To: Kevin Pendergraft
Ad Hoc Committee on Canadian Guidelines for HIV PrEP and nPEP
c/o CIHR Canadian HIV Trials Network
1081 Burrard Sreet, Vancouver, BC
V6Z 1Y6, Canada

Tuesday, May 31, 2016

Dear Members of the Committee,

Re: Canadian Guidelines for HIV PrEP and nPEP Draft Guidelines
(Executive Summary May 12, 2016 Preliminary Version)

My name is Andrew Sorfleet and I am the president of the board of the Triple-X Workers' Solidarity Association of B.C. Triple-X is an association that makes it possible for Triple-X workers to represent themselves and their interests to everyone from government policy-makers and public health officials, to employers and potential clients. The First Directors were drawn together because of our genuine interest in promoting rights for workers in the Triple-X — adult entertainment and health enhancement — industry.

Thank you for this opportunity to provide feedback on the draft guidelines for HIV PrEP and nPEP .

Triple-X helped organize the CAHR conference ancillary session "PrEP in the Context of Sex Work: Possibilities and Limitations," held at Sunshine House in Winnipeg. The session was attended by colleagues from Winnipeg, Toronto, Montreal, Calgary, Washington D.C. and Vancouver. We attended the CAHR session in which the draft guidelines were presented and discussed. At that time, we were invited to provide feedback. We held a teleconference on May 26 to discussion the implications for sex workers of the draft guidelines. We would like to offer the following comments for your consideration.

First, we would like to outline some general advice regarding the draft guidelines overall:

1) The draft guidelines do not explain who your Ad Hoc Committee is, or what relationship your committee has to federal or provincial/territorial jurisdictions. The draft guidelines do not provide any context regarding who specifically is responsible for the draft guidelines, what the purpose is for creating the draft guidelines, who their audience is, what they are to be used for, or who has funded their development. The document would benefit from a preamble that explains this.

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2) For the average layperson, the draft guidelines employ language that is at times so specific it is opaque. If the committee aims to encourage input from community who have a stake in PrEP and nPEP you would benefit from providing a companion guide which explains in plain English and refrains from acronyms and other professional shorthand. We can't provide quality feedback about something that is difficult to understand.

3) What is the logic or benefit for creating a single set of guidelines for both PrEP and nPEP together? It would be much clearer for there to be two separate documents: one addressing PrEP and one addressing PEP. Differentiating PEP from PrEP may change the way in which risks are defined.

4) Both occupational PEP and non-occupational PEP should be explained together in the PEP guidelines. Access to occupational PEP is an important issue for sex workers, one that sex workers have had little opportunity to understand and discuss collectively. This is on our agenda for further discussion in 2016.

5) In the background statement of the draft guidelines, "survival sex trade" workers are listed as a population with elevated incidence of HIV. The use of the term "*survival sex trade*" encourages stigma and discrimination toward certain citizens. Our group feels strongly that the emphasis on "populations" rather than "behaviours" is problematic when describing sex workers in general. The implication is that risks for HIV infection and transmission are inherent in sex work. However, sex work (as opposed to other forms of sexual exchange) most often takes place within a sex-industry workplace.

   Sex work is different from other social-sexual behaviours because it is performed in the context of employment and earning income. To suggest that sex workers are a population at higher risk for HIV infection and transmission assumes that professional sexual services are not performed safely in an occupational setting. This is a gross generalization. You have provided no evidence or references for this. The draft guidelines would greatly benefit from the inclusion of research references throughout the document.

6) To focus guidelines for assessing risk on populations rather than activity is in its own way stigmatizing. To quote the "Principles and Beliefs," *Maggie's Constitution*, Toronto Prostitutes' Community Service Project, 1993:

   > *"There are no high risk groups, only high risk practices. AIDS and sexually transmitted diseases (STDs) are not spread by sex work; they are spread by unsafe sex and needle sharing."*

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7) In Table 6B, the statement "*HIV status unknown but source from a priority population with high HIV prevalence compared to the general population: Men who have sex with men, Persons who inject drugs, sex trade workers.*" should be removed.

8) Sex work is not listed as an exposure category in PHAC's Epi Update data (Table 1 and Table 2, PHAC HIV/AIDS Epi Update October 2014). Few provinces or territories in Canada include sex work as an exposure category when compiling HIV prevalence or incidence data. The statement in Table 6B is not evidence-based in the context of guidelines that are intended to be pan-Canadian.

9) The above statement in Table 6B is particularly troubling when read in the context of the section of the draft guidelines called "Evaluation of the Source; Source: HIV status unknown," Rec. 45: "*If the source is available and provides consent, HIV testing with a 4th generation assay is recommended.*" Our groups feel strongly that if sex workers are framed as a "*significant risk*" or as a "*likelihood source [of] transmissible HIV,*" that this will encourage clients and others to report sex workers' contact information to public health authorities for the purposes of contact tracing (Recs. 45-47). While we appreciate the suggestion that consent from the "*source*" should be provided, this recommendation has not taken into account that provincial/territorial public health authorities have the legal jurisdiction to order testing (and even confinement) if you are named as a contact.

In addition to these general observations above, here are more specific questions and concerns listed according to recommendation numbers:

10) Background: "Aboriginal" should be capitalized.

11) Rec. 1: This recommendation is neither strong nor clear. PrEP is not a replacement for condoms. If condoms are not used you are putting yourself at risk for other serious sexually transmitted infections. Combination prevention strategies can include PrEP and PEP for HIV. This recommendation should include a public education strategy (e.g. online factsheets) that includes materials on side effects, drug resistance and any possible long-term effects on health, so that people can make informed decisions before contacting a health care professional.

12) Rec. 3: "Linkages to PrEP prescribers." This recommendation may need to more explicitly address the full range of health care providers that those seeking PrEP may access, including family practice physicians, nurse practitioners and walk-in clinics.

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13) Recs. 1-5: This set of recommendations makes reference to a series of "Grades" (Grades 1C, 1D, 2D) but these Grades do not appear to match up with any of the tables. (Table 7 does reference "Grades," but these are specific to treatment regimens.)

14) Rec. 7a: Recommending PrEP based on a history of bacterial STI infection does not take context into consideration. Past STIs does not equate to future risk-taking. People, contexts and behaviours can change and are in flux. There is an implied stigma when past sexually transmitted infections are considered evidence of future risk.

15) Rec. 10: Why do people need to be engaged in other harm reduction strategies in order to be recommended for PrEP? The justification for this is not made and remains unclear.

16) Rec. 13: "On demand" PrEP regimen is not adequately discussed as an option elsewhere in the document.

17) Rec. 21: We are concerned about the frequency of HIV and STI testing suggested (i.e. every three months) and the impacts of clinical and laboratory surveillance on PrEP access for marginalized persons.

18) Rec. 27: The recommendation that health care providers (who may or may not be trained in trauma-informed care) determine whether a possible exposure to HIV was consensual or not, and based on this determination whether to refer individuals to sexual assault services, is extremely problematic.

    The issue of whether sexual activity was or was not consensual should not be a factor in providing PEP access. This recommendation could result in misunderstandings based on assumptions about whether or not a sex worker could be a victim of sex trafficking. In the case of a migrant sex worker, this could result in unwanted interventions by police or other authorities such as immigration.

    This recommendation as it relates to consent of sexual activity becomes even more complicated when considering the implications of the criminality of HIV-status non-disclosure. Making distinctions between consensual and non-consensual exposure can feed into victim discourses where non-consensual exposures may be deemed more innocent and thus more deserving of PEP.

19) Rec. 29: Include the word "unprotected" prior to the word "*exposure*" for emphasis throughout this section. When sex workers use condoms consistently HIV incidence is low. Concerns about "*source*" ("*…with a person who has a significant risk of having transmissible HIV…*") and Table 6B have been outlined

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above. With respect to clients of sex workers, purchasing sexual services is a criminal offence in Canada. Would clients be prepared to disclose contacts with sex workers to clinical staff in order to access PEP?

20) Rec. 55: This recommendation does not contemplate interventions in criminal environments when discussing issues of clinician/patient trust. This recommendation would put clients, sex workers and families of sex workers in the vulnerable position of having to incriminate themselves or others close to them.

21) Rec. 56: "*For patients with low adherence … intensified counselling using principles of cognitive behavioural therapy and problem-solving therapy may be beneficial.*" What is the relationship between these therapy principles and medication adherence? This is unclear and unreferenced.

22) Recs. 58-59: Concerns were raised regarding recommendations to assess substance use and mental health problems and making referrals for harm reduction, addiction services and psychiatric counselling, as well as the consideration of conducting on-going assessments. These recommendations imply that these assessments may impact access to PrEP/nPEP based on concerns about medication adherence. This is unclear and unreferenced.

Triple-X and partner organizations are committed to effective HIV prevention. As safe sex professionals and safe sex educators we work towards informed HIV prevention and healthy sexuality for all.

With the support of the Elton John AIDS Foundation, Triple-X in partnership with the Dalla Lana School of Public Health, University of Toronto will convene a national consultation with sex workers and advocates on PrEP in the Context of Sex Work: Possibilities and Limitations, in Toronto in late October. With this in mind we hope that the Ad Hoc Committee's deadline for feedback of May 31, 2016, is not an indication that there will be no more opportunity for input.

We welcome updates on any plans or next steps for stakeholder consultation regarding these draft guidelines, and we look forward to opportunities to be involved early in that process.

Sincerely,

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President
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This letter is endorsed by the following organizations:

- Alison Clancey, Executive Director, SWAN Vancouver Society
- Margaret Ormond, Sunshine House, Winnipeg
- Dominique Denis-Lalonde, SHIFT Calgary
- Anlina Sheng, Winnipeg Working Group, Winnipeg
- Sandra Wesley, Directrice Générale, Stella, L'amie de Maimie, Montreal
- Jean McDonald, Coordinator, Maggie's – Toronto Sex Workers Action Project, Toronto
- Dan Allman, HIV Studies Unit, Dalla Lana School of Public Health, University of Toronto

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