional (Benoit et al., 2019).

Sex workers report that healthcare providers are using patronizing and dehumanizing behaviors, disrespectful and abusive language, humiliation, inferior service, denial of care, and blame when reporting sexual assault after disclosure of their occupation (Benoit et al., 2019). This forces sex workers to spend excessive time and resources to find a healthcare provider or clinic where they feel valued and understood (Bristowe, 2020).

Often when seeking care, sex workers are not looked at as a whole patient. Instead, **their care is led by healthcare providers' preconceived notions of sex work, reducing treatment to sexual health only** (Lazarus et al., 2012). Sex workers have complex healthcare needs that greatly involve risk prevention and harm reduction (Orchard et al., 2019; Socias et al., 2016), but there is a lack of healthcare providers knowledgeable about the needs of sex workers (Phillips et al., 2011; Shumka & Benoit, 2007). This is due to the limited formal training healthcare providers receive (Gustafson & Reitmanova, 2012; Singh et al., 2017; Vogel, 2018). While sexual health is an important issue for many sex workers, they are complete human beings and seek medical attention for more than just those issues.

Solutions landscape

It is well established that sex workers have poorer health than the general Canadian population (see Figure 3) (Bungay et al., 2021; Orchard et al., 2019). The main attributing factor to sex workers' worse health outcomes and high rates of unmet healthcare needs are the social and physical barriers that they face. In order for this to be lessened various changes, ranging from social structures to healthcare training, need to take place.

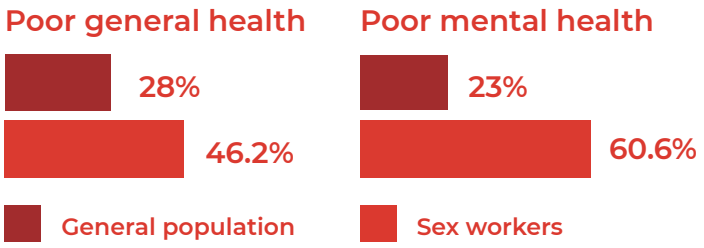
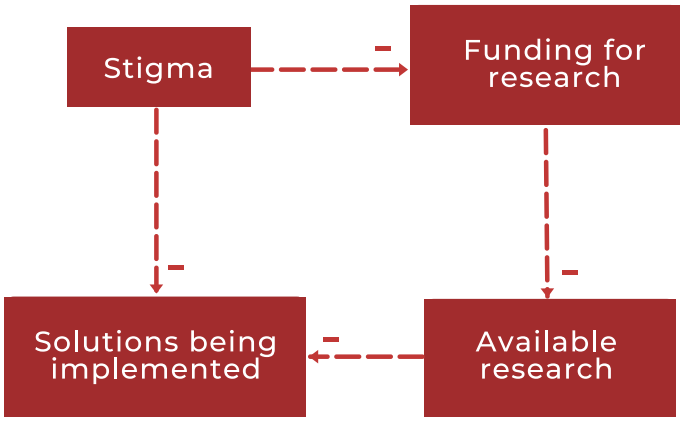


Figure 3. Comparison of CCHS responses from sex workers and the general Canadian population on reported poor general and mental health; data from Benoit et al. (2016).

This issue has **limited research available**; likely due to the stigma surrounding sex work. This makes it more difficult to gain funding when compared to other less "tainted" topics. There is also a **limited range of solutions currently being implemented.** Most large cities have sex worker support organizations, but there is a lack of collaboration between regions and between stakeholder groups.



OUTREACH TO THE MINISTERS OF HEALTH

A letter was sent bringing this issue to the attention of the Minister of Health of Canada, Jean-Yves Duclos, and Alberta, Jason Copping. There is a lack of solutions being mobilized as can be read in their responses (Appendix B and C).

Community scale

These organizations represent the progress and work being done to help sex workers within the community. They also represent organizations that have a team focused on sex workers' health in particular. This is important as many support services are instead oriented primarily towards human trafficking and sexual violence prevention.

SafeWORKS

Safeworks is an outreach program under the provincial health body, Alberta Health Services (AHS), located in Calgary, Alberta. The program is comprised of nurses, social workers, and outreach workers who bring comprehensive healthcare and harm reduction services directly to vulnerable populations with the goal of "creating a safe space that reduces stigma and discrimination" (AHS, n.d.-b).

Shift is a Calgary-based support organization that provides services to current and former sex workers to "improve their quality of life and achieve individualized goals" (Shift, n.d., para. 1). The organization takes a harm reduction and humans rights-based approach to sex work, which includes practical, legal, and emotional support; free safe sex supplies and STI testing; advocacy; education; and through partnership with AHS, onsite harm reduction nurses.

National scale

This organization represents the success that can come from cross-country collaboration to further research and advocacy efforts.

An Evaluation of Sex Workers Health Access (AESHA) is a community-based, sex worker-led research project located in Vancouver, BC, which conducts cohort-based semi-annual questionnaires and health visits, and documents the lived-experiences of sex workers and other parties who provide services to sex workers (CGSHE, n.d.). AESHA is part of the Centre for Gender & Sexuality Health Equity (CGSHE), an academic research center working to "advance gender and sexual health equity among under-serviced populations in BC, Canada, and globally" (CGHSE, n.d., para. 1). A similar organization is the Sex Work Research Hub (SWRH) at the University of York (UK) (SWRH, n.d.).

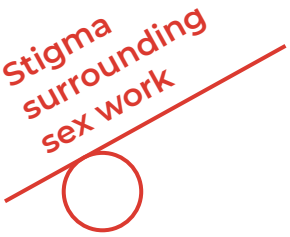
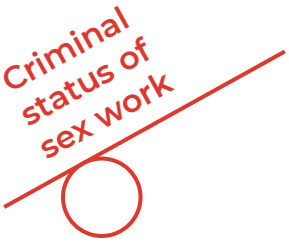
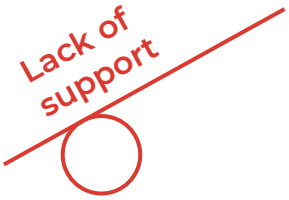
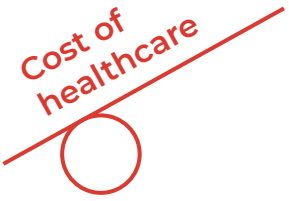
International scale

These represent leaders in sex workers' human rights. Other organizations and countries can look at their successes to model and adapt their own policies and practices accordingly.

New Zealand implemented the Prostitution Reform Act in 2003, becoming the only country in the world to have decriminalized sex work. The Act provided a framework to safeguard the human rights of sex workers and promote welfare and occupational health and safety (New Zealand Government, 2008). Resulting in sex workers gaining greater control over their lives and increased occupational benefits; as well, higher condom use, lower rates of STIs, and increased access to health services (Bristowe, 2020; Harcourt et al.,2010; New Zealand Government, 2008).

Global Network of Sex Work Projects (NSWP) is a non-profit organization based in Edinburgh, Scotland, that works to "uphold the voice of sex workers globally and connect regional networks advocating for [sex workers'] rights" (NSWP, n.d., para. 1). This includes fostering collaboration between sex worker-led organizations, advocacy, developing tools to guide policy, and bringing sex workers to decision-making bodies to share their perspectives and expertise.

Gaps & levers of change

Gap	Lever of change
	**Collectivization of sex workers** **Collaboration between stakeholders** As stigma is the largest barrier that sex workers face and impacts all aspects of sex work, it is fundamental to change. Its removal will have a ripple effect and reduce all other barriers.
	**Federal policy changes** Decriminalization ensures the stigma surrounding sex work will no longer be written into the Criminal Code of Canada, resulting in improved health outcomes, access to services, and human rights (Argento et al., 2020; Crichton, 2015; Lazarus et al., 2012).
	**Improved training for healthcare professionals** **Anti-discriminatory health policies** Training healthcare professionals in trauma-informed care practices, will enable practitioners to be able to understand how the role of trauma plays in their patient's life (Bristowe, 2020; Covington et al.,2011) and will bring the values of safety, trustworthiness, choice, collaboration, and empowerment to the forefront of care (Fallot & Harris, 2009; Potter et al., 2021).
	**Community-based healthcare services** **Increased funding for support services** Both will improve access and help to reduce personal costs associated with treatments and accessibility (Benoit & Millar, 2001; Shareck et al., 2021; Orchard et al., 2019). Mobile medical clinics (e.g., Safeworks van, Health Bus) are an effective way to bring healthcare directly to vulnerable populations. Services provided should include drugs composition tests, thus lowering overdose rates and drug epidemics; wound care; blood testing; vaccinations; safe injection and sex supplies; and referrals, support, and advocacy.
	**Universal coverage of "secondary" healthcare components** Incorporating more necessary services (e.g., prescriptions, dental, optometry) into Canada's universal healthcare system will allow access for those without secondary insurance.

Final insights & lessons learned

After researching this issue, it has become apparent that even though most people in society have a depiction of what a sex worker is, very few people understand the vast scope of all the sex industry encompasses. The **hope of sharing this project with a broader community is to raise awareness of the issue and encourage readers to reflect on the biases they possess surrounding sex workers.**

The issue of sex workers' access to healthcare is intricate yet **solvable**. Through **reducing the stigma** surrounding sex work, **making changes that improve the healthcare services** that sex workers receive, and **collaboration between stakeholders**, sex workers can be prevented from falling through the cracks of the Canadian healthcare system; lessening the health inequities sex workers face and improving their health outcomes.

This problem not only exists in Canada, but around the world. While the barriers and recommendations explored in this paper pertain to Canada, this issue may be applicable to where you live.

Report limitations

This study is limited by the lack of research available on this topic. As mentioned above, this gap in academic literature is most likely due to the stigma surrounding sex work. The research conducted for this project aimed to address some of the gaps in information available.

Appendix A

Glossary

Collectivization – bringing together and organizing a group as a collective body (e.g., organizing into a labor union)

Criminality – "the quality or state of being criminal" (Merriam-Webster, n.d.).

Human trafficking – recruiting, transporting, harbouring and/or exercising control, direction or influence over the movements of a person in order to exploit that person or help someone else exploit them, typically through sexual exploitation or forced labour (Department of Justice, 2021).

Institutional exclusion – "the alienation of [people] from [the] government and their inability to rely on the law and official procedures when being engaged in everyday activities" (Oleinik, 2012).

Moralism – making moral judgements about others' behaviors and trying to make them behave according to stoic standards of right and wrong, which may be too severe or unfair (Cambridge Dictionary, n.d.-a)

Objectification – the degrading act of seeing and/or treating a person, usually a woman, as a mere object or thing (Papadaki, 2020).

Otherization – to consider a person/group to be different or make them seem different (Cambridge Dictionary, n.d.-b)

Paternalism – interference against another's will, defended/motivated by a claim that the person will be "better off" or protected from harm (Dworkin, 2020). It assumes that the person interfered with is less than capable of making decisions for themselves.

Structural violence – the injustice and inequity embedded in social structures and society, including political, legal or cultural norms, and legislation that shapes society (Bristowe, 2020).

Victimization – treating someone in an unfair way intentionally, often due to race, sex, beliefs, etc. (Cambridge Dictionary, n.d.-c). The process of being victimized, either from a physical, psychological, moral, or sexual point of view (Muratore, 2014).

Appendix B

Letter from the Canadian Minister of Health

Thank you for your letter of January 11, 2022 to the Minister of Health, the Honourable Jean-Yves Duclos, concerning access to health care services for sex workers in Canada.

The Government of Canada continues to take an active leadership role and to engage with provinces and territories to support them in strengthening health care in Canada. The Government is committed to preserving and improving our publicly funded health care system, which values equity and fairness.

As outlined in the November 2021 Speech from the Throne, the Government's top priority is to get the pandemic under control through vaccination, including securing the next generation of COVID-19 vaccines, boosters and doses for children aged 5 to 11, and continuing to work with international partners to ensure fair and equitable access to vaccines and other resources.

The Speech from the Throne also noted the need to strengthen the health care system to improve care for all Canadians, but especially for seniors, veterans, persons with disabilities, vulnerable members of our communities, and those who have faced discrimination in the health care system. Working collaboratively with provinces and territories to deliver results, the Speech from the Throne identified actions in several areas:

1. Accessibility to care;
2. Care in rural communities;
1. Working to address the backlog of delayed procedures;
2. Mental health and addictions treatment;
3. Long-term care; and
4. Improving data collection across health systems to inform future decisions and get the best possible results.

In December 2021, the Prime Minister released mandate letters for Ministers that set out their list of commitments. The mandate letter for Minister Duclos reaffirms the Government's commitment to finish the fight against COVID-19 and support a strong economic recovery for Canadians. It also includes strengthening Canada's universal public health system.

In addition to taking action on these commitments, the Canada Health Transfer (CHT) continues to provide a stable and flexible funding base that supports provinces and territories in addressing the broader health care needs and priorities of their residents. In fiscal year 2022-23, the Government of Canada will provide over $45 billion in cash

support to provinces and territories through the CHT. For Alberta, the CHT will amount to almost $5.3 billion in 2022-23.

If you require further clarification or have questions about the information provided in this reply, you can contact Jenny Tremblay, Director General of the Health Care Strategies Directorate, Strategic Policy Branch, at spb-dgps@hc-sc.gc.ca.

Thank you for your interest in Canada's health care system and for taking the time to share your views.

Yours sincerely,

Strategic Policy Branch
Health Canada

Appendix C

Letter from the Albertan Minister of Health

AR 198283

Dear Kaitlyn Squires:

Thank you for your email regarding difficulties accessing health care for persons involved in sex trade work. I apologize for the delay in my response.

The Government of Alberta is committed to supporting the well-being of all Albertans and recognizes that many face complex issues of intersectional marginalization including poverty, discrimination, past and current trauma, and mistrust of the health care system. In your letter, you highlighted criminalization, stigma, accessibility and cost as the main barriers to health care faced by those engaged in the sex trade. Please allow me to provide you with some information regarding these barriers and the provincial government's work to address them.

In your correspondence, you propose decriminalizing sex trade work in Canada, which would help improve health outcomes, access to services and human rights for sex trade workers. Legislation related to the criminality of such work is under federal jurisdiction, so the Government of Alberta must work within the existing federal legislative framework. Only the Government of Canada has the right to make or amend federal criminal law. As such, you may wish to relay your thoughts to the federal Justice Minister. The Honourable David Lametti can be reached at mcu@justice.gc.ca or by mail at:

The Honourable David Lametti
Minister of Justice and Attorney General of Canada
284 Wellington St
Ottawa ON K1A 0H8

The Alberta government is committed to building strong, safe communities, where vulnerable Albertans are protected from the harms of prostitution and exploitation. The Ministry of Culture and Status of Women leads the Government of Alberta's commitment to prevent and address all forms of gender-based violence and advances work in this area by:

1. Leading the government's commitment to end sexual violence, aiming to deliver a coordinated, provincewide response to sexual violence in Alberta in collaboration with nine cross-ministry partners.
2. Raising public awareness through the Sexual Violence Awareness Month during May and the 16 Days Campaign to End Gender-Based Violence.
3. Supporting key cross-ministry initiatives such as the *Disclosure to Protect Against Domestic Violence (Clare's Law) Act*, nine-point action plan to Combat Human Trafficking, and Alberta's response to the National Inquiry into Missing and Murdered Indigenous Women and Girls.
4. Supporting key community initiatives including IMPACT's Primary Prevention Framework for sexual and domestic violence.

The Alberta Joint Working Group on Missing and Murdered Indigenous Women and Girls has developed recommendations to help support findings of the National Action Plan, *The Federal Pathway to Address Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA+ People*. One focus is to increase the number of trauma informed, culturally responsive and safe programs available within the health care system for survivors of sexual exploitation and trafficking. Government of Alberta ministries are reviewing the report recommendations, which are to inform policy moving forward.

With regard to your concerns about stigma and accessibility, the Alberta Health Charter sets out key values, expectations, and responsibilities within the health system. The Charter addresses how Albertans can expect to experience the delivery of health care services. Specifically, the right of each Albertan to have their health status, social and economic circumstances as well as their personal beliefs and values acknowledged, and to be treated with respect and dignity.

The health service system is complex and difficult to understand, particularly for those who are suffering, in pain, and are vulnerable. The Alberta Health Advocate assists Albertans to find their way to the appropriate health services, health related programs, and resources to meet their expressed needs.

All Alberta Health Services' (AHS) employees are expected to conduct themselves in accordance with AHS Organizational Values for every patient interaction, regardless of who the patient is. These values include compassion, accountability, respect, excellence, and safety. Additionally, as sex trade workers have typically experienced complex histories, AHS does not focus on labelling groups of people. Interventions and education are solely focused on addressing the needs of clients. Stigma toward sex trade workers is often rooted in people's perceptions of the work, gender, and sexuality. Understanding and taking action to reduce stigma toward sex trade workers is an ongoing process, and an important component of increasing access to health care.

In response to your comments about improving training, educational institutions and other health system stakeholders are best positioned to make changes to the training and education opportunities that are currently available to regulated health professionals. AHS provides its staff with a number of learning modules for providing care to populations at risk. These include:

1. LGBTQ2S+ Basics: Creating Safer and more Welcoming Care;
2. Harm Reduction: Making a Difference in Practice;
3. TIC E-Learning Module: What is Trauma Informed Care?; and
4. four modules on diversity and inclusion.

Staff from the sexually transmitted and blood borne infections (STBBI) and vulnerable women programs are also actively engaged in providing education and training on stigma and working with vulnerable populations to local service providers and health care workers.

Alberta's publicly funded post-secondary institutions operate under the authority of their boards of governors, which are responsible for their day-to-day management. Institutions are responsible for the development and delivery of their programs of study, including adjusting course content to remain up-to-date and relevant. You may wish to connect with post-secondary institutions that deliver health care programs, including the board of governors at Mount Royal University where you are studying, to suggest improvements to course content.

Alberta Health invests over $4 million annually to organizations across the province to prevent STBBI and provide wrap-around supports for people living with those infections. The province also provides almost $2 million annually to five organizations that provide support to vulnerable women who are pregnant or of childbearing age and are vulnerable due to circumstances, such as homelessness, street-involvement, sex trade work, and addiction and mental health concerns, to optimize their health and well-being. Through a combination of physical locations and targeted outreach, these provincially funded STBBI and vulnerable women programs focus on increasing accessibility for street involved people. The programs leverage relationships and partnerships, reaching hidden and stigmatized populations, such as sex trade workers, and connecting them to health care and social services, education, and STBBI testing and treatment.

In Edmonton, the AHS Sexually Transmitted Infections Outreach team has significant experience working with people engaging in the sex trade, predominantly through a partnership with the Centre to End All Sexual Exploitation, which includes presenting during the Sex Trafficking Offender Program. Outreach staff have also worked closely with massage parlours to provide group STBBI testing.

The Government of Alberta also invests in a number of mental health programs and services accessible in community-based settings. Many recent investments focus on increasing access to virtual supports and services so all Albertans, regardless of where they live in the province, can access the support they need. One example is funding to support Alberta 211, which provides information, referrals and crisis support, including local addiction and mental health referrals and resources, via telephone, text, and chat.

AHS also offers a number of telephone, virtual, and in-person mental health services across Alberta, including:

5. The Mental Health Helpline to provide confidential, anonymous service, including crisis intervention, information on mental health programs, and referrals to other agencies if needed.
6. Togetherall, a clinically moderated, online peer-to-peer mental health community that empowers individuals to anonymously seek and provide support 24-7.
7. Telehealth is the long-distance delivery of health-related services and information using video conference technology through one of the largest Telehealth networks in North America as well as a multitude of technology solutions. Services at local addiction and mental health clinics increase mental health service delivery to rural and remote communities.

Thank you again for writing. I hope the above information will prove valuable to you.

Sincerely,

Jason Copping
Minister of Health

Classification: Protected A