Women's Harm Reduction & Community Safety Project

South Riverdale Community Health Centre

Written by Molly Bannerman

April 2007

"I feel as though our level of life, our ability and freedom of our expressions, be it tears or laughter, are non-existent. We are not on the food chain until we are trying to get clean. Can't we have quality of life as we are? Maybe we will enjoy life more eventually….I hope."

~ Comment submitted by a woman who participated in the Community Safety Audit.

WOMEN'S HARM REDUCTION & COMMUNITY SAFETY PROJECT TEAM

Jason Altenberg, Urban Health Manager
Raffi Balian, COUNTERfit Harm Reduction Program Coordinator
Molly Bannerman, Project Coordinator
Jennifer Chaves, Master of Social Work Student
Sang Won Kim, COUNTERfit Outreach Worker
Leah Palmer, Case Coordinator
Lynne Raskin, Executive Director
Kristina Ulicki, COUNTERfit Outreach Worker

THANK YOU'S & COMMUNITY CONTRIBUTORS

Thank you to everyone who was involved in this project. This project was dependent on the input of many community members, agencies and stakeholders.

South Riverdale Community Health Centre would like to say a sincere thank you to the women who participated in this project by giving their feedback, attending meetings and sharing their expertise. Your commitment, compassion and thoughtfulness have made this project possible and successful.

South Riverdale Community Health Centre would like to thank the AIDS Bureau of the Ministry of Health, Province of Ontario for the funding to conduct this project. Thank you to the local politicians for supporting this work and to Wendy Babcock for all your extra consultation, information and support. Thank you to Krista Hunt for your compassionate commitment to community development and community well-being; to Peggy Millson and Carol Strike for your assistance with gathering information and guidance on the development of this project.

South Riverdale Community Health Centre would also like to acknowledge the contributions of the Urban Health Team and many other community agencies and stakeholders that participated in and supported this project in a variety of ways. Thank you to:

Breakaway
Centre for Addiction and Mental Health
Elizabeth Fry
Fred Victor Centre Women's Drop In
HIV Social, Behavioural & Epidemiological Studies Unit
Institute for Life Course and Aging
Maggie's: Toronto Prostitutes' Community Service Project
METRAC
Nellie's
Pathways to Health Families, Jean Tweed Centre
Queen West Community Health Centre
Ralph Thornton Centre
Regent Park Community Health Centre
Sex Professionals of Canada (SPOC)
Sherbourne Health Centre
Street Health
Toronto Police, Special Victim's Unit, Sex Crimes Unit
WoodGreen Community Services
416 Drop In & Addiction Case Management Program

TABLE OF CONTENTS

INTRODUCTION

The Women's Harm Reduction & Community Safety Project was conducted at South Riverdale Community Health Centre (SRCHC) and within the local community during the winter and spring of 2007. Rooted in concerns brought forward by the community and a need to improve community safety, this project focused on women who are using illicit substances, involved in sex work and / or living on the streets. This group of women had been identified as a particularly marginalized population within the local area. Moreover, these women were at increased risk of violence, were not accessing services and were stigmatized within the community. Statistics also show that HIV/AIDS rates are increasing rapidly among this group of women, a further indication of their marginal status within society (The Public Health Agency of Canada, June 2006). Working together with community agencies, politicians, concerned community residents and women who are using illicit substances / are involved in sex work and / or are living on the streets; the Women's Harm Reduction & Community Safety Project worked to gain an understanding about the issues and challenges women face, what their needs are, and how as a community we can begin to respond and improve community safety and well-being for all.

The intention of this report is two-fold. Firstly, our hope is that the process of this research project and the key learnings will add to the existing body of knowledge and will ultimately serve as a tool for education, learning and skills building. Secondly, from this body of knowledge and information, we hope that workers, community stakeholders and women can work together to build partnerships and create change.

BACKGROUND

How did the project get started?

This project came directly out of community, grass roots action. It began out of concerns regarding community safety and occurrences of sex work in the local area which gave rise to discussions about women involved in sex work in the South Riverdale area. Subsequently, community residents and agencies came together to discuss these concerns and strategize ways to make the South Riverdale area a safer and healthier community. Ultimately, this community action paved the road for the Women's Community Safety and Harm Reduction Project. The following section gives a detailed overview of how this project initially developed.

Community Concern

In the summer of 2006, a community meeting was held where residents expressed concern about safety within the local South Riverdale area. Residents and politicians voiced strong concerns regarding the practices of Sex Workers in the community and the risks brought to the local area as a result of sex work.

The community responded to this concern in a number of ways. Firstly, community resident Krista Hunt was moved to action, motivated by exclusionary comments brought forward by other local residents. In response, Krista organized a meeting to ensure the voices of Sex Workers could be heard. COUNTERfit Harm Reduction Program at SRCHC, METRAC, Nellie's,

Maggie's and Sex Professionals of Canada (SPOC) were invited to participate in this meeting. This quickly became an initiative to examine safety issues for Sex Workers in the local area that would ultimately impact the safety of the broader community. Through the direction of METRAC, a Toronto community-based organization committed to eliminating violence against women and children, Krista Hunt along with community agencies organized a focus group and Safety Audit to mobilize local women involved in sex work to assess safety realities within the local area from the perspective of Sex Workers.

Concurrently, SRCHC management began to meet with local politicians and the AIDS Bureau to discuss these concerns and find ways to work with community stakeholders to further explore and respond to the issues being brought forward. SRCHC subsequently received project funding from the AIDS Bureau to hire a coordinator / researcher to further examine these issues.

Existing Knowledge and Context for the Project

In addition to the concerns raised by community members, politicians and local agencies, SRCHC drew on the knowledge of internal staff to provide a context that contributed to the development of this project. Broadly, SRCHC staff were aware that this group of women face an array of challenges within the context of poverty and substance use. Below is a summary of SRCHC's preliminary understanding of these issues:

Violence: Workers reported that many women were experiencing violence in their intimate relationships or within their social networks. Workers were also aware that many women reported being raped or assaulted while using cocaine / crack. Workers theorize that in many ways this trend is directly connected to the different ways women and men experience the effects of crack / cocaine. Moreover, workers reflect that, while men become hyper-aroused sexually when they use cocaine, women become less aroused and more 'standoff-ish'. Workers also recognized the high-risk situations women who are involved in sex work are exposed to, leading to increased risk of violence.

Women & Harm Reduction Services: COUNTERfit Harm Reduction Program has always been aware of the need to close the gap between male and female service users accessing harm reduction services. Recent studies indicate that Toronto Harm Reduction services are used predominately by men (Public Health Agency of Canada, August 2006). Evidence suggests that women comprise a mere third of service users. At COUNTERfit Harm Reduction Program, statistics show that only approximately 28% of service users are women. Other anecdotal information indicates that there are almost as many women who use illicit drugs as men. Therefore, we investigated the hypothesis that the discrepancies between women and men accessing harm reduction programs have to do with systemic barriers. The fact that women use harm reduction services less than men indicates that they are likely engaging in high risk substance use practices and are at a higher risk of contracting HIV / AIDS and other sexually transmitted infections (STI's). These statistics also indicate that women are isolated from harm reduction services which serve as a springboard to health services and other community supports.

HIV / AIDS & Women: According to *The Public Health Agency of Canada (June 2006),* there are an increasing proportion of HIV cases among females. Statistics from 2000 and before indicate that 14% of positive HIV / AIDS cases were among females while in 2005, this

percentage was up to 26%. Statistics from 2005 also indicate that the majority of new HIV cases are from firstly, injection drug use (IDU): 34.5%; and secondly, sexual contact with an infected person: 22.5%. In fact, more than 29% of women who use needle exchange programs in Toronto have reportedly shared drug paraphernalia in the last 6 months (Public Health Agency of Canada, August 2006).

Parenting: In brief, workers were aware that substance use creates specific challenges for women who are parenting. These women often face challenges in going through difficult withdrawal and / or treatment programs while maintaining their parenting responsibilities. Workers were also aware that women fear loosing their children to Children's Aid Society during this process. For some women, they avoid using harm reduction or other substance use support services in the community as a result of this fear.

Intimate Relationships: In terms of relationships for substance using women, workers were aware of specific challenges and issues women were struggling with. Specifically, workers were aware that women often rely on their intimate partners to obtain drugs and / or inject them. In some cases, intimate partners were also responsible for connecting with harm reduction programs and other supportive community services, in essence creating and / or furthering isolation for women.

Case Coordination Pilot Project at SRCHC: The Case Coordination Pilot Project was a project at SRCHC in the spring of 2005 (Palmer, 2005). This project aimed to improve service delivery, reduce barriers, and increase access to programs / services, internally and externally, through the development of a centre-wide standardized system of coordinated intake, assessment and referral.

This project provided important insights into issues for women who are involved in sex work and / or use illicit drugs. Specifically, a review of client profiles collected through this project indicates that more than a quarter of the women referred for Case Coordination during the project were experiencing violence in combination with substance use, sex work, mental health and / or poverty. Many, if not all of these women were experiencing all of these concerns presently and simultaneously. This project also demonstrated that a significant portion of substance using women experience physical / sexual violence and emotional / psychological abuse, often repeatedly and routinely by partners, acquaintances and / or Johns. Structural inequalities associated with gender, heightened exposure to trauma as well as relationship reliance as a result of substance dependency often result in women enduring repeated episodes of abuse.

Overall, these multiple developments paved the road for the development of the Women's Harm Reduction and Community Safety Project. This background information created the impetus for the agency to secure resources and informed the framework and approach employed throughout the project.

METHODOLOGY

This project drew on two main theoretical frameworks to define the structure, process and intentions of the research: Community Based Research (CBR) and Anti-Oppressive Theory.

Community Based Research (CBR)

CBR has been defined as research that links "community members and external researchers in investigation that promotes progressive social change as well as deeper understanding of specific issues important to communities" (Savan & Sider, 2003: 303). This theoretical approach was ideal for this research as it encouraged the integral participation of the community while also recognizing structural and systemic inequalities and how these are manifested in significant health and social disparities (Barnsley & Ellis, 1992; Fals-Borda & Rahman, 1991; Freire, 1981; Alinsky, 1972). As Flicker, Savan, Kolenda and Mildenberger point out, "health and social disparities exist not only across income lines but also across racial and ethnic groups, immigrant status, gender, ability and indigenous status. The complexities of these intractable inequalities make them ill-suited to traditional research approaches" (2007:9). Ultimately, this research approach helped in examining and recognizing structural inequalities and systems of oppression while bringing women together to share information with each other, support each other and be a central part of community development within the South Riverdale community.

Anti-Oppressive Theory

Anti-Oppressive Theory emerged in the mid 1990's, providing a unique blending of critical approach theories. This theory focuses on the multi-dimensional, intersecting elements of oppression and identity. Anti-Oppressive theorists examine notions of 'normal' and 'difference' and how these define systems of social exclusion and oppression (Moosa-Mitha, 2005). While many feminist frameworks and theories observe how systems and social structures work to create and reinforce inequalities and social exclusion related to the oppression of women, Anti-Oppressive Theory takes this examination a step further to study how factors such as gender / sexual identity and income / class, for example, intersect and create complex and multi-dimensional social realities of oppression and marginalization (Canadian Research Institute for the Advancement of Women, 2006). These multi-dimensional aspects of identity and social location define the lived realities of women involved in sex work and / or substance use within the South Riverdale Community. This theoretical approach was critical for this research provided us with a framework from which were able to work with women and the community to examine the lived realities of women through a multi-dimensional research approach and analysis.

Project Planning

This project was initially conceptualized as participatory action research, which would have allowed for the community to guide and inform the entire research process and ensure that the project was relevant to their lived experiences. The research team envisioned the project being centered around the insights and ideas of a working group of women who were involved in sex work and / or illicit substance use.

It was quickly realized that there would be significant challenges to implementing this approach. A few of the key challenges were:

- Time constraints of the project meant that a project coordinator was hired and given 3 months to complete the project with no certainty for subsequent sustainable programming resources after this project was complete and issues identified
- Recruiting and engaging women through the COUNTERfit Harm Reduction Program was difficult because women were not consistently present at the program
- The chaotic nature of women's lives who are involved in sex work and / or illicit substance abuse made it difficult to meet with and get to know women over the short time period

The project plan was revised in such a way that it would still be guided by principles of community participation and action but would also accommodate these challenges. As such, this project was guided by the Project Coordinator and staff at SRCHC and drew on relevant community resources including literature and research, community agencies and networks, community projects and women who engage in sex work and / or use illicit drugs. By drawing on these multiple sources of information, this project sought to build community capacity, and examine the multi-dimensional elements of oppression and identity for women within the community.

Conducting the Research

Below is a summary of the techniques used in this research, as well as the rational and importance of each for this research project. The methods employed include: an initial engagement process, a literature review, community agency consultations, community research audit, community networking, Sex Worker safety audit and interviews with women.

1. Engagement Process

One of the first steps of this research was for the Project Coordinator to spend time connecting with women, learning casually about the experiences and lives of women and building trust and relationships with this population. In an effort to do so, the Project Coordinator designated daily time to sit in the COUNTERfit Harm Reduction office and meet service users. This involved sitting in the harm reduction program space, at times helping to prepare program supplies, casually chatting with service users and volunteers, and simply being present in the space. It became evident quickly that women took up very little social and physical space in the program area. Women service users made up a very small portion of those coming in to the office and further, when women did enter the office they often got what they needed and left quickly.

2. Literature Review

In order to strengthen our research, we conducted a review of relevant literature. We conducted a search of literature using a combination of relevant terms including "women", "female", "sex work", "prostitution", "addiction", "substance use", and "crack".

3. Community Agency Consultations

Concurrently to the Engagement Process, we began very early in the project to consult with community agencies. This involved meeting with staff who had experience working with street-

involved women who are actively using illicit substances and / or involved in sex work. In doing this, our hope was to gain a basic understanding of:

- What programs and services existed in the community
- What challenges and issues women are facing
- The barriers women experience in accessing services
- What service gaps exist
- And what types of services should be developed or expanded

In total, we talked to 25 staff from 15 different agencies.
See Appendix A for a copy of the Community Agency Consultation Questions.

How did we select the Agencies?

Initially, we identified relevant agencies by searching Toronto's 211Community Connections Directory (www.211toronto.ca). We also consulted with staff at SRCHC to find out about agencies that would be relevant to consult with. We began to consult with staff at these agencies and these staff referred us to other relevant agencies. In selecting agencies, we aimed to identify service providers that are either located in East Toronto; or provide services in East Toronto. However, a couple of agencies that did not fit these criteria were also included because they held particular expertise that could be offered to this project.

4. Community Research Audit

Through the process of conducting the Community Agency Consultations, we became aware of various community research initiatives that had taken place throughout Toronto's downtown core and provided important insights into the challenges and issues marginalized women face. These research projects specifically examined issues of substance use, harm reduction, and sex work. As such, we spent time collecting and learning from this existing body of information and expertise and using this information to guide the structure of this project.

5. Community Networking

Through the process of conducting the community agency consultations we also became aware of existing projects and networks doing work relevant to this project. Learning about and where appropriate, joining with these existing community networks was a critical piece of the research we conducted. Participating in various community meetings and forums allowed us to gain an understanding of current issues and support existing efforts in the community that pertain specifically to women who are involved in sex work and / or illicit substance use. Some of the committees and networks we have been working to learn from include:

Bad Date Coalition

The Bad Date Coalition is made up of Sex Workers, social service providers, and activists who share the common goal of working towards making the streets a safer place for all Sex Workers, who we see as being the most vulnerable because their work leaves them wide open to all kinds of attacks from predators. This Coalition publishes The Bad Date book on a monthly basis. The Bad Date Book is a way for Sex Workers to share information with each other about bad dates. This book alerts Sex Workers about known attackers and removes the power of the attackers anonymity.

Health Bus Sex Worker Line Planning Committee
This committee is made up of Sex Workers, social service providers and activist who are interested in adding a specific Health Bus route to meet the needs of Sex Workers. The Sherbourne Health Bus provides mobile, on the spot nursing and outreach services to homeless and under housed individuals.

Sex Professionals of Canada (SPOC)
SPOC is a political and social group with the objective of working toward the decriminalization of sex work through political activism, community building and public awareness. SPOC is a grassroots, volunteer organization made up of current sex workers, former Sex Workers and allies. The goals of this organization are to enhance the quality of life of Sex Workers by providing resources and referrals to Sex Worker-friendly agencies, promoting workplace safety, engaging in political advocacy and decreasing the isolation experienced by many Sex Workers.

All of these committees / networks have been working to create support services, increase safety and mobilize Sex Workers and they provided us with important insights which influenced how this project was developed.

6. Sex Worker Safety Audit

A Safety Audit was facilitated in partnership with a community resident, METRAC, Nellie's, SPOC, SRCHC and a group of women with experience using illicit substances, sex work and street life in the South Riverdale area. The Audit included both a group discussion component to examine social safety issues (i.e. attitudes and behaviours, issues of harassment and discrimination, comfort levels in using services etc.); and a community walk about to examine structural safety issues (i.e. lighting, availability of pay phones, alleyways etc.). The information from this Safety Audit will be used to define priority areas and strategies to improve community safety for women and the community at large.
See Appendix B for a copy of the Safety Audit Survey

Who Participated?
Women who had experience in sex work, using illicit substances and were familiar with the local area were recruited. We advertised the Audit through postering and women were asked to sign up in the COUNTERfit Harm Reduction Program. Women also referred each other to participate in the project. A total of 11 women participated.
See Appendix C for a copy of the Safety Audit Recruitment Poster.

7. Interviews with Women

Meeting with and interviewing women who have lived experience in sex work, using illicit substances and are involved in street-life in the South Riverdale area was one of the most critical parts of this research. Our intention from this part of the research was to hear directly from women about their concerns, what the problems were that they were struggling with, what services they used and benefited from and what they would like to see happen in the community. Furthermore, we hoped that this process of connecting with women and discussing their needs and concerns with them would create space for women to begin to actively define the changes they want to see in the community and work toward change. Quotes from these interviews are

found throughout the FINDINGS section of this report. We have done our best to ensure the language and wording women used is replicated directly.

How did we develop the interview tool?
The Project Coordinator spent time sitting in the COUNTERfit clinic and had begun to make connections with some of the women accessing the COUNTERfit Harm Reduction Program. From this experience, and the information collected through the other stages of research, an initial framework of questions was developed. This framework was then shared with the Urban Health Team and academic partners at the Centre for Addiction and Mental Health and University of Toronto for feedback. The Coordinator collected feedback which included requests to broaden the interview framework to include some program assessment and evaluation, and to ask questions that would help guide existing programs at SRCHC. Once feedback was received and incorporated, SRCHC's Plain Language Committee reviewed the interview framework to simplify the questions and ensure the language used was clear and appropriate.
See Appendix D for a copy of the Women's Interview Questions

How did we Recruit Participants?
We used postering and word of mouth referral to recruit women to participate in this research. We asked that participants be involved in the SRCHC COUNTERfit Harm Reduction Program and / or be involved in sex work in the local area; however, we did not overtly state this in the poster because women who use the COUNTERfit Harm Reduction Program may also have male partners who attend the program. We did not want to jeopardize their safety or confidentiality about engagement in sex work.
See Appendix E for a copy of the Recruitment Poster

Who Participated:
In total, 20 women were interviewed for this project. In terms of age: 70% of the women were between the ages of 36 and 50; 20% were between the ages of 26 and 35; and 10% were 51 or older. In terms of housing status: 30% of the women were under housed (staying with friends or family, couch surfing etc.); 30% were renting an apartment or had permanent housing, 15% were staying in shelters; 10% were sleeping on the streets; 10% were living in social or subsidized housing and 5% were living in a rooming house.

How did we conduct the interviews?
We conducted interviews over the course of 1 week. Each interview took between 20 minutes and 1 hour, depending on the women's feedback. Data was collected by hand (note taking), with an effort to use the women's own words. The data was then collated and where appropriate, organized into theme areas. Each participant was given $20.00 for sharing her expertise. Each woman was also offered information about how to report Bad Dates to Toronto Police Special Victim's Unit and the Bad Date Coalition. Women were also given a pamphlet with information about services available in South East Toronto. If women had questions or wanted additional information, this was also made available either through direct follow up with the Project Coordinator or referral to other services / workers.

Limitations

Some of the limitations in this research included time frames, staff resources and the engagement process. As mentioned earlier, the 3 month time frames of this project limited the ways in which women could engage in the process although useful preliminary data was obtained which could form the basis for further research recommendations.

Given the parameters of this current project, South Riverdale Community Health Centre has worked to extend the project's development. As such, the components of the research within this report can be seen as a starting point to further research and community development within a participatory community action based research framework. Ultimately, this extension would create a mechanism for women to engage with each other and build community capacity while also ensuring service recommendations are fully rooted in the ideas and actions of the women effected. In order to respond to this current limitation, SRCHC is in the process of creating funding proposals to work toward securing further, longer term funding and continuing with this project.

FINDINGS

We have summarized the findings from this project into key theme areas. This section provides an overview of the major themes. Ultimately, each of these themes speak to the experiences of women and how systemic community, health and social structures perpetuate the marginal location of women within the South Riverdale Community and more broadly within society. Many of the themes are interconnected. Direct quotations from the women's interviews are presented throughout this section to emphasize the experiences, feelings and needs women expressed.

VIOLENCE

Women face high rates of violence & abuse:

- 95% of the women we interviewed reported experiencing violence in their life.
- 65% reported experiencing violence in the last year
- 40% named violence as one of the main challenges in their life

> ***"It's a barbaric lifestyle. One step up from a lion's den. Violence is huge. We need to promote non-violence."***

- 60% of the women we interviewed had been on a Bad Date
- 92% of the women who had been on a Bad Date said they did not report it to the Bad Date Coalition, Special Victim's Unit of the Toronto Police or a community worker. However, 42% had reported their bad date to friends or other women who engage in sex work

> ***"I was too ashamed. I'm embarrassed. It's personal. I try to think I'm tough. I think I can handle it on my own."***
>
> ~ A woman's comments about why she didn't report a bad date**.**

- 73% of the Community Workers identified high rates of violence, serious violence and assault as the most pressing issues the women they worked with face
- One worker who works specifically with street involved Sex Workers reported that, on average, 6-8 Sex Workers are assaulted per night. Other workers specifically emphasized violence and assault to be the most predominate issue marginalized women face.

- Statistics show that 50% of Canadian women have experienced physical or sexual violence at least once since the age of 16. Statistics also show that 1 in 4 Canadian women experience violence by their intimate partner. (Rights of Non-Status Women).

- Women in abusive intimate relationships report that the risk of violence is further increased if they try to negotiate safe sex (condom usage), (Larkin, 2000; Bogart, Collins, Cummingham, Beckman, Golinelli, Eisenman & Bird, 2005).

- Research clearly demonstrates that women who experience violence are at greater risk for contracting HIV and other sexually transmitted infections (STI's) (Eby, 2004; Beadnell, Baker, Morrison & Knox, 2000) and are at greater risk of transmitting HIV and other STI's to other sex partners (Bright, 2006).

Marginalized groups of women are at greater risk of violence & abuse:

- Community workers reported that women who are transsexual or transgendered, Sex Workers, immigrant women and / or women who are using illicit substances are at particularly high risk for violence
- **Women who use illicit drugs are three to five times more likely to experience assaults than non-users** (Burke, Thieman, Gielen, O'Campo & McDonnell, 2005).
- Research has demonstrated that **women who are involved in sex work and / or using illicit drugs have higher rates of past physical and sexual abuse and related life trauma** (Tucker, Wenzel, Elliot, Marshall & Williamson, 2004; Beadnall et al., 2000, James, Johnson & Raghavan, 2004; Butters & Erickson, 2003; Canadian Public Health Association, October 2005).

There is a lack of safe spaces for women who are experiencing violence:

- Women do not have safe spaces where they can recover from violence. Workers reported that women come in to drop in settings for essential services and return to the streets immediately without taking time to seek medical attention or support around obviously serious assaults.
- The barriers women face in accessing services such as drop-ins, shelters, health care and other community supports put women at higher risk of violence.

"You see women so beaten up, so afraid. They've been beaten for hours and need a place to go."

VIOLENCE, SEX WORK & SUBSTANCE USE

- More than 50% of the women we interviewed have engaged in sex work in the past 6 months and 100% of the women actively use illicit substances.
- A significant body of research exists examining the various ways that sex work, substance use and violence intersect with each other, perpetuating and exacerbating the marginalization of street involved women (Taylor, 2003; El-Bassen, Gilbert & Rajah, 2003; Butters & Erickson, 2003; Green, Ward & Day, 1999; Tucker et al., 2004; Larkin, 2000; Bogart et al., 2005; & Erickson, Butters, McGillicudy and Hallgren, 2000; Gielen, McDonnell & O'Campo, 2002).
- In a study of crack using women from downtown Toronto's East side, 21% of the interviewed women reported being raped in the previous year and 73% of the women

reported that they had been victimized as a result of the crack market. Many women reported that the risk of violence is higher for Sex Workers. Women explicitly discussed their experiences being raped, beaten, stabbed, held at gun point and other various acts of brutal violence when crack was involved (Butters & Erickson, 2003; Erickson et al., 2000).

- A United Kingdom based study noted that 100% of interviewed street involved Sex Workers believed crack led to increased rates of violence among Sex Workers (Taylor, 2003).
- Many studies, including the above noted research, indicate that violence is indisputably and significantly higher for women involved in sex work (Burke et al., 2005; Green et al., 1999).
- Many studies link how the relationship between violence, substance use and sex work is a reciprocal one. It is not simply that participation in sex work or illicit substance use increases women's risk of violence, but also that woman's experiences of violence increase women's use of substances and participation in sex work (Edwards, Halpern & Wechsberg, 2006; Butters & Erickson, 2003; Gielen et al., 2002; Green et al., 1999; Taylor, 2003; Canadian Public Health Association, October 2005).

Based on the above information, it is clear that the intersection of sex work, substance use and violence create circumstances that indisputably exacerbate and perpetuate the risks street involved women face.

SUBSTANCE USE

Women stated that drug use is one of the main challenges they face. They specifically talked about the difficulty of staying clean around people who are using. Women also identified problems in personal relationships associated with using. Women noted that people "play games", "want to rob you", and men "think you are a whore".

> ***"Smoking drugs. It's stressful. The people around me. There's so much bullshit. Unnecessary games. People want to rob you."***

> ***"If you use, men think you're a whore."***

CRACK USE, SEX & GENDER

Crack is the most popular substance women from COUNTERfit Harm Reduction Program report using. 55% of the women we interviewed named crack as their primary drug of choice. The combination of sex and crack use arguably increases the risk of violence for women. While limited research indicates otherwise, there is a substantial body of research indicating that women experience reduced arousal and men experience heightened arousal when using crack cocaine:

- In their research on crack use and prostitution, Erickson et al., (2000) illustrate clearly that men become hyper aroused while women lose interest in sex when using crack.
- Examples of women's comments when asked about their observations of gendered arousal during crack use included: "men seem to be real ….perverts…it just makes me sick", "men want to have sex but a lot of women just hate the thought", and "men get extremely horny" (Erickson et al., 2000: 6-7).
- McKay (2005) notes that, while "cocaine does not directly or specifically impact on the human sexual response cycle ….. the feelings of well being that result from taking the drug may intensify, spark, or enhance feelings of sexual desire and sensuality". Furthermore, McKay notes that "contrary to the notion that crack cocaine may act as an aphrodisiac for women, a study of female crack cocaine users found that the drug diminished sexual desire and increased the likelihood of sexual dysfunction" (Henderson, Boyd & Whitmarsh, 1995 as cited in McKay, 2005:52).

These gender specific arousal experiences put women at increased risk for sexual assault and violence

"When I'm using I can't have sex. I feel dirty. They always offer money."

POVERTY

- Women who are facing mental health challenges and / or are using illicit substances often live chaotic lives
- These women often have a difficult time accessing support services (i.e. Ontario Works & Ontario Disability Support Program) because of systemic barriers (Larkin, 2000)
- The need for financial stability often prevents women from exiting sex work. This is especially true for women with children (Larkin, 2000; Currie, 2001; Beadnell et al., 2000)

"There is a lack of money. Women need to do a lot more [sex] work to get money."

HOUSING & HOMELESSNESS

Many women talked about the problems associated with the current housing situation in Toronto.

"There are stereotypes being on assistance and not enough money for a decent place. You can't pay first and last rent or there is discrimination if you're on welfare. You end up living in a shit hole and if you're addicted, you end up staying addicted. If you had money to live in decent housing you would feel better and drug use would be better."

"When you don't have a place it screws you up."

"If you were in better housing, you would be more likely to use services like drug counseling. You would have the self-esteem to go to meetings and take care of yourself."

CHILDREN & PARENTING

Child Friendly Spaces: It is difficult for women with children to access harm reduction services and supplies or connect with community programs that advocate for safer use because:

1. They are embarrassed and experience judgment about their life style
2. Harm reduction spaces are not usually child friendly spaces
3. Women fear being reported to Children's Aid if they use a harm reduction service and have children.

As a result, women are at increased risk of unsafe use practices and in turn, are at greater risk for infection and disease.

"I don't want people to see me because I'm a mother and it's embarrassing. I don't want people to know."

- **Loss of Children:** Many women who are street involved do not have custody of their children and are dealing with complex mental health issues, substance use and trauma issues. For many women, having lost children to Children's Aid further complicates these already difficult issues. As reported in a research bulletin by the Centre for Urban and Community Studies, University of Toronto: many women experience grief, anger, guilt and depression after having to give up their child. For women who are living on the streets, these issues often go unresolved. The effects of this emotional trauma can translate into increased risk of long terms physical, psychological and social problems (Novac, Paradis, Brown & Morton, 2006).

- **Children's Aid:** Some Community Workers talked about a lack of support and knowledge in the community about the role Children's Aid can play in terms of supporting women with children, providing parenting support and helping to ensure women can keep their children. Other workers talked about a lack of support for women who have children in the care of Children's Aid in terms of stress and trauma management, coping, and how to re-gain custody of their children. Community Workers also talked about the overly punitive, judgment based and overall horrific interactions the women they've worked with have had with Children's Aid.

"They took my children and wouldn't help. I tried to get help but can't get it. I can only talk to my children on the phone. That's the worst part. Agencies give so many excuses to not help."

INTIMATE RELATIONSHIPS

- **Loss of Power:** Community workers talked about the loss of power vulnerable women face in relationships where substance use is involved:
  - Male partners frequently facilitate substance use within the male-female substance using relationship by defining what substance is used, when it's used, how much, how often, and facilitating the actual usage (i.e. injecting the female partner).
  - Male partners often inject themselves first with a single use needle and subsequently use the same needle to inject their female partner. As a result, the needle is duller when the female partner is injected and puts the female at increased risk of injury (i.e. abscesses and infection) and infection (i.e. HIV, HCV).

  The result of these power differentials is that women become exceptionally marginalized within the relationship and increasingly dependent on the male partner

"Women use services less because of prostitution and stigma and judgment. People criticize women more about drugs. People judge without knowing the circumstances. Pimps also don't allow you to get clean. Women are measuring their steps, men are watching them. Pimps don't allow women to look for help."

- **Violence:** Many workers indicated that women's dependence on their partner for the facilitation of substance use and the consequent loss of power puts them at increased risk for violence. This is especially heightened when serious addictions are involved and women become more 'desperate' to score.
  - Women noted that it is very difficult to leave an abusive relationship because you risk loosing everything. And there is no place to go if you want to leave. Women talked about not wanting to stay at shelters because of fear of harassment, discrimination and violence.
  - Findings about violence are discussed in further detail in the section on Violence, Sex Work & Substance Use.

"You have to deal with abuse because there is no where to go and if you want to leave, you have to loose everything and go to a shelter."

- **Sex Work:**
  - Community workers talked about the interrelationship and interdependence within male – female intimate relationships whereby the female is responsible for going out and making money through sex work and the male is responsible for using the money to buy illicit substances and facilitate their use.
  - In this situation, the female partner is frequently required to make certain amounts of money or else be at risk of violence and / or abuse.
  - Women in this situation also face a significant loss of control over their lives.

- **Safe Sex Practices:** Community workers noted that women who are involved in sex work are more likely to use a condom when working but are less likely to use a condom within intimate relationships (because of pressure from their partner / intimacy within their relationship). As a result, women are at increased risk of contracting STI's within their intimate relationships.

- **Access to Services:** Embedded in the male-female substance using relationship is the inevitable issue of access to services. In relationships where the male is facilitating the substance use, the male is often also facilitating access to harm reduction services. Problematically, these services often serve as an access point to other support services such as health care, counseling and education. Ultimately, the result is that the female partner is unaware of these services and is therefore disempowered from making safe and healthy choices and access to important community resources.

- **Abandonment & Risk:** Workers noted that the dynamics within the substance using relationship often mean that women are exceptionally vulnerable if their partner leaves them, is arrested or if the female partner wants to leave the relationship. In this instance, women are left to figure out their substance use independently. Because of the relationship norms; however, these women are often without the connections to harm reduction services, dealers and are not knowledgeable about injecting themselves. As a result, women are more likely to put themselves in unsafe circumstances to facilitate their substance use. Women are at risk of buying their drugs from unsafe dealers, asking strangers to inject them or trying to inject themselves without knowing how to do so safely. As such, women are reportedly more likely to stay in abusive relationships because of their reliance on the male partner. This dynamic becomes more complicated if the female is a mother and fears being reported by an angry ex-partner if she leaves.

BASIC EDUCATION & INFORMATION SHARING

- Workers identified that there are many issues that women are uneducated about including harm reduction information, safe sex information, how and where to access health care etc.
- Workers reported that they've recently seen an increase in women who are IDU's and women are frequently uneducated about how to inject properly putting them at increased risk for injury, infection and / or overdose.

"There is a lack of information about condoms. People are not using them. Women say they use a condom but they don't."

- **Informal Information Sharing:** Workers noted that there is a lack of low-threshold, drop in style spaces and programming (i.e. creative arts groups, cooking groups) that support informal discussion and information sharing. Workers also emphasized that informal ways of connecting with vulnerable women were important to educating women and getting them connected with the community supports.

POLICE & LEGAL SERVICES

"I tried to tell the police, but the police were more interested in where drugs and guns are."
~ A woman's comment about trying to report a bad date to the police

"They're horrible. They stop you for no reason. I know my rights and they abuse them. It's unethical. But it's easier to comply."

Many Community Workers we consulted with discussed the challenges marginalized women face in dealing with the police. Workers noted that women often report the following experiences:

- Being arrested and beaten by the police
- Being targeted by police as a result of substance use
- Being targeted by police as a result of homelessness
- Being targeted by police as a result of sex work

Overall, workers talked about the negative relationship between women and the police. Workers report that women do not trust the police and therefore don't rely on the police for safety or support. Ultimately, this negative relationship perpetuates the marginalization and isolation of women.

"I don't like them. All they do is harass you. They dragged me in to the police station to rat on people. They thought we were drug dealing and they threw me down on the street and hurt my back. They searched me and found nothing and still held me for 3 hours."

WOMEN & PRISON

- Women who actively use illicit drugs and / or are involved in sex work are at increased risk for incarceration. Over 50% of all offences that federally sentenced women are convicted of are either property or drug related offences. Additionally, 43% of federally sentenced women are dealing with substance use issues and 69% report that drugs and / or alcohol "played a major role in their criminalization" (Canadian Association of Elizabeth Fry Societies).
- As noted the previous section, women experience regular questioning and 'harassment' by the police. Many women reported being picked up for suspicion of engaging in sex work and being held for anywhere from a few hours to a few days or longer. In situations where women are incarcerated they often loose access to any supports they are receiving from the community. The same is true for women who are accessing supports within the jail / prison system and are released to the community. For these women, services and relationships with workers are continuously changing and it becomes difficult to establish any sort of supportive, trusting and productive relationship. Workers explained that community supports fail women who are in jail and supports offered to women in jail fail them when they are released into the community. Workers expressed significant concern about this, especially within the context of this specific group of women who are often in and out of jail frequently. Workers emphasized the importance of continuous supports and services that women have access to whether they are in or out of jail.

"I'd like to see more police watching out to see if the girls are alright instead of arresting them. They should know that the money women are getting is for their habit. Police need to leave them alone. We're not trying to build an empire or anything. Why do they harass us? If they helped us it would be safer."

BARRIERS TO SERVICES

This project continuously emphasized the multiple systemic barriers women face in accessing community support services. From our review of literature, we learned that:

According to Currie (2001) & Beadnell et al., (2000):

- There is an overall stigma applied to women who use and / or are involved in sex work.
- These women frequently do not access important community programs because of fear, shame and guilt associated with their use and / or involvement in sex work.
- Services are reportedly not accessible because of structural issues such as lacking flexibility, unavailability of childcare services and lacking availability of useful community support information.

- Larkin (2000) notes that women face barriers in accessing health care services, essentially putting women at greater risk for developing serious and complicated health problems.
- Butters & Erickson (2003) note that, in a Toronto based study, 1/3 of crack using women reported that the health care system is not meeting their needs. Some felt "their access to

health care was compromised because they were pre-judged as drug users, while others stated the lack of a health card was the primary reason for their difficulties." Women also noted that at times they were afraid of what their doctor would say to certain health concerns (p.11-12).

Furthermore, Larkin (2000) states that:

- Many women face significant economic pressures as a result of cuts to social assistance plans, child care supports, inadequate and lacking subsidized housing, inadequate legal aid services and family violence prevention programming.
- Due to structural barriers, women are forced to find alternative means to income and are generally without access to essential services and supports.

Overall, this research clearly indicates that women face significant barriers to services and have less access to community supports.

Findings from our interviews with women and consultation with local community workers were consistent with research. Below is an outline of the main barriers women face:

- **Time:** Services are often not available at times that are appropriate for women who are working in the sex industry and / or using illicit substances. Many services are available during 9 – 5 hours and in some cases, during the evening hours; however, workers noted the need for services during late night and early morning hours to meet the needs of the women.

"There are no drop in services for Sex Workers during the night and early morning."

- **Transportation:** Many women identified the cost of transportation as a barrier to accessing services. Without money to buy tokens and get to an appointment or community agency, women are not able to use those services.

- **Health:** Not feeling well, depression, not being able to get out of bed and general lack of motivation were all barriers described by the women we interviewed. Overall, if women are not feeling well, they are not likely to access community services.

- **Hygiene & Cleanliness:** Many women discussed the need to have clean spaces such as shelters and drop ins. Women talked about bugs, dirt and general lack of cleanliness as barriers that prevented them from using services. They also associated experiencing theft with this barrier. This barrier was specifically emphasized when it came to women not utilizing shelters.

- **Subculture:** Many women talked about the challenges they face in going to service providers and being around others who are using. For those who are trying not to use, the ever-present subculture of substance use makes it harder not to use. Other women talked

about their concerns regarding people within this subculture being dishonest, gossiping, and generally having negative relationships with other service users.

- **Appointment Based Services:** Many workers reported that appointment based services are not accessible for the women they work with because of their often chaotic lifestyles. As a result, many services that are typically offered on an appointment schedule (i.e. health care, counseling etc.) are not utilized.

- **Stigma & Judgment:** Services are systemically laden with blame and judgment that increases isolation and risks for street involved women. For example, women involved in sex work are often denied beds at shelters if they are out too late or cannot provide documentation of their professional work schedule (which of course, Sex Workers cannot provide). Similarly, women reported being overtly denied services because of their substance use or because they didn't have identification. Women also talked about feeling judged by workers and being treated "inhumanely".

> ***"They don't give a shit about anything. Maybe 2 out of 10 workers care. They don't give a shit."***
>
> ~ A woman talking about shelter workers.

> ***"I tried to get a bed on Danforth. When I phoned they said they would hold a bed for me. When I got there I was turned down."***

- **Accessible Information:** Consistently, the women we interviewed and the agency workers we talked to reported the lack of information and services available in a range of languages and literacy levels causes barriers for women (i.e. Bad Date Booklet). Women also talked about the need for translators and to ensure information is available in appropriate literacy levels

- **Parenting & Childcare:** Women who have children face challenges in accessing services that do not provide child care services. Many services are not appropriate for women to bring their children (i.e. harm reduction / needle exchange programs, drop ins etc.). As a result, women are less able to access important community services.

In addition to the above, when we asked specifically about health care services, workers specified these additional factors commonly acted as barriers to access:

- **Non-Harm Reduction Approach:** Many community workers reported that doctors frequently provide judgment based, non-harm reduction services. As a result, health recommendations from doctors are not only unrealistic but they also prevent women having an open and honest relationship with their doctor (i.e. women don't disclose their use of illicit substances, sexual health or other health concerns due to the nature of the relationship). Similar experiences are reported with other health care providers.

- **Stigmatization:** Women who do access health care services reportedly face excessive stigmatization as a result of their substance use and or involvement in sex work. For example, Sex Workers have given examples about going to the doctor for a common cold and being pressured to have a Pap Smear and other intrusive services without attention to their cold symptoms.

> ***"Workers don't believe me and my story. My experiences."***

> ***"They always think I'm scamming. They assume I'm there to get drugs."***
> ~ A woman's comments about health care providers

- **Serious Health Complications:** In the case that serious health complications arise (i.e. a breast lump), accessing services is even more complicated. Following through with waitlists, complicated examination appointments and doing appropriate preparation for the examinations becomes challenging for women with chaotic lifestyles.

- **Health Care Coordination:** Women reportedly face challenges in coordinating services pertaining to different health related issues. This applies to the coordination of medications for ongoing health problems, episodic medication, illicit substances and other community-based support services.

- **Preventative Health Care:** Literature and information from the community agency consultations indicate that, as a result of these barriers, many women often don't access preventative health care (i.e. breast examinations and pap smears). Consequently, women are at a higher risk of serious health complications.

Overall, these barriers are fundamentally rooted in systemic social service infrastructure. These barriers serve to maintain women's status on the margins of society and ultimately perpetuate further health and safety problems. However, these barriers are also often simple elements of service provision that can be changed and / or accommodated into services.

HEALTH RISKS

Based on the above information, it is not surprising that there is a significant body of research exploring how illicit substance use, sex work and violence lead to increased risk of serious health implications including the risk of:

- HIV / AIDS
- Hepatitis C
- Other STI's,
- cardiac problems,
- seizures,

- sexual dysfunction,
- gynecological symptoms,
- mental health problems,
- suicide
- and death

(Lejuez, Bornovalova, Daughters & Curtin, 2005; Ross, Hwang, Zack, Bull & Williams, 2002; Beadnell et al. 2000; Taylor, 2003; Tucker et al., 2004; Bright, 2006; Public Health Agency of Canada, June 2006; Currie, 2001; Eby, 2004; James et al., 2004; Gielen et al., 2002; Canadian Public Health Association, October 2005).

- Research proves that women who experience violence are not only at a greater risk for contracting HIV and other STI's (Eby, 2004, Beadnell et al., 2000), but are also at greater risk of transmitting HIV and other STI's to other sex partners (Bright, 2006).

- Statistics from a study conducted with COUNTERfit Harm Reduction service users indicated that approximately 40% of women did not use a condom during their last sexual encounter (Public Health Agency of Canada, August 2006).

"How many people have Hepatitis C and STD's. And they don't know. All the women are sleeping with the same guys. Its not safe."

- Some of the women we interviewed talked about women not using condoms and the associated risks. Women explained that many women say they are always using condoms but they are not. Further, women expressed concern that many people have HCV and / or other STI's and don't use condoms.

Based on this body of research, the marginalization of street involved women who are involved in sex work and / or substance use have serious public health implications.

GROUPS OF WOMEN WHO FACE ADDITIONAL BARRIERS

Through this research the following groups of women were identified as particularly marginalized within this particular subculture of women. It is important that services work to ensure these groups of women have access to appropriate services:

- Women with Children
- Immigrant / Non Status Women
- Transgender / Transsexual Women
- Women in their 30's & 40's
- Young Women
- Aboriginal Women
- Women with disabilities

RECOMMENDATIONS

Throughout this project we have gathered information from women, community workers and the literature we've reviewed about the needs in the community and ideas about how to respond to these needs.

Other Sources

For detail about Recommendations from the Community Agency Consultations, see Appendix F: Community Agency Consultations, Summary of Recommendations.

For literature on best practices and program development for women who are involved in sex work and / or illicit substance use, see:

Currie, J. C. (2001). *Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems. Health Canada*. Retrieved 04/10/07 from (http://www.hc-sc.gc.ca/ahc-asc/alt_formats/hecs-sesc/pdf/pubs/drugs-drogues/bp_women-mp_femmes/women-e.pdf)

The European Network for HIV/STD Prevention in Prostitution (EUROPAP/TAMPEP). (1998). *Hustling for Health: Developing Services for Sex Workers in Europe*. Retrieved 04/10/07 from http://www.europap.net/dl/archive/publications/H4H%20UK_version.pdf

Mens, L. V., Kabakchieva, E., Gaffney, J., Ward, H., Chaveiro, Al., Mak, R., Claeyssens, M., Traen, A., Mortier, A., & Nitschke, H. (July 2003). *Practical Guidelines for Delivering Health Services to Sex Workers.* Retrieved 04/10/07 from http://www.europap.net/dl/guidelines/layoutENG.pdf

Recommendations Made by the Women

The remainder of this section is dedicated to the recommendations and suggestions put forward by the women who participated in this project. Their suggestions are by far the most relevant and important for this research, and furthermore, they reiterate the information in literature and from community workers.

Women's Drop In: 100% of the women we interviewed stated that they would like to see a Women's Drop In started in the local area. Below is a list of things women would like to have at the drop in:

- Access to tokens
- A separate phone
- Clothing / Clothing Exchange
- Showers & towels
- Laundry facilities
- Hygiene supplies (i.e. tampons, sanitary napkins)
- Condom kits & other harm reduction supplies
- Contraceptive sponges (to reduce the exchange of blood during menstruation)
- Bad Date Booklets / a Bad Date list
- Access to resources (i.e. pamphlets, things women can pick up to look at without having to talk to workers if they don't want to).

Food was identified repeatedly as something needed in a Women's Drop In Program. Many women specifically identified the need for nutritious food.

Women also talked about the types of workers they would like to have access to through a Women's Drop In program. They made the following comments about this:

- Counselors
- Workers with experience (i.e. peer counselors)
- Workers who are supportive & compassionate
- Workers who are able to listen and have time to listen.
- Workers who can make referrals to withdrawal or detox programs, housing workers, outreach workers,
- Workers who can help women who are being abused
- A female health nurse
- A pastor

Women also identified that it would be helpful to have mobile services with workers who walk around the community providing services / support.

When we asked women what time of day would be best, responses included:

- Daily (5)
- It doesn't matter (2)
- Thursday (2)
- Wednesday / mid week (1)
- Monday to Friday (1)
- Saturday (1)
- Sunday / weekends (1)
- Not weekends (1)

When we asked about the time of day that would be best for a Women's Drop In program, the times women identified as most helpful were:

- Early Mornings (6)
- Daytime (6)
- Late Afternoon (4)

Women's Group: Many women talked about the need to have a women's group. The details of this type of group ranged. Suggestions included:

- A support group
- Nutritious cooking
- A discussion group
- A recreational group (activities such as physical fitness, cooking, and creative activities).
- An education group
- Art therapy
- A spirituality group
- A wellness group

Women identified the following as topics they would like to discuss with other women in the form of a group:

- Abuse & trauma
- Violence prevention (i.e. Breaking the Cycle)
- Relationships & abuse
- Substance use / alcohol / addictions
- Safe needle disposal / injection safety
- Education about sharing pipes / needles etc.
- Sexual health & STI's
- Life skills
- Body language / communication
- Stress, anger, anxiety
- Housing
- Parenting
- What women are going through
- Wellness
- ODSP / OW
- General venting and support between women

Women also noted that access to transportation tokens and food would be important parts of organizing a women's group.

Sexual Health Clinic: 95% of the women we interviewed said they would like to see a Sexual Health Program developed. Women talked about the importance of Anonymous HIV testing, access to Bad Date reporting and STI education.

Housing: Women identified clean, harm reduction, non-judgmental housing as a critical need. Women talked about the importance of being able to stay in housing without being around women who are using, and also about the importance of being able to access a shelter or housing if you are using.

Employment Supports: Women identified the need for employment services, job placement opportunities and resume help. One woman talked about the need for women to have flexible and low-threshold work opportunities. This would allow women to get money without putting themselves at risk. Women also identified that these opportunities would help to prevent women from experiencing violence. Women gave examples for work placements including cleaning up the community, making poppies or doing work for charitable organizations.

NEXT STEPS

This research project is simply a starting point. There is a great deal of action that can and needs to happen at a community level, an organizational level and a systemic level. To date, South Riverdale Community Health Centre has worked to keep this project going by:

1. Creating a strategic 5 year plan;
2. Preparing a report to the AIDS Bureau with recommendations for further action;
3. Meeting with local politicians;
4. Partnering with Institute for Life Course and Aging, University of Toronto, to conduct research regarding migrant Sex Workers in the Toronto area;
5. Submitting funding applications to a range of potential funders;
6. Preparing this report in order to ensure the information from this research is effectively shared with community stakeholders;
7. Planning a meeting with community agencies, stakeholders and women to share this report, present information about the research and begin to plan next steps in partnership with others in the community; and
8. Planning a meeting with women who have been involved in different aspects of this research to talk about the research and create space for further discussion.

South Riverdale Community Health Centre is committed to finding ways to carry this research forward and work toward creating meaningful change. We hope to do this by partnering with women, other community agencies and community stakeholders.

CONCLUSION

The Women's Harm Reduction & Community Safety Project examines issues of safety and well-being within our community by looking at a specifically marginalized group of women: women who are involved in sex work, illicit substance use and street life. This project worked to bring together the voices of community stakeholders including agency workers, politicians, concerned community residents and women involved in sex work / illicit substance use and street life. By engaging in Community Based Research through an Anti-Oppressive Theoretical framework, this project unequivocally demonstrates that:

- Women who are involved in sex work, illicit substance use and / or street life face exceptionally high rates of violence. These rates are significantly higher than rates for other women;
- Women in this subculture have higher rates of past physical and sexual violence than other women;
- Women who use crack face higher risks of violence than other women;
- Many of these women are living in poverty and the need for financial stability both encourages them to engage in sex work and in some cases, prevents them from exiting sex work;
- There are not enough safe, affordable housing options for women. The lack of affordable and safe housing in Toronto often:
    - Prevents women from leaving abusive relationships;
    - Prevents women from dealing with problematic substance use issues;
    - Forces women to continue engaging in sex work;
    - Prevents women from building self esteem, health and well-being;
- Women with children face additional systemic barriers and challenges when it comes to dealing with substance use issues, accessing harm reduction services and linking with other community supports;
- This group of women has less access than other women to information about safe sex, harm reduction programs, health care and other basic information about health, well-being and safety;
- This group of women has a negative relationship with the police and legal systems. As such, these systems cannot provide trust, support or safety for women;
- These women face a broad range of barriers to services including, for example, discrimination, stigmatization and a lack of relevant and appropriate services;
- These women face increased risk of serious health problems;
- The situation is NOT improving for this group of women.

At present, community agencies are doing incredible work to deal with this crisis situation. However, the resources available are entirely inadequate on every level. As a community we need to take this information seriously and pull together to build community capacity, collaborate and dedicate specific resources to this ongoing problem.

REFERENCES

Alinsky, Saul D. (1971). *Rules for radicals*. New York: Random House.

Barnsley, J. & Ellis, D. (1992). *Research for change: Participatory action research for community groups.* The Women's Research Centre.

Beadnell, B., Baker, S. A., Morrison, D. M. & Knox, K. (2000). HIV / STD risk factors for women with violent male partners. *Sex Roles*, 42(7/8), 661-689.

Bogart, L. M., Collins, R. L., Cunningham, W., Beckman, R., Golinelli, D., Eisenman, D. & Bird, C. E. (2005). The association of partner abuse with risky sexual behaviours among women and men with HIV / AIDS. AIDS and Behaviour, 9(3), 325-333.

Bright, R. (March 2006). Evaluation of Street Health's Hepatitis C Community Care and Awareness Program. Street Health Nursing Foundation.

Burke, J. G., Thieman, L. K., Gielen, A. C., O'Campo, P. & McDonnell, K. A. (2005). Intimate partner violence, substance use, and HIV among low income women. *Violence Against Women*, 11(9), 1140-1161.

Butters, J. & Erickson, P. G. (2003). Meeting the health care needs of female crack users: A Canadian example. *Women & Health*, 37(3), 1-17.

Canadian Association of Elizabeth Fry Societies. Retrieved 04/10/07 from http://dawn.thot.net/election2004/issues32.htm.

Canadian Research Institute for the Advancement of Women (CRIAW). (2006). *Disentangling the Web of Women's Poverty and Exclusion: An Information Tool*. Retrieved from http://www.criaw-icref.ca, 1-16.

Canadian Public Health Association. (October 2005). Leading Together: Canada Takes Action on HIV / AIDS (2005-2010). Retrieved from http://www.leadingtogether.ca/pdf/Leading_Together.pdf.

Currie, J. C. (2001). Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems. Health Canada.

Edwards, J. M., Halpern, C. T. & Wechsberg, W. M. (2006). Correlates of exchanging sex for drugs or money among women who use crack cocaine. *AIDS Education and Prevention*, 18(5), 420-429.

Eby, K. K. (2004). Exploring the stressors of low-income women with abusive partners: Understanding their needs and developing effective community responses. *Journal of Family Violence*, 19(4), 221-232.

El-Bassel, N., Gilbert, L. & Rajah, V. (2003). The relationship between drug abuse and sexual performance among women on methadone: Heightening the risk of sexual intimate violence and HIV. *Addictive Behaviour*, 28, 1385-1403.

Erickson, P. G., Butters, J, McGillicudy, P. & Hallgren, A. (2000). Crack and prostitution: Gender, myths, and experiences. *Journal of Drug Issues*, 30(4), 767-788.

Fals-Borda, O. & Rahman, M. A. (1991). *Action and knowledge*. London: Intermediate Technology Publications.

Flicker, S., Savan, B., Kolenda, B., & Mildenberger, M. (2007). *A snapshot of community-based research in Canada: Who? What? Why? How?* Health Education Research. February 25, 2007.

Freire, P. (1981). *Education for critical consciousness*. New York: Seabury Press.

Gielen, A. C., McDonnell, K. A. & O'Campo, P. J. (2002). Intimate partner violence, HIV status and sexual risk reduction. *AIDS and Behaviour*, 6(2), 107-116.

Green, A., Ward, H. & Day, S. (1999). Crack and female prostitution in west London: Executive Summary. *The Centre for Research on Drugs and Health Behaviour*, 65.

Henderson, D. J., Boyd, C. J., & Whitmarsh, J. (1995). Women and illicit drugs: Sexuality and crack cocaine. *Health Care for Women International*, 16, 113-124. As cited in McKay, A. (2005). Sexuality and substance use: The impact of tobacco, alcohol, and selected recreational drugs on sexual function. Sieccan *Newsletter in the Canadian Journal of Human Sexuality*, 14, 47-56.

James, S. E., Johnson, J., Raghavan, C. (2004). Contextualizing violence and drug abuse: A social Network Study. *Violence Against Women*, 10(9), 991-1014.

Larkin, J. (2000). Women, poverty & HIV infections. Woman Studies, 20(3), 137

Lejuez, C. W., Bornovalova, M. A., Daughters, S. B. & Curtin, J. J. (2005). Differences in impulsivity and sexual risk behaviour among inner-city crack/cocaine users and heroin users. *Drug and Alcohol Dependence*, 77, 169-175.

McKay, A. (2005). Sexuality and substance use: The impact of tobacco, alcohol, and selected recreational drugs on sexual function. Sieccan *Newsletter in the Canadian Journal of Human Sexuality*, 14, 47-56.

Mens, L. V., Kabakchieva, E., Gaffney, J., Ward, H., Chaveiro, Al., Mak, R., Claeyssens, M., Traen, A., Mortier, A., & Nitschke, H. (July 2003). *Practical Guidelines for Delivering Health Services to Sex Workers.* Retrieved 04/10/07 from http://www.europap.net/dl/guidelines/layoutENG.pdf

Moosa-Mitha, M. (2005). Situating anti-oppressive theories within critical and difference-centred perspectives. In Brown, L. & Strega, S. (eds.), *Research as Resistance: Critical, Indigenous and Anti-oppressive Approaches*. Toronto: Scholars' Press, 37-72.

Novac, S., Paradis, E., Brown, J. & Morton, H. (October 2006). A visceral grief: Young homeless mothers and loss of child custody. Centre for Urban Community Studies Research Bulletin (34), February 2007. University of Toronto.

Palmer, L. (2005). Case coordination pilot project. South Riverdale Community Health Centre Final Report. South Riverdale Community Health Centre.

Palmer, L. M. (2006). *Meeting the health and health care needs of low-income women*. Master of Social Work Thesis, August 2006. McMaster University.

Public Health Agency of Canada. (June 2006) HIV and AIDS in Canada. Surveillance Report to June 30, 2006. Surveillance and Risk Assessment Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada.

Public Health Agency of Canada. (August 2006). *I-Track: Enhanced Surveillance of Risk Behaviours Among people Who Inject Drugs. Phase 1 Report, August 2006*. Surveillance and Risk Assessment Division, Centre of Infectious Disease Prevention and Control, Public Health Agency of Canada, 2006.

Rights of Non-Status Women Network. Non-status women in Canada: Fact Sheet. Retrieved 04/11/07 from http://www.dadttoronto.org/members/publications/factsheet-women.pdf.

Ross, M. W., Hwang, L., Zack, C., Bull, L. & Williams, M. L. (2002) Sexual risk behaviours and STIs in drug abuse treatment populations whose drug of choice is crack cocaine. *International Journal of STD & AIDS*, 13, 769-774.

Savan, B. & Sider, D. (2003). *Contrasting Approaches to Community-Based Research and a Case Study of Community Sustainability in Toronto, Canada*. Local Environment, 8(3), 303-316.

Taylor, Diane. (2003). Sex for sale: New challenges and new dangers for women working on and off the streets. A Report for Mainliners.

The European Network for HIV/STD Prevention in Prostitution (EUROPAP/TAMPEP). (1998). *Hustling for Health: Developing Services for Sex Workers in Europe*. Retrieved 04/10/07 from http://www.europap.net/dl/archive/publications/H4H%20UK_version.pdf

Tucker, J. S., Wenzel, S. L., Elliot, M. N., Marshall, G. N. & Williamson, S. (2004). Interpersonal violence, substance use and HIV – related behaviour and cognition: A prospective study of impoverished women in Los Angeles County. *AIDS and Behaviour*, 8(4), 463-474.

Appendix A: Community Agency Consultation Questions

Community Agency Consultation Questions
Women's Harm Reduction & Community Safety Project, 2007
South Riverdale Community Health Centre

What do you do in relation to women who are using illicit substances and / or working in sex trade?

What works / doesn't work?

What are the issues for women (i.e. around Substance use, Harm reduction, Sex trade work, HIV / HCV, and Safety)?

What are the primary risks for women?

What do you see as the barriers for women in accessing community services?

What are the most helpful services for these women?

What service gaps exist?

Do you have any suggestions about how to increase women's access to harm reduction services?

Appendix B: Safety Audit Survey

METRAC
Metropolitan Action Committee on Violence Against Women and Children

Safety Audit Survey

Everyone should feel safe where they live, work, and play. This survey focuses on how safe people feel in this area with regards to **physical features and design**. The questions will help to identify safety issues, especially those of women and other marginalized communities, which are often forgotten. Please answer all the questions.

Date: _____ Time of audit: _____

Name of group doing the audit: _____

Area/building being audited: _____

SAFETY AUDIT SURVEY QUESTIONS:

1. **I feel safe in this area** ☐ Yes ☐ No

Part 1: Lighting

2. **Are all the lights working in this area?** ☐ Yes ☐ No

   If no, which lights need to be fixed? _____

3. **Do any lights need to be added in this area?** ☐ Yes ☐ No

   If yes, where should they be added? _____

4. **I feel safe in the alleyways at night.** ☐ Yes ☐ No

Part 2: Signs & Traffic

5. **Are there signs missing in the area** (like street and building names)? ☐ Yes ☐ No

   If yes, which ones? _____

6. **Are there any crosswalks, or traffic lights that need to be added?** ☐ Yes ☐ No

   If so, where?_____
   _____

Part 3: Feeling Isolated

7. **Are there enough payphones in this area?** ☐ Yes ☐ No

   If no, which streets need more payphones?
   _____

8. **At night, is this area deserted?** ☐ Yes ☐ No

9. **In the day, is this area deserted?** ☐ Yes ☐ No

10. **If you were screaming, do you think people would hear you, and come to help?** ☐ Yes ☐ No

Part 4: Maintenance

11. **There is a lot of garbage/litter in the area.** ☐ Yes ☐ No

Part 5: Surveillance/Security

12. **Do you feel safe when walking outside at night**? ☐ Yes ☐ No

    If no, what would make you feel safer?_____

13. **If I am assaulted, I know where to get help.** ☐ Yes ☐ No

    If yes, where would you go for help?_____

14. **I feel comfortable speaking with Police Officers**. ☐ Yes ☐ No

15. **Police patrol the area**. ☐ Yes ☐ No

Part 6: TTC

16. **Are there bus stops that need bus shelters?** ☐ Yes ☐ No

    If so,
    where?_____
    _____

17. **Are there bus stops that are missing time schedules, or have time schedules that need to be updated?** ☐ Yes ☐ No

    If so,
where_____

18. **Are there any bus routes that need to run later in the night?** ☐ Yes ☐ No

If so, which ones_____

Part 7: Services

19. **Check off the services you use the most**.

- ☐ COUNTERfit Program
- ☐ Walk-in Clinic/Health Centre
- ☐ Women's Drop-in
- ☐ Shelter
- ☐ Food Bank
- ☐ Other, please specify: _____

20. **Do you feel uncomfortable entering any places in this area**? (Check all that apply)

- ☐ Community centre
- ☐ Recreation centre
- ☐ Shops or businesses
- ☐ Parks
- ☐ Other, please specify: _____

21. **What is one change you would like to see in any of the services you use?**

_____

22. **What other services would you like to see in this area?**

_____

Part 8: Attitudes & Behaviours

23. **Do other people make you feel unsafe in this neighbourhood?**

☐ Yes ☐ No

If yes, how:

_____

24. **Have there been incidents of violence, assault, or harassment in the area?**

☐ Yes ☐ No

25. **I have experienced harassment, mistreatment or discomfort in this area.**

☐ Yes ☐ No

26. **I feel that I am discriminated against in the area**

☐ Yes ☐ No

27. **In what form was the discrimination or harassment expressed**? (Check all that apply)

- ☐ Physical assault or injury
- ☐ Glances or staring
- ☐ Ignoring
- ☐ Graffiti in the area
- ☐ Threats of physical violence
- ☐ Verbal comments
- ☐ Written comments
- ☐ Being chased or followed
- ☐ Being spit on
- ☐ Discriminated against in a job, housing, or services
- ☐ Subtle forms, please specify: _____

28. **Where did the discrimination or harassment incident(s) occur**?

- ☐ On the street
- ☐ In the park
- ☐ On public transit
- ☐ At work
- ☐ At a store
- ☐ At a restaurant
- ☐ Night club/bar
- ☐ Other location, please specify:

29. **Did you tell anybody about the incident**? ☐ Yes ☐ No

30. **If yes, who did you tell?** (Check all that apply)

- ☐ Family
- ☐ Friend(s)
- ☐ Police
- ☐ Community worker
- ☐ Neighbour
- ☐ Other person, please specify:_____

31. **In your opinion, was there a positive outcome to you telling and/or reporting the incident**? ☐ Yes ☐ No

COMMENTS

Are there any other things that would make you feel safer in this area? _____

_____

_____

_____

_____

_____

_____

_____

These **optional** questions will help to analyse the survey to ensure it measures safety for diverse people. Your answers are appreciated.

Age: _____ Ethno-racial or cultural identity: _____

Any other information about your identity that you would like to share:

_____

Appendix C: Safety Audit Recruitment Poster

Hey Women!

Have you experienced:

Violence
Discrimination
Harassment

If so, then join us for a Safety Audit in the South Riverdale area. We want to see what is safe about the community, and what is unsafe. Safety Audits are based on the idea that communities that are safe for women are safer for everyone.

We are seeking street-involved women to participate. Food & TTC will be provided.

Date: Thursday, March 22nd

Time: 6:00 – 8:00 p.m.

Who: Women from COUNTERfit

What: Participate by joining with other women and walking around the neighbourhood to evaluate safety

Pay: Participants who complete the audit with us will receive $20.00 & TTC

Sex Professionals of Canada
spoc.ca

Sign Up With Molly
416-461-3577 ext. 281

METRAC
Metropolitan Action Committee on Violence Against Women and Children

Appendix D: Interview Questions

Interview Questions
Women's Harm Reduction & Community Safety Project, 2007
South Riverdale Community Health Centre

Preamble:

- This is a confidential interview.
- We are interviewing women who use COUNTERfit so we can understand what you need.
- We want to use the information we are collecting to make programs better.
- We won't use your name.
- If you don't know the answer from your own experiences, we also want to hear about what you've observed about other women.

First, we need to gather a bit of information about you:
Age:

0 - 15	16-25	26-35	36-50	51 and up

Housing:

Street Sleeping		Supportive housing	
Shelter		Renting apartment / Permanent Housing	
Staying with friends/family/couch surfing		Room	
Social / Subsidized housing		Other	

What services have you used at SRCHC?

COUNTERfit		Dietician	
Social Worker		Good Food Box	
Doctor / Nurse		Bike Clinic	
Chiropractic		Outreach Clinic	
Foot Care		Hepatitis C Support	
Health Promotion		Environmental Advocacy	
Other: _____		Other: _____	

1. How did you find out about the COUNTERfit Harm Reduction Program
2. Tell me about your experiences with the program
3. Do you have any suggestions for improving the COUNTERfit program
4. What are the main challenges and problems that women face?
5. What community services / programs help you the most?
   What is it about them that make them helpful?
6. What community services / programs help you the least?
   What is it about them that make them unhelpful?
7. What prevents you from using programs that are available?
8. What services / programs do you think should be created in the Riverdale area? What times of day, locations, types of workers would be best?
9. Would you like to see a women's drop in started?

If so, what kinds of things would you like to have at the drop in?
What time of day, day of the week, location would be best?

10. Would you like to see a Sexual Health Program at COUNTERfit (with things like STD testing, PAP tests etc.)?
11. Do you have any other suggestions about how the health centre and community can provide better services to women?
12. We have a few questions about your use of health care services:
    - What are your most pressing health concerns?
    - Do use any health care services? If so, what services do you use?
    - How often do you use health care services?
    - Do you feel like your health care provider(s) listen to you?
13. What drugs do you use?
14. What is your drug of choice? (if more than one, please list in order of preference)
15. Have you experienced any physical or sexual violence (i.e. threats, coercion, hitting, rape etc.)?

In your life?	Y	N
In the last year?	Y	N
In the last 6 months?	Y	N

16. Has someone offered you drugs to have sex with them in the last 6 months?
    Yes: __ No: __
    Comment:
17. Have you, or have you had to, trade or sell sex for money or drugs in the last 6 months?
    Yes: __ No: __
    Comment:
18. Have you ever had a bad date?
    Yes: __ No: __
    If yes, did you report it to:
    __ Bad Date Line __ Special Victim's Unit of the Toronto Police
    __ A COUNTERfit Worker __ A worker at another location
    If not, were there reasons for not reporting?

Before we finish, we want to ask your opinion about a couple of things:

19. There are more men than women accessing Harm Reduction Services at COUNTERfit and other harm reduction services in Toronto. Why do you think that is?
20. Do you have any suggestions about how we could reach out to women who are not using services here?

Appendix E: Recruitment Poster

Women

&

COUNTERfit

Harm Reduction Program

Do you have ideas about programs for women in the community? We want your feedback!

We are conducting interviews with women to find out about women's needs in the local community. If you are interested in participating, talk to:

Molly, 416-461-3577 ext. 281

Each participant will receive $20.00

Appendix F: Community Agency Consultation, Summary of Recommendations

Community Agency Consultation, Summary of Recommendations
Women's Harm Reduction & Community Safety Project, 2007
South Riverdale Community Health Centre

Recommended Program Qualities
Inclusive Services: Services need to be inclusive of marginalized groups including: ➢ Women with children ➢ Aboriginal women ➢ Immigrant / non status women ➢ Trans ➢ Young women ➢ Women in their 30's & 40's ➢ Disabled
Coordinated / Consistent Services: ➢ Services need to be coordinated and consistent between workers and different agencies. If the information given to women needs to be consistent and accurate to help build trust.
Choices: ➢ Women need to have access to a range of services that ensure they are able to make choices without judgment or loosing supports ➢ Services need to focus on increasing women's network of support & counseling options
Trust: ➢ Women have a hard time trusting service providers for a range of reasons. Building trust takes time but it is important to creating pathways into other supportive services. To do this, it is important to provide services without judgment / blame
Sex Worker Specific Programming: ➢ There is a need for sex worker specific programs in the east end
Harm Reduction: ➢ Programs need to work from a harm reduction model and provide harm reduction supplies. ➢ Supplies need to be offered at services where women would go to get something else so that women can still access supplies even if they are in an abusive relationship
TTC: ➢ TTC must be provided for any program to make it accessible
Low Threshold: ➢ Programs need to be low threshold whereby women can participate at whatever level they want to (passively to actively)

Recommended Program Qualities
Provide Nutritious Food: ➢ Programs need to ensure nutritious food is available
Flexible Services: ➢ Non appointment based ➢ Hours of service need to be appropriate and relevant (i.e. night time, early morning for sex worker) ➢ Low threshold in terms of commitment (women can drop in without having to commit to anything) ➢ A range of supports (workers, hr supplies, health care, food, phone etc.) ➢ Flexible about where services are offered (at homes, coffee shops, community centres etc.)
Established Programs & Spaces: ➢ It is important to use program spaces where staff have already established trust and connections (i.e. Adelaide Women's Resource Centre, Nellie's etc.).
Child Friendly Harm Reduction Spaces: ➢ This is important to ensure that women with children are able to get clean and safe supplies. Women with children can't usually access harm reduction programs because they've got their children with them – its unsafe space for children and women fear being reported to CAS
Women Centred: ➢ Its important to let women direct conversations ➢ Workers should work to provide support without judgment
Non-Punitive Services: ➢ Its important for workers to understand how services can be punitive (either intentionally or not)
Complex Needs: ➢ It is important for services to be understanding of and knowledgeable about trauma issues, loss and mental health issues
Long Term: ➢ Women who are using / pregnant / in and out of jail often take a few years to develop stability in their lives and may need support over an extended period of time.
Language Appropriate: ➢ Programs need to be provided in relevant languages ➢ Programs & information need to be provided at appropriate literacy levels

Program Development Suggestion
Education based programs for women including: ➢ Importance of condom use ➢ Self—injection ➢ Needles, safety, cleaning needles ➢ Negotiating safe sex / wrapping for BJ's ➢ Violence prevention ➢ What to do if assaulted ➢ HIV / AIDS prevention & education ➢ HCV prevention & education ➢ Basic care around substance use for sex work (i.e. wash your hands) ➢ How / Where to get supplies ➢ Role of CAS in supporting women ➢ Trauma & loss ➢ Parenting (i.e. Nobody's perfect Training) ➢ Preventative health care (i.e. breast exams) ➢ Information about services in community ➢ Violence prevention ➢ Bad Date / Police ➢ Legal Services ➢ Rights – what the police can / can't ask etc.
Educate men: ➢ The importance of condom use & safe sex practices
Worker Education: ➢ Workers need to be educated about the issues that are relevant so that they can provide appropriate and relevant information / support. For example, it would be helpful for workers to know to create spaces where women can talk about negotiating safe sex. ➢ Workers need to be aware of issues around loss, trauma, etc. ➢ Workers need to be aware of relevant & available (non discriminatory) services for women ➢ Workers need to be able to create pathways for women to access other services It is important for there to be opportunities for workers to debrief and share information about what works / doesn't work
Advocacy & Public Education: ➢ Agencies that have an abundance of information (i.e. Casey House). It would be great to attend workshops and information from their expertise ➢ Need advocacy around shelters. Workers report repeatedly that women are not able to access shelters and are safer staying on the street. Shelters are reportedly not harm reduction based, do not support sex workers etc. Also, workers report that there is a significant lack in shelter – women need nighttime shelter and daytime shelter. Neither of these are available for many women who are using / sex working and / or have children. Workers also struggle because shelters deal either with abuse or use – so workers have to

Program Development Suggestion
prioritize one over the other if trying to get a woman in to a shelter. ➢ Education / advocacy around the role of police (educate workers about special victim's unit and educate police about issues for women, sex workers, women who use etc). ➢ Education with hospitals (emergency rooms, specialty testing departments such as breast examinations etc. around treatment & experiences of marginalized women) ➢ OW / ODSP – women have a difficult time accessing these, for some it is impossible and unhelpful. ➢ PAID ID Program is essential – need to advocate for its continuance ➢ Education about the role of CAS / the rights of women ➢ Decriminalization of sex work / prostitution
Network: ➢ Develop east end committee to do advocacy and community development on issues (including Maggie's RPCHC, Nellie's, Street Health, SPOC, Health Bus etc.
Recreation Based Programs / Fun: Programming such as hobby groups which do not focus specifically on sex work / substance use. It is important to develop these aspects of women's identity and develop commonalities between women. When women are using, these aspects of identity are usually diminished. This is a good way to connect with women without stigmatizing women and creating barriers for women. Suggestions include: ➢ Cooking group ➢ Writing group ➢ Trips out of city (i.e. apple picking etc.) ➢ Self care ➢ Beauty nights – pamper self ➢ Physical activities
Outreach: ➢ There is a need for community outreach services
Ask women: ➢ Do surveys ➢ What are the needs ➢ What are the barriers ➢ What are their experiences
Bad Date Booklet Distribution / Condom Kits: ➢ Put the bad date booklet in the condom kits ➢ Make the bad date booklet & condom kit available in different languages ➢ Make them available at Nellie's ➢ Make them available at places like Adelaide Women's Resource Centre ➢ Make them available in washrooms on each floor at SRCHC

Program Development Suggestion
Withdrawal Management Programming: ➢ There is a need for appropriate and relevant withdrawal management programming that is flexible and harm reduction based. It would be great if programs like this were located out of relevant program spaces (i.e. ARC)
COUNTERfit Harm Reduction Program Volunteer Cards: ➢ Might be helpful to expand / replicate COUNTERfit Card program for Sex Workers
Drop In Program: ➢ evening hours / early morning hours ➢ idea of partnership between Nellie's and SRCHC ➢ suggestion of drop in with some activities (groups / workshops) – something to engage women if they are interested in engaging ➢ harm reduction based ➢ women specific ➢ space for women to sleep during day ➢ shower facilities ➢ Clothing
Child Friendly Harm Reduction Spaces: ➢ Women with children can't access harm reduction programs because they've got their children with them – its unsafe and they fear being reported to CAS
Access to Health Care: ➢ Preventative health care (i.e. PAPS, immunizations, breast examines etc.) ➢ Support in dealing with complex health needs (i.e. preparing for tests, attending appointments, getting in to services etc.) ➢ foot care ➢ dental services ➢ health care provided in relevant hours ➢ need to do health outreach ➢ Non judgmental, flexible, supportive health care ➢ TTC ➢ Important for health care workers to ask open questions and let women direct conversations (i.e. what do you know about your health, what are you using, do you know how that interacts with the medication you are taking, how often are you using, etc)
Safe Housing: ➢ women need access to safe, supportive housing that is harm reduction based and non-punitive

For a copy of this report, or for further information about the research, please contact:

South Riverdale Community Health Centre
955 Queen Street East
Toronto, ON
M4M 3P3
416-461-1925