Centering Health, Respecting Rights

A training manual for police

on the provision of service to people living with or affected by HIV and/or Hepatitis C in Canada

HIV LEGAL NETWORK | MARCH 2021

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About the HIV Legal Network

The HIV Legal Network (formerly the *Canadian HIV/AIDS Legal Network*) promotes the human rights of people living with, at risk of, or affected by HIV or AIDS, in Canada and internationally, through research and analysis, litigation and other advocacy, public education, and community mobilization. We envision a world in which the human rights and dignity of people living with HIV or AIDS and those affected by the disease are fully realized and in which laws and policies facilitate HIV prevention, care, treatment, and support.

The HIV Legal Network acknowledges that the land on which we live and work is traditionally known as Turtle Island and home to the Haudenosaunee, the Wendat, and the Anishinaabe, including the Mississaugas of the Credit First Nation. We are all Treaty People. As settlers and as human rights advocates working for health and justice, we are called to honour the Calls to Action of the Truth and Reconciliation Commission in our work. We must do our part to address the ongoing injustices and resulting health inequities faced by Indigenous Peoples, which contribute to the disproportionate impact of the HIV epidemic on Indigenous communities. We are actively committed to this effort, working in collaboration with our Indigenous colleagues and others.

HIV LEGAL NETWORK

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Introduction

Police wield immense power over many marginalized and criminalized communities, who are also disproportionately affected by HIV and/or hepatitis C (HCV). Current movements to reimagine and reduce the role of police and reinvest in community-led initiatives are imperative to promote public health and uphold human rights. At the same time, providing law enforcement with knowledge about HIV, HCV, human rights, and harm reduction can create a more "enabling environment" that reduces harm.

There is a recognized need to equip the police with greater knowledge — and the capacity to apply that knowledge in their law enforcement practice — so as to promote access to HIV and/or HCV and other health, social, and support services, particularly those targeting *priority populations*.[1] In response, the HIV Legal Network embarked on a multistage, community-based project to develop a training manual to improve the health and safety of people living with and affected by HIV and/or HCV in Canada. This project involved two rounds of research and literature review, as well as input from community and police stakeholders.[2]

This training manual draws on current scientific evidence and best practices related to police education and HIV and HCV health and safety training. It is intended for use by police departments to assist them in meeting their professional obligations to provide safer service to people living with and affected by HIV and/or HCV.

This manual comprises two sections. The first section, **HIV, HCV, and Occupational Health and Safety,** provides a broad overview of the HIV and HCV epidemics in Canada and highlights how police can manage occupational safety concerns on the frontlines of service provision. The second section, **Human Rights, Public Health, and the Role of Police,** explores how police can support HIV and HCV prevention efforts in ways that reduce stigma, promote health, and uphold the human rights of priority populations. Each section includes learning objectives that outline key takeaways for readers. Diagrams and other relevant academic or grey literature are also included and cited as necessary. This document serves as the basis for an interactive training, instructions for which can be found in Appendix C, *Best Practice Guidelines for Implementation and Uptake*.

Glossary

AIDS – Acquired Immunodeficiency Syndrome.

ARVs – Antiretroviral medications used to treat HIV.

CD4 Count – The number of CD4 immune cells present in the blood.

DAAs – Direct Acting Antiviral medications used to treat HCV.

HCV – hepatitis C Virus.

HIV – Human Immunodeficiency Virus.

HIV Stigma – Negative thoughts, attitudes, and/or beliefs about people living with or affected by HIV.

HIV Vulnerability – The particular configuration of risk factors (cellular, psychological, behavioral, social, structural) that shape the risk of HIV infection among an individual, community, or priority population.

NSI – Needle Stick Injury, a potential source of occupational exposure to HIV or HCV.

PEP – Post-Exposure Prophylaxis, an emergency medication to be taken within 72 hours after HIV exposure to prevent infection.

PrEP – Pre-Exposure Prophylaxis, a prescribed daily medication taken by people to significantly reduce their risk of HIV infection in the event of exposure.

Priority Populations – Groups who are disproportionately affected by HIV and/or HCV. As defined by the Public Health Agency of Canada, in Canada these groups include gay/bisexual/and other men who have sex with men; people who use drugs; Indigenous peoples; people from ethno-cultural communities (particularly those representing countries with high HIV or HCV prevalence, including immigrants, migrants, and refugees); sex workers; people living in, or recently released from, correctional institutions; transgender people; people living with HIV and/or HCV and related conditions; as well as women and youth among these populations.

Social Determinants of Health – Socioeconomic factors that influence individual health. Some social determinants can affect the HIV and HCV vulnerability of an individual or community.

Viral Load – The amount of HIV present in the blood.

Section I: HIV, HCV, and Occupational Health and Safety

Learning Objectives:

1. Identify the biological and virological foundations of HIV and HCV, including transmission, symptoms, progression, and the difference between HIV and AIDS
2. Explore the current epidemiology of HIV and HCV in Canada, including their impacts on priority populations
   - Identify Indigenous peoples as a priority population shaped by colonialism
3. Examine up-to-date information on treatment and prevention, including antiretroviral therapy (ARVs), direct-acting antivirals (DAAs), pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP)
4. Highlight the various routes of HIV and HCV transmission, emphasizing those officers may encounter in occupational settings
5. Identify universal precautions that can prevent infections
6. Examine post-exposure protocols and appropriate follow-up procedures

HIV Biology 101

Human Immunodeficiency Virus (HIV) weakens the body's immune system, our natural defense against infection. Once inside the body, HIV attaches to and destroys CD4 cells, which are white blood cells that play a central role in our immune response.[3] As the infection spreads over time, the amount of virus present in the blood (or "viral load") increases, and the number of CD4 cells (or "CD4 count") decreases. When a person's CD4 count falls, their body's ability to recognize and defend against infections and other illnesses is weakened.[4]

HIV Progression and Symptoms

The natural course of HIV infection can be described in three stages, each of which is marked by different clinical indicators and symptoms.

Stage 1 - Acute HIV Infection:

This is the earliest stage of infection, occurring generally within 2-4 weeks of initial contact with HIV. During this stage, HIV rapidly multiplies and spreads throughout the body. A person's viral load tends to be *very* high during acute infection, which increases their risk of transmitting HIV.[5]

Some people describe feeling flu-like symptoms during this stage, such as fever, rashes, chills, headaches, or sore throat. These common symptoms can cause people to mistake acute infection for another illness and delay seeking HIV testing. Further, some standard HIV screening technology won't necessarily detect the virus during acute infection. This is because some technology tests for the presence of HIV antibodies, which can take the body many weeks to produce. However, there are other screening technologies that test for the virus itself (not antibodies) and so can detect HIV at this stage. Anyone who has been exposed to HIV and is experiencing symptoms of acute infection should get tested right away.[6]

Stage 2 - Chronic HIV Infection:

This is the second, intermediate stage of HIV infection between acute infection and the onset of AIDS. During chronic infection, HIV continues to multiply, but at lower rates than in acute infection. The length of this stage depends very much on whether a person is able to access and maintain treatment. *Without treatment,* CD4 cells will continue to decrease, the immune system will weaken, and the body will gradually advance towards the onset of AIDS. With treatment, however, people living with HIV can remain in the chronic stage for decades, leading healthy lives.[7]

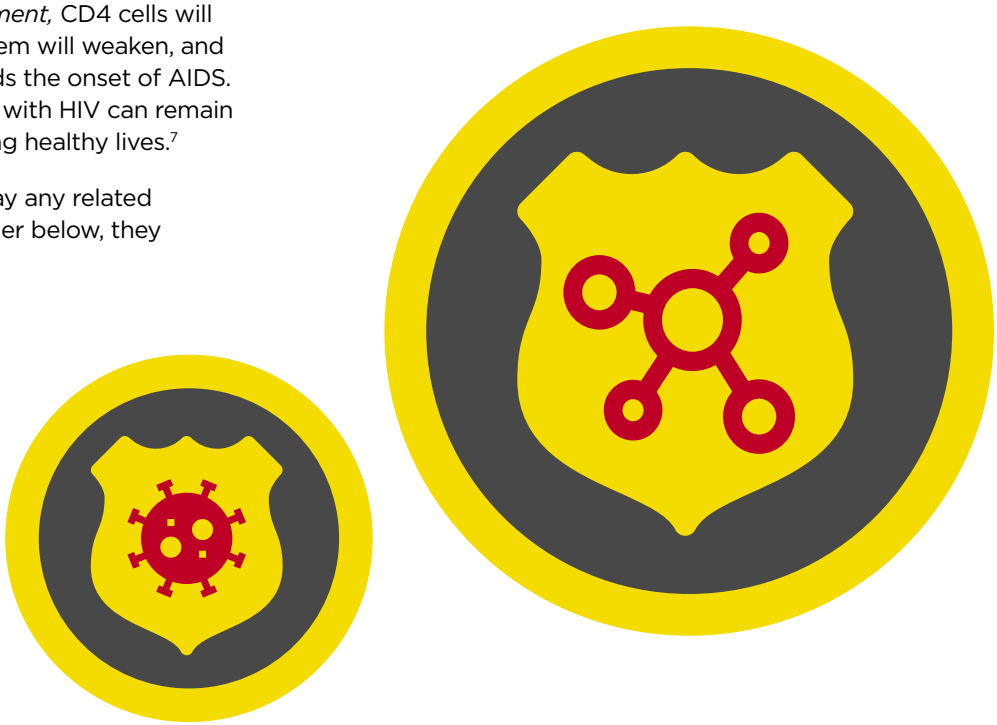
People with chronic HIV may not display any related symptoms. However, as explained further below, they can still transmit HIV to others.

Stage 3 - AIDS:

AIDS is the final and most severe stage of HIV infection. AIDS is not a distinct condition with its own set of symptoms, but rather a term that describes one or more conditions (including opportunistic infections and infection-related cancers) that occur in people whose immune systems have been seriously compromised by HIV over a long period of time.[8]

Without treatment, HIV will continue to diminish the body's immune functioning to a point where a person can no longer defend against opportunistic infections. Opportunistic infections are infections that "take advantage" of an incapacitated immune system to take root in the body and spread.[9] Some of the most common opportunistic infections associated with AIDS are cryptococcal meningitis, pneumonia, tuberculosis, and certain infection-related cancers.[10]

A person living with HIV is diagnosed with AIDS *only* if they satisfy a certain set of clinical criteria (i.e. if they develop one or more opportunistic infections *or* if they have a CD4 cell count lower than 200 cells per mm^3 of blood). People who have been diagnosed with AIDS can exhibit a number of symptoms, including rapid weight loss, persistent fever, various sores and skin lesions, and neurocognitive impairments. Many of these symptoms are the result of concurrent opportunistic infections.[11]



The Difference between HIV and AIDS

Historically, HIV and AIDS have been incorrectly conflated in the media and common conversation. The interchangeable use of the terms "HIV" and "AIDS" to describe what are entirely different conditions is not only factually untrue but has also contributed to the intense stigmatization of people and communities living with or affected by HIV.

To be clear: HIV and AIDS, although related, are different conditions. If left untreated, HIV can develop into AIDS. However, with the increasing accessibility of effective treatment in many parts of Canada, it is unlikely that someone diagnosed with HIV will remain untreated for so long that they will develop AIDS. In fact, recent data indicates that 85% of people in Canada diagnosed with HIV are on treatment.[12] In most cases, therefore, it will be incorrect to refer to someone living with HIV as having AIDS. Further, it is *never* AIDS that is transmitted, but HIV. **In short,** it is rarely, if ever, accurate or appropriate to use the term "AIDS" in relation to someone living with HIV. Doing so can reinforce misinformation, moral panic, and harmful stigma that hampers HIV prevention efforts.

HIV Transmission

HIV is spread through blood, pre-seminal fluid (pre-cum), semen, breast milk, vaginal fluids, and rectal fluids. These fluids must either be injected directly into the bloodstream or come in contact with a mucous membrane or damaged tissue for transmission to occur. Mucous membranes that HIV can penetrate exist inside the rectum, vagina, penis, and mouth.[13]

In Canada, HIV is transmitted primarily through unprotected sexual contact (vaginal or anal) between someone who is living with HIV and someone who isn't.[14] The risk of transmitting HIV through oral sex is negligible to none.[15] There is no possibility of HIV transmission through oral sex performed on a person living with HIV who has a low viral load, or a condom is used, or the HIV-negative partner is on PrEP (more information on PrEP later).[16]

The sharing of used injection equipment (needles, syringes, or other "works") accounts almost entirely for those cases of HIV not transmitted sexually. In 2018, an estimated 13.9% of new HIV cases in Canada were attributed to injection drug use.[17] Although increasingly rare in Canada, it is also possible for HIV to be transmitted from a birth parent to child during pregnancy, at birth, or through breast/chest feeding.[18]

Other exceedingly rare routes of transmission include the injection or transfusion of blood or blood products, donations of semen, and skin grafts or organ transplants.[19] While also extremely rare, it is also possible for people to be exposed to HIV occupationally, such as in hospitals or on the frontlines of policing. These cases will be discussed in greater detail later.

There are a lot of myths about HIV risk and transmission. While it is important to know how to manage one's own risk, it's equally important to dispel the kinds of harmful misinformation that contribute to HIV stigma. Below are some common misconceptions about HIV risk and transmission:[20]

- HIV **cannot** be transmitted through body fluids other than those already mentioned. This means contact with saliva, tears, sweat, urine, feces, or vomit is not a route of HIV transmission.
- HIV **cannot** be transmitted through social contact. This means that you cannot contract HIV from shaking hands, high-fiving, hugging, or kissing someone living with HIV.
- HIV is **not** spread like the common cold or flu. This means that you cannot contract HIV from someone coughing or sneezing in your vicinity.
- You **cannot** contract HIV from using shared utensils or a toilet seat.
- HIV **cannot** be carried and transmitted by insects like mosquitoes or ticks.

HIV Treatment

At present, there is no known cure for HIV. However, people living with HIV can take antiretroviral medications (ARVs), which inhibit HIV's ability to replicate in the body. This ultimately reduces a person's viral load, gives their immune system an opportunity to recover, and increases their CD4 count. Although HIV will still be present in the body, people on ARVs can restore immune function.[21]

There are many different classes of ARVs that interfere with HIV replication in different ways and at different stages of the viral life cycle. To increase protection, multiple ARVs from different drug classes are usually taken at the same time by a person living with HIV.[22]

ARVs not only reduce the amount of HIV in the body, but also lower the risk of HIV transmission. A person living with HIV who remains on treatment for a sustained period can suppress their viral load to such an extent (fewer than 40-50 copies of the virus per ml blood) that HIV becomes "undetectable" in the blood.[23] The term "undetectable" refers to the fact that the viral load is so low that HIV cannot be detected by standard testing. A person with an undetectable viral load is effectively incapable of transmitting the virus to others, a scientific finding that has spurred the popular "Undetectable=Untransmittable (U=U)" movement. U=U is gaining attention around the world and was officially endorsed by Canada's Minister of Health and Chief Public Health Officer on World AIDS Day, 2018.[24]

In July 2018, 20 of the world's leading HIV scientists published a peer-reviewed "Expert Consensus Statement on the Science of HIV in the Context of the Criminal Law," which has been endorsed by more than 70 leading scientists from 26 countries, including Canada, and also the International AIDS Society (IAS), the International Association of Providers of AIDS Care (IAPAC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS).[25] Their consensus was that, in most instances, the per-act possibility of transmitting HIV ranges from low to none. In the event of a supressed viral load (i.e. fewer than 200 copies per ml of blood), there is zero possibility of transmission.

HCV Biology 101

The term hepatitis refers to inflammation of the liver, which can be caused by a number of factors including heavy alcohol consumption, certain medications, and environmental toxins. Hepatitis A, B, and C are specific types of liver infection caused by three different viruses.[26]

Hepatitis C is a liver infection caused by the Hepatitis C virus (HCV). HCV primarily targets cells in the liver called **hepatocytes.**[27]

HCV Progression and Symptoms

The course of HCV infection can be separated into two stages that range in duration and severity:

Acute HCV: This stage occurs between two weeks and six months following exposure to HCV. During the acute stage, the vast majority of people won't exhibit any symptoms. Those who do may report fever, fatigue, nausea, dark urine, joint pain, or jaundice. The World Health Organization (WHO) reports that for approximately 30% of people with acute HCV, the condition is a mild, short-term illness that clears up on its own. For the remainder of those infected, HCV can advance into the chronic stage.[28]

Chronic HCV: Chronic HCV is a lifelong condition. As the virus progresses, it gradually kills more hepatocytes and replaces them with scar tissue in a process called fibrosis.[29] Left untreated, chronic HCV can lead to serious health problems including chronic liver infection, cirrhosis (scarring of the liver), liver cancer, and death. Among those with chronic HCV, the risk of cirrhosis falls somewhere between 15-30%, and will usually develop within 20 years of infection.[30]

HCV Transmission

HCV is a bloodborne virus, meaning that it is transmitted when the blood of a person who has HCV comes into contact with the blood of someone who does not. Commonly, HCV is transmitted through the sharing of injection equipment (needles, syringes, other "works").[31]

Less commonly, HCV is transmitted through the transfusion of unscreened blood or blood products, the sharing of tattoo and/or piercing equipment, sexual practices that increase exposure to blood, from parent to child during birth, or through occupational exposures (discussed further below).

Like HIV, there is a lot of misinformation about how HCV is transmitted. Below, we address some common misconceptions about HCV risk and transmission:[32]

- HCV is **not** spread through casual social contact like shaking hands, hugging, or kissing.
- HCV is **not** transmitted through breast/chest milk.
- HCV is **not** spread like the common cold or flu. This means that you cannot contract HCV from someone coughing or sneezing in your vicinity.
- HCV is **not** present in food or water.
- You **cannot** contract HCV from sharing utensils or a toilet seat.
- HCV is **not** spread by insects like mosquitos or ticks.
- HCV is **not** spread by contact between healthy skin and body fluids such as saliva, urine, feces, or vomit.

HCV Treatment

Remember that for some, HCV never requires treatment and will clear up on its own before reaching the chronic stage. Those who test positive for acute HCV should contact a physician about treatment options.

Once the infection enters the chronic stage, treatment is required. The World Health Organization (WHO) currently recommends a course of direct-acting antivirals (DAAs) to combat chronic HCV. Like HIV treatment, this class of oral medications fights against HCV by interfering with the viral lifecycle and preventing the spread of infection. Unlike HIV medications, however, DAAs can completely cure most people with HCV over a relatively short treatment (lasting 8-12 weeks, depending on the severity of infection).[33] However, for people who develop cirrhosis, there is a continued risk for liver cancer even after successful HCV treatment. People with chronic HCV or cirrhosis should remain in contact with a physician to monitor and maintain their liver health.

What this means for police officers: Knowledge about HIV and HCV can help enhance occupational safety during frontline service provision. It can also prevent police from contributing to the spread of misinformation and HIV and HCV stigma through their professional practice. When engaging people living with HIV and/or HCV, it is important to remember what is known about risk, transmission, and stigma, and act accordingly.

HIV and HCV Prevention

A lot of HIV and HCV prevention happens at the individual level. Using a condom and sterile injection equipment minimize the spread of HIV and HCV. Just as important are public health policies and programs that promote access to vital prevention resources and educate people about HIV and HCV prevention.

Beyond these strategies, there are two important prophylactic (preventative) medicines that people can take to protect against HIV infection.

(1) Pre-Exposure Prophylaxis (PrEP):

PrEP is an everyday oral medication that is taken *before* exposure to HIV. PrEP contains two specific drugs normally found in ARVs that help control HIV infection. When someone on PrEP is exposed to HIV, the medicines counteract the virus and prevent the establishment of permanent infection.

When taken daily, PrEP reduces risk of acquiring HIV by about 99%.[34]

(2) Post-Exposure Prophylaxis (PEP):

PEP refers to treatment with ARVs immediately *after* exposure to HIV. PEP is used primarily in emergency scenarios and must be taken within 72 hours of initial exposure to HIV.[35] During this 72-hour period, time is critical. In the event of exposure, a person should head to an emergency room. The sooner they start on PEP, the more effective the treatment will be at preventing transmission.

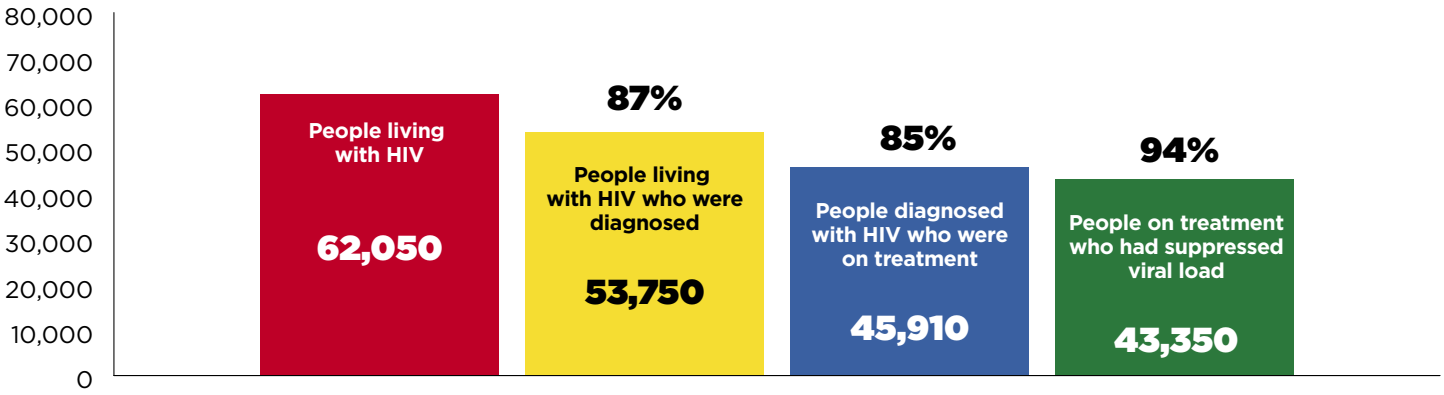
What about HCV prevention?

Unlike hepatitis A and B, there is no effective vaccine against HCV, nor any prophylactic medications such as PrEP or PEP.[36]

HIV Epidemiology in Canada

According to the most recent figures published by the Public Health Agency of Canada (PHAC), there were an estimated 62,050 people living with HIV in Canada at the end of 2018.[37] Due to advances in the accessibility and efficacy of HIV treatment, huge strides have been made in addressing the epidemic and increasing the number of people living with HIV who are diagnosed, on treatment, and virally suppressed (see chart below).

Estimated number and percentage of persons living with HIV, diagnosed, on treatment, and virally suppressed in Canada at the end of 2018



HCV Epidemiology in Canada

Surveillance data for HCV in Canada are less robust. In 2018, PHAC estimated an HCV infection rate of 33.6 cases per 100,000 people.[38] Data from 2017 suggest that there were 317,100 people in Canada who had ever had hepatitis C. Among these, 194,500 were living with chronic HCV infection.[39]

HIV and HCV Epidemiology and Priority Populations

Despite considerable progress in detection, treatment, and prevention, many communities in Canada still face disproportionate HIV and HCV risk. According to PHAC, these priority populations include gay men and other men who have sex with men (MSM); Indigenous Peoples;[40] people who use drugs; transgender people; people with experience in the prison environment; people from countries where HIV, HBV, and HCV are endemic; and sex workers.[41]

But what does "disproportionate HIV or HCV risk" look like?

In 2018, PHAC estimated 2,242 new cases of HIV in Canada, of which just under half **(49.5%)** were reported among gay, bisexual, or other MSM, despite the fact that this group accounts for only 3-4% of the adult male population.[42] Indigenous Peoples also continue to be overrepresented in the HIV epidemic in Canada. An estimated **14.0%** of all new infections in 2018 were diagnosed in Indigenous People, whereas this group represents 4.9% of the total population in Canada.[43] Indigenous people are also disproportionately represented in provincial, territorial, and federal prisons, where inadequate access to harm reduction measures increases the risk of infection.

Indigenous women in Canada are especially affected by HIV, representing **36.2%** of all new HIV cases among women in 2016. The same data indicate that Indigenous women represented **42%** of the total number of new cases among Indigenous Peoples, whereas women overall represented **23.3%** of all new cases;[44] this is a result of the intersectional nature of oppression under colonialism (discussed further below).

In 2018, **43%** of federal prisoners living with HIV were of Indigenous ancestry, and HIV prevalence was higher among those with Indigenous ancestry compared to non-Indigenous ancestry (1.48% versus 0.82%).[45]

In 2011, an estimated **66%** of people who inject drugs were antibody positive for HCV. The same study also indicated that **24%** of federal prisoners and **23.3%** of provincial prisoners were also antibody positive.[46] These data stand out compared to a Canada-wide prevalence of only 0.64%. In 2018, **13.9%** of the estimated new HIV infections were among people who inject drugs.[47]

Why do priority populations account for such a large proportion of HIV and HCV cases? This isn't an easy question to answer, and it will be discussed further in Section II. For now, suffice it to say that HIV and HCV are "multifactorial" conditions, meaning that there are many different factors to consider when examining HIV or HCV among certain communities or priority populations. Throughout this manual, specific attention is drawn to HIV among Indigenous communities, especially as it has been shaped by Canada's legacy of settler colonialism.

Reflection: Why might Indigenous people be disproportionately affected by HIV? How might colonial projects like the dispossession of Indigenous land, the residential school system,[48] and the Sixties Scoop[49] contribute to increased HIV risk?

HIV and HCV Exposure and Occupational Safety

While there is some risk of contracting HIV or HCV on the job, occupational transmission is exceedingly rare. Jobs with the greatest degree of exposure are in healthcare settings.[50] Police officers working on the frontlines *may* still encounter risk through contact with blood or other body fluids. However, **there is no evidence of transmission** of HIV to a police officer in Canada while on the job.

Below are some of the most commonly cited examples of potential occupational exposure to HIV and HCV among police officers.

(1) Needlestick Injury (NSI): This is one of the most common concerns among police who are worried about HIV or HCV risk on the job. It is possible for someone to contract HIV or HCV if their skin is punctured by a needle that has been recently used by someone who is HIV- or HCV-positive, but the actual rates of transmission are exceedingly low.[51] For one, HIV is a very fragile virus. It is incredibly sensitive to temperature and moisture and so is virtually incapable of surviving or replicating outside the body. This means that dried blood on a discarded needle is unlikely to pose much risk for HIV transmission.[52] HCV can live longer outside the body, and so poses more risk. Second, while a recently used needle stored on a person can puncture an officer's skin during a body search, precautions can be taken to avoid such risk. Studies have shown the average risk of HIV infection following a NSI is about 0.3% (or 1 in 300 cases).[53] The average risk for HCV infection following a NSI is approximately 1.8%.[54] Regardless, NSI can still pose risk for other blood-borne infections such as hepatitis B, so it is always a good idea to seek medical attention immediately following an NSI.

(2) Biting: The likelihood that HIV is transmitted through a bite where the person living with HIV has a significant amount of blood in their saliva, *and* their blood comes into contact with a mucous membrane or open wound, *and* their viral load is unsuppressed varies from negligible to none.[55] In any case, if a person is bitten on the job, and especially if the bite draws blood, they should seek medical attention.

(3) Blood in the mouth or eyes: It is hypothetically possible for HIV or HCV to penetrate the mucous membranes in the mouth or eyes and cause infection. Contact between these membranes and blood containing HIV or HCV might occur during an agitated physical altercation or if an officer is performing mouth-to-mouth resuscitation on someone who is living with HIV or HCV. A medical risk assessment should be sought after either of these incidents, but on average, the risk of contracting HIV following exposure of the eyes or mouth is estimated to be 0.1% (or 1 in 1000 cases). The risk of contracting HCV is unknown but also believed to very small.[56]

Reducing Risk on the Job

Following any of the scenarios described above (NSIs, biting, and blood in the eyes or mouth), it is advisable to seek medical care, but mainly for other possible health risks or infections which are much more likely to occur than the transmission of HIV or HCV.[57] Post-exposure protocols and the choice to administer PEP are quite rare for occupational HIV or HCV exposure. These decisions are made on a case-by-case basis and should be judged by a medical professional.[58]

Additionally, officers working on the frontlines should be aware of and adopt several universal precautions that can prevent infections:[59]

- Gloves should always be worn at crime scenes and during body searches.
- Any cuts or open sores on an officer's body should be covered with waterproof bandages to avoid the potential entry of pathogens.
- Disposable protective devices should always be used for mouth-to-mouth resuscitation
- Other personal protective equipment such as waterproof goggles or masks must be provided, available to officers, and worn where and when appropriate (e.g. when in contact with people who may behave unpredictably).
- Good hygiene practices (regularly washing hands, removing soiled equipment, maintaining clean work areas/uniforms) should also be followed.

These precautions should be followed whether or not officers are working with someone who is living with HIV or HCV. Remember, **there is no need to engage in extra precautionary measures** when working with someone who you suspect might be living with HIV or HCV.[60] Doing so can spread public misinformation about risk and contribute to stigma.

The most significant source of HIV or HCV risk an officer is likely to encounter on the job is NSI. To avoid such risk, officers should engage in the safe searching, handling, and disposal of needles and syringes as a matter of occupational safety. The United Nations Office on Drugs and Crime has outlined a three-stage best practice model for officers to reduce their risk during and after body searches.[61]

Post-exposure Protocols

The importance of universal precautions like wearing gloves, washing hands, and carefully handling sharps cannot be overstated. However, sometimes despite best efforts, accidents happen. Post-exposure protocols can help minimize the risk of post-exposure infection and ensure the necessary care is received as soon as possible. Post-exposure protocols will vary based on the nature of the incident:[62]

(1) Protocol following exposure to blood or other body fluids:

- Flush exposed area with running water
- Wash the area with plenty of soap or other disinfectant
- Report the incident to the appropriate authority
- Seek immediate medical attention
- Record the incident according to relevant procedure

(2) Protocol Following NSI:

- Flush the exposed area with running water
- Wash the exposed area with plenty of soap or other disinfectant
- Do **not** force the wound to bleed
- Do **not** lick, suck, or place mouth on or near the wound
- Report the incident to the appropriate authority
- Seek immediate medical attention
- Record the incident according to relevant procedure

In either case, depending on the nature or extent of exposure, PEP and/or HIV and/or HCV testing may be warranted. Ultimately, the course of action is for a medical professional to decide on a case-by-case basis. There may be additional steps taken to prevent other infections.

It is always advisable to seek HIV and/or HCV testing if there is a concern about risk. While testing may be required following a possible occupational exposure, primary care providers or local sexual health clinics can also provide testing. Provinces and territories across Canada have established toll-free info-lines to answer questions about HIV and AIDS.

Section II: Human Rights, Public Health, and the Role of Police

Learning Objectives:

1. Explore how HIV and HCV are shaped by broader and interacting social determinants:
    - Highlight the enduring impacts of colonization on HIV and/or HCV risk for Indigenous communities
2. Define human rights and identify specific laws in Canada that undermine human rights and/or create barriers to HIV and/or HCV and other health, social and support services among priority populations with whom police may engage.
3. Identify the role of police in responding to the social determinants of HIV and/or HCV using practices that better respect the health and human rights of priority populations, including:
    - Exercising discretionary enforcement to minimize the negative impact of police contact
    - Using appropriate and destigmatizing language and practices when engaging members of priority populations
    - Practicing cultural safety in relation to Indigenous communities and other priority populations

HIV, HCV, and the Social Determinants of Health

Recall that certain "priority populations" (gay/bisexual/ and other men who have sex with men; people who use drugs; Indigenous Peoples; people from ethno-cultural communities; sex workers; people living in, or recently released from, correctional institutions; transgender people; people living with HIV and/or HCV and related conditions; as well as women and youth among these populations) continue to represent a disproportionate share of Canada's HIV and/or HCV cases. Even with advances in treatment, increases in scientific knowledge around HIV risk and transmission, and the arrival of preventative medications like PrEP, individuals from priority populations face far greater structural constraints that increase their risk of acquiring HIV and/or HCV infection over their lifetime. Why might this be the case?

HIV and HCV are "multifactorial" conditions, meaning that they are caused by a number of different factors. In this manual, some **community and societal/structural factors** are highlighted (for a more detailed breakdown of these factors, see Appendix B). Some of these factors are also termed **social determinants of health,** as they influence many other conditions beyond just HIV or HCV.[63] Different factors at the level of the individual, interpersonal (between people), community, and society interact to determine HIV vulnerability. We use the term **HIV vulnerability** to describe the particular configuration of risk factors that shape the risk of HIV infection among an individual, community, or priority population.

HIV Stigma

HIV stigma refers to negative attitudes and beliefs about people living with or affected by HIV. HIV stigma often leads to discrimination and social exclusion or isolation. These factors can lead people to avoid seeking HIV testing, prevention, or treatment services for fear of being judged and mistreated. Experiencing or fearing discrimination based on HIV stigma is therefore one of the many factors that can increase someone's HIV vulnerability.

While there has been some progress in the fight against HIV stigma, there is still a lot of work to be done. The two most recent attitudinal studies[64] commissioned by the Public Health Agency of Canada revealed that:

- **15%** of people in Canada feel afraid of catching HIV when they are near people living with HIV;
- **24%** of people in Canada feel uncomfortable wearing a sweater once worn by a person living with HIV;
- **51%** of people in Canada would be uncomfortable if a close family member or friend dates someone living with HIV;
- **22%** of people in Canada feel uncomfortable shopping at a small neighbourhood grocery store owned by someone living with HIV;
- **40%** of people in Canada would not use the services of a dentist or doctor living with HIV and 24% would not use the services of a hairstylist or barber living with HIV;
- **66%** of people in Canada hold low discriminatory beliefs towards people living with HIV, 19% hold medium-level discriminatory beliefs, and 15% hold high-level discriminatory beliefs; and
- **88%** of people in Canada believe that people living with HIV can have trouble getting housing, health care, and employment because of HIV-related stigma.

HIV and Priority Populations in Canada

When thinking about the social determinants of HIV, people tend to think of things like poverty, lack of access to education, employment, and food, lack of access to healthcare (including HIV and HCV prevention, testing, and treatment or harm reduction services), insecure or inadequate housing, abuse, trauma, lack of social supports, colonialism, racism, sexism, homophobia and transphobia, among other determinants.[65] These social determinants can influence whether or not someone is able to access HIV testing and treatment or take measures to prevent HIV transmission (e.g. using condoms or sterile drug equipment). Priority populations are profoundly shaped by different social determinants over the course of their lives.

But what is behind the social determinants? What structural forces create the conditions within which priority populations face poverty and lack of access to harm reduction and other health services, housing, or nutritious food?

Below are some first-hand accounts from individuals from priority populations describing the conditions that result in greater vulnerability to HIV, and how factors often intersect in ways that compound HIV vulnerability. These excerpts are drawn from a number of qualitative research studies examining "HIV risk" in the hopes that they will highlight how there are often many social determinants that affect someone's likelihood of acquiring HIV.

Social Determinants that Affect All Priority Populations

Social exclusion and inadequate access to healthcare are frequently reported by all priority populations as major determinants affecting HIV vulnerability.

Social Exclusion

Many people living with and affected by HIV face stigma and social exclusion. Individuals often report feeling ostracized from society or being "treated like garbage."[66] They may also experience internalized stigma and shame that deters them from seeking appropriate medical treatment or disclosing their status to friends and family. Social exclusion varies depending on one's social location and can intersect with other social determinants of health such as gender, race, and other status.

> "A lot of people don't even tell their families because of fear of being judged. So that can discourage people from disclosing and getting the proper supports and help that they need."[67]
>
> **– Person living with HIV who injects drugs**

> "If I go out three or four times with a woman, after three or four times: 'Why do we always use a condom?' Then I explain it to her, and it's 'Bye!'"[68]
>
> **– Man living with HIV**

> "Accepting yourself with HIV is hard. It's really hard. It's hard to live with it. It's hard to have a normal life."[69]
>
> **– Trans woman living with HIV**

> "I think that if there is more education, the discrimination will also go away a little bit because people will have a better understanding of what these people actually go through."[70]
>
> **– Sex worker**

Accessing Healthcare

Priority populations often face barriers to accessing healthcare. For individuals who are looking for HIV or HCV prevention resources, inadequate access to healthcare increases the risk of HIV and HCV infection. For individuals living with HIV, prejudice in the healthcare system can be a major deterrent in accessing and maintaining care.

Numerous examples in Canada demonstrate the deadly consequences of anti-Indigenous and anti-Black racism in the healthcare system, and racist and discriminatory behaviours can be more overt and extreme when an individual is living with HIV.

LGBTQ2S individuals may face homophobic and transphobic violence, which may serve as a barrier to seeking appropriate healthcare and deter individuals from disclosing their status to family and friends.

People in prison also face a far greater risk of HIV and HCV infection because of a lack of access to sterile injection equipment, condoms, and other harm reduction measures that are available to people outside prison,[71] and formerly incarcerated individuals also describe the healthcare system as difficult to navigate. People who inject drugs report prejudice when trying to access supervised consumption services or other harm reduction programs — which can deter them from seeking sterile drug use equipment and other harm reduction services.

Research on women who use drugs and engage in sex work on the street found that they are subject to heavy policing and high rates of violence that likely minimize the impact of harm reduction efforts and expose them to many health and drug-related harms.[72]

All of these experiences may be compounded for women and gender-diverse people living with HIV, who may also experience sexism, homophobia, and transphobia from healthcare providers. For example, transgender individuals have reported great difficulty in obtaining trans-specific information about HIV prevention and treatment programs.[73]

> "They don't treat you like a normal patient."[74]
>
> **– Friend of woman living with HIV**

> "When she [the doctor] came in she had three pairs of gloves and yet it wasn't even a problem related to HIV!"[75]
>
> **– Woman living with HIV**

> "I've spent quite a bit of time down [there] learning the ropes on what you have to do to get this free healthcare because you know how it's free healthcare, but by golly you're going to wait quite a long time and you gotta kind of know, you know, the ins and outs."[76]
>
> **– Formerly incarcerated man living with HIV**

> "If there is only one needle and there's two of you, they're going to share... when you're in your addiction, you don't care."[77]
>
> **– Formerly incarcerated person who uses drugs**

> "Stores won't sell you needles if you look like a 'junkie'...and then you would go use somebody else's needle."[78]
>
> **– Formerly incarcerated person who injects drugs**

> "There is no information. Talk about the way a lesbian can and cannot get HIV prevention."[79]
>
> **– LGBTQ2S female**

> "Women of color are silent about their needs and what they want exactly from an [AIDS service organization] because we think it can't be changed. They're afraid if they say anything, it will be taken from them."[80]
>
> **– Black woman living with HIV**

Indigenous Peoples

Colonialism in Canada is a structural determinant of Indigenous health.[81] The effects of colonialism, which included the creation of institutions like the North West Mounted Police to forcibly displace Indigenous Peoples, repressed Indigenous self-determination, destabilized Indigenous language, culture, and society, and dispossessed individuals of their lands.[82] Moreover, the creation of the reserve system, the relocation of families and communities to new and unfamiliar territory, "stolen generations" of Indigenous children subjected to physical and sexual abuse as wards of the residential school and child welfare systems, restricted access to both traditional and western medicines, racism and discrimination against Indigenous Peoples that persists today act as profound determinants of Indigenous health.[83] Settler colonialism, combined with the social determinants above, explain why Indigenous Peoples are disproportionately affected by HIV and HCV.

Collectively, these narratives illustrate how HIV vulnerability and risk are shaped by many social and structural determinants of health and should be recognized when interacting with individuals belonging to these priority populations.

HIV Resiliency

It is important to note that despite the numerous structural factors that increase their vulnerability to HIV and HCV, priority populations embody resiliency, tenacity, and optimism and thrive in our society.

> "We have a lot to face. And, at the end of the day we sit and we feel depressed, we feel bad, but we have children to look after, send them off to school, some of us work. So, we get up and we face the day like nothing is going on, although we're hurting inside. I think that's our greatest strength."[84]
>
> **– Woman living with HIV**

Social networks and peer support groups are vital coping resources for people living with HIV. These groups provide open environments where individuals can support one other.

HIV and Human Rights

Human rights are the basic rights and freedoms that all people are entitled to from birth. Central to these rights is the entitlement to a life of equality and freedom from discrimination, dignity, respect, health, security, liberty, and privacy.[85]

In Canada, the human rights of people living with HIV and/or HCV and priority populations are protected by numerous laws. For the purposes of this manual, we focus on the *Canadian Charter of Rights and Freedoms,* federal and provincial/territorial human rights legislation, the Calls to Action of the Truth and Reconciliation Commission of Canada, and the *International Guidelines on HIV/AIDS and Human Rights.*

(1) Canadian *Charter of Rights and Freedoms:*

The *Canadian Charter of Rights and Freedoms* (Charter) is part of the Constitution and guarantees certain rights and freedoms.[86] Two provisions of the Charter bear particular relevance for priority populations. Under section 7, the Charter guarantees that:

> *Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.*

This section of the Charter has been interpreted, for example, to uphold the rights of people who use drugs, sex workers, and people in prison to "liberty" and "security of the person."

Under section 15, the Charter guarantees that:

> *Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*

The term "disability" in this section has been interpreted in various cases to include HIV and AIDS, which means that people living with HIV are entitled to constitutional protection from HIV-related discrimination perpetuated by all levels of government throughout the country.[87] This section has also been interpreted to defend women and LGBTQ2S people from discriminatory acts of governments.

(2) Federal Protection Under the *Canadian Human Rights Act:*

The *Canadian Human Rights Act* (CHRA) is a federal law that prohibits discrimination on a variety of grounds in areas including employment; accommodation; the provisions of goods, services, and facilities; and membership in a union.[88] The CHRA recognizes discrimination on the grounds of race, ethnicity, nationality, religion, colour, creed, age, sex, sexual orientation, gender identity, gender expression, marital status, family status, disability, genetic characteristics, and prior convictions for which a pardon has been granted.

Similar to the Charter, courts and tribunals have recognized HIV and AIDS as a disability under the CRHA.[89] Unlike the Charter, the CHRA (and its provincial/territorial counterparts) applies to *both* the public (i.e. federally regulated employers and service providers) and private sector. That is, the CHRA protects people living with HIV from discrimination in federal governmental departments, agencies, and crown corporations *as well as* in federally regulated private industries such as chartered banks, airlines, media and telecoms companies, and public transportation.

(3) Provincial and territorial human rights legislation

Provinces and territories also have anti-discrimination legislation that protects people from discrimination by provincial and municipal governments, businesses, non-profit organizations, and individuals within that province or territory on grounds including accommodation (housing), goods, services and facilities, schools, housing, and employment.

Not all provinces and territories in Canada offer the same human rights protections, but they all prohibit discrimination based on a person's HIV status. There is no explicit reference to HIV in the various anti-discrimination laws, but it is clear that living with HIV is covered by terms such as "disability," a prohibited ground of discrimination.

(4) Truth and Reconciliation Commission of Canada: Calls to Action

The Truth and Reconciliation Commission of Canada (TRC) was established in 2008 to bear witness to the disastrous impacts of residential schools on the lives of Indigenous Peoples and to facilitate reconciliation among former students and their families, their communities, governments, and all Canadians. To redress the legacy of residential schools and advance reconciliation, in its final report the TRC called on governments, educational and religious institutions, civil society groups and all Canadians to act on the 94 Calls to Action it identified.[90]

Call to Action 19 urges the federal government, "in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities" with a focus on, among other issues, mental health, drug dependence, chronic illnesses (which include HIV and HCV), and the availability of appropriate health services.

Calls to Action 30 and 38 urge federal, provincial, and territorial governments to commit to eliminating the "overrepresentation of Aboriginal people in custody" and the "overrepresentation of Aboriginal youth in custody" over the next decade.

Call to Action 57 urges federal, provincial, territorial, and municipal governments to "provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal–Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism."

As part of the executive branch of government, police officers have an obligation to help realize these Calls to Action.

(5) *International Guidelines on HIV/AIDS and Human Rights* (Guidelines), Office of the High Commissioner on Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS)

These Guidelines emphasize the protection and promotion of human rights as a key strategy in the global response to HIV.[91] Further, they highlight that the fundamental human right to health should include access to HIV prevention, treatment, care, and support for all people. Guideline 6 specifically states that governments should "take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services, and information for HIV prevention, treatment, care, and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV and related opportunistic infections and conditions."

For police, this means that when enforcing criminal law, there should be an emphasis on supporting priority populations (guideline 4c) and ensuring police are not an impediment to measures like supervised consumption services that reduce the risk of HIV and HCV transmission among people who use drugs (guideline 4d).

The laws and policies described above clarify that people living with and affected by HIV and HCV in Canada are entitled to protection from discrimination and have a right to health, including access to HIV and HCV testing, prevention, treatment, and care. **As officers of the law, police have a responsibility to ensure that these fundamental rights are upheld.** However, there are laws in Canada that undermine the health and human rights of people living with HIV and/or HCV and priority populations. These laws create barriers to HIV and/or HCV and other health, social and support services, thus impeding proven public health strategies.

Criminal Laws and Policies that Affect Access to HIV/HCV and Other Health, Social, and Support Services

In Canada, a number of criminal laws affect the access of priority populations to HIV and/or HCV and other health, social, and support services. For the purposes of this manual, we have focused on three that are most pertinent to the scope of practice for an officer engaged in street-level policing. As the Global Commission on HIV and the Law has emphasized:

> *The use of laws and policies to discriminate against people living with HIV..., or to criminalise sex work, drug use... are often enacted and enforced in the name of public health and safety. However, they usually result in the opposite, especially for marginalised groups.*[92]

(1) The Criminalization of HIV Non-disclosure

A person living with HIV in Canada can be criminally prosecuted for failing to disclose their HIV status to a partner in advance of sex that carries a "realistic possibility of transmission." Canada has the highest number of HIV non-disclosure prosecutions worldwide. By the end of 2020, there had been at least 225 prosecutions for alleged HIV non-disclosure in Canada, and people have been most commonly charged with the offences of sexual assault and aggravated sexual assault.[93]

The criminalization of HIV may have been meant to prevent what our society considers morally unacceptable behaviour, but instead this punitive policy response reinforces HIV stigma, perpetuates racist media discourse about Black people accused of the offence,[94] and undermines the human rights of people living with HIV. It is also not helpful in the context of public health. Such prosecutions may disproportionately affect the most marginalized people living with HIV, including those who may not have access to medications or sustained healthcare, such as racialized newcomers and Indigenous people, or those who are in abusive relationships and/or cannot safely insist on condom use or disclose their HIV status to sexual partners.[95] In Canada, a large proportion of criminalization cases against women involve Indigenous women and women with a history of experiencing abuse. Further, criminalization can deter people from getting tested and knowing their HIV status for fear that their health information might be used to lodge criminal charges. This fear acts as a barrier to HIV testing and prevention, treatment, and care.[96]

Officers of the law may be tasked with engaging complainants, making arrests, or laying charges in cases of non-disclosure. Prosecutions for HIV non-disclosure are highly sensitive and complex, and will have lasting, harmful impacts on the prosecuted individual. It's important to be familiar with the most recent science surrounding the criminalization of HIV non-disclosure and conduct investigations with sensitivity, restraint, and caution in order to decide whether to pursue legal action. Best practice is for police to consult, at an early stage in the investigation, with an expert in HIV law and science. On the law, one resource to consult is *The Criminalization of HIV Non-Disclosure in Canada: Current Status and the Need for Change.*[97]

Based on the most recent scientific evidence, prosecutions should not be pursued in cases of alleged HIV non-disclosure where a condom was used or the person living with HIV had a low or undetectable viral load or is under effective antiretroviral treatment or in cases involving only oral sex.[98] When deciding to lay charges in case of alleged HIV non-disclosure, police should also consider public interest factors that are specific to cases of alleged HIV non-disclosure, such as a possible power imbalance in intimate relationships where the accused is in a subordinate position. Many people living with HIV live in fear of being falsely accused by vindictive partners. Because it is very hard for a person living with HIV to prove that they did in fact disclose their HIV-positive status to their sexual partner, the criminalization of HIV non-disclosure can be weaponized to blackmail those in abusive relationships.

Complainants should be advised, when warranted, of Post-Exposure Prophylaxis (PEP) treatment in cases of exposure to HIV and provided with adequate referrals for PEP treatment, HIV testing, support, counselling and information about HIV, victim support, and legal advice. Complainants should also be informed, in a highly sensitive manner, about the consequences of making a complaint in relation to HIV non-disclosure, including privacy concerns. Police should ensure complainants have received the necessary information and support to make an informed decision.

And while not involving sexual activity, it is important to stress that because of the negligible risk of transmission, HIV should not be a relevant element in cases involving spitting, scratching, and biting.[99] In particular, police should not pursue arrest on charges of aggravated assault against people living with HIV in any cases involving spitting, biting, or scratching because there is no possibility of endangerment of life.

Police should consider the negative impacts of publicly disclosing a person's HIV-positive status given the high level of stigma experienced by people living with HIV.[100] Police must ensure that the privacy of HIV status and other medical information is respected to the greatest extent possible (applies to accused and complainants). Media releases including the name, picture, or health information of an accused are extremely prejudicial for people living with HIV. Police should be mindful that even where HIV is

not specified on a police or media release, members of the general public or people associated with the accused may understand that the accused is living with HIV because of general awareness of HIV non-disclosure prosecutions in Canada.

(2) The Criminalization of People Who Use Drugs

Under the *Controlled Drugs and Substances Act* (CDSA), it is illegal to possess, obtain, or distribute certain drugs in Canada.[101] Criminalization and the associated stigma deter many people from accessing harm reduction and other health services.

This is perhaps most readily apparent when people are fearful of calling 911 in the context of an overdose. Research in Canada has shown that the most common barriers to calling 911 are the fear of being arrested and the fear of losing custody of children.[102] The *Good Samaritan Drug Overdose Act* amends the CDSA to exempt both victim(s) and witnesses from being charged or convicted of simple possession of drugs when emergency help is sought for an overdose, if the evidence in support of the offence was obtained or discovered as a result of seeking assistance or remaining at the scene.[103] Seeking emergency help could include calling 911, leaving the scene to call 911, or leaving the scene to locate emergency medical assistance. An individual who calls 911 but leaves before emergency services arrive has the same exemption. In the context of an unprecedented overdose crisis in Canada, it is vital that police are aware of and uphold this law in order to encourage people to call 911 in the context of an overdose. At the same time, police presence at an overdose event, even if the absence of charges being pursued for simple drug possession, poses an ongoing barrier to people calling 911, because people continue to report being interrogated by police at an overdose.

For further reading on this topic, see *The Good Samaritan Drug Overdose Act: The Good, The Bad, and The Ineffective*[104] and *"That's why people don't call 911": Ending routine police attendance at drug overdoses.*[105]

Police presence can also deter people who use drugs from harm reduction services such as needle and syringe programs or supervised consumption services. Many people who use drugs have reported police surveillance and interrogation of people accessing these health services, as well as confiscating equipment obtained from these services.[106] Police should consider how they may carry out their work without discouraging people from accessing these crucial health services. Better yet, police departments should have a clear and consistent policy that does not impede access to harm reduction and other community-based initiatives. Discussion with harm reduction providers may assist in developing constructive protocols for police operations in their vicinity.

(3) The Criminalization of Sex Work

In Canada, current sex work–specific criminal offences under the *Criminal Code of Canada,* including those introduced in December 2014,[107] prohibit:

- impeding traffic or pedestrians or communicating in a public place next to a school ground, playground or daycare center, for the purpose of offering, providing or obtaining sexual services (section 213);
- purchasing or attempting to purchase sex in any place and at any time (section 286.1);
- materially benefitting from sexual services (section 286.2);
- procuring sexual services (section 286.3); and
- advertising sexual services (section. 286.4).

Research has consistently demonstrated that the criminalization of sex work and the police response to it forces sex workers to move to more hidden street and indoor locations; reduces their ability to screen prospective clients and to negotiate terms of sexual transactions (such as condom use) that are vital to their informed consent, and limits access to health services including HIV care. Excessive or aggressive police enforcement have been independently linked to increased and targeted violence, refusal of clients to use condoms, and fear of sex workers to carry condoms.[108]

Police should be aware of the implications of surveillance on sex workers' access to health services (including HIV and HCV testing, prevention, treatment, and care) and the ways in which such profiling reinforces an antagonistic relationship between sex workers and the police. Further, officers should refrain from engaging in initiatives (including the application of laws unrelated to sex work, i.e. those that regulate vagrancy or loitering) to remove and displace sex workers from public spaces; nuisance-based complaints made against sex workers should be resolved using the least intrusive method possible.

At the same time, there is a long history of police being less inclined to investigate offences committed against sex workers.[109] Police should uphold their obligation to treat all complainants fairly and with dignity and respect, and provide police protection to sex workers when it is requested.

For further reading on this topic, see *The Perils of "Protection": Sex Workers' Experiences of Law Enforcement in Ontario*.[110]

Importance of Maintaining Privacy and HIV Treatment

If an arrest is made in any of the cases described above, it's crucial to maintain the privacy of a person living with HIV. If someone in custody discloses their HIV or HCV status to an officer, the officer must determine if that person is currently on treatment and facilitate access to that medication as soon as possible.[111] Missing doses of HIV medication can negatively affect someone's viral load and CD4 count.[112] Detention can also decrease access to other appropriate medical care and introduce serious personal safety concerns for people living with HIV, which remains heavily stigmatized within the prison system and may result in threats, intimidation, or violence directed at an accused living with HIV.

One should also never assume that a person living with HIV or HCV has disclosed their status, even to close friends or relatives. To uphold their right to privacy, one should always ask for their consent before disclosing their status to anyone.

Police and Public Health

Public health experts sometimes refer to priority populations as "hard to reach populations" because of their social, political, and economic marginalization. Yet, we know that police encounter priority populations all the time in street-level service. Below, we outline practices police can employ to better respect the health and human rights of priority populations.

Practice 1. Exercise Discretionary Enforcement to Minimize the Negative Impact of Police Contact

Police officers are often afforded a fair degree of discretion in their provision of service. In line with the United Nations Office on Drugs and Crime[113] and legal scholar Kenneth Davis,[114] we define "discretion" as such:

> *An officer has discretion whenever the effective limits on [their] power leave [them] free to make a choice among possible courses of action or inaction.*

The exercise of discretionary enforcement, especially when unguided, has been identified as a tool the police use that contributes to the disparate arrest and charging of Black and other racialized people.[115] A 2020 study, for example, found that Black and Indigenous people were overrepresented in cannabis possession arrests across Canada, despite not engaging in more substance use than other people in Canada.[116] For many priority populations, especially those who are under constant threat of criminalization, any police encounter can be perceived as intrusive, frightening, and coercive. But police can also use their discretion to minimize contact with priority populations that impedes their access to HIV and/or HCV services, particularly as it pertains to drug possession and sex work. This means pursuing less punitive action, including exercising police discretion not to engage in aggressive surveillance, arrest, or to confiscate drug use equipment or safer sex materials, and not to attend overdoses unless their presence is requested to respond to a security threat. Each of these represents a mode of discretionary enforcement that can reduce the impact of policing on people's access to health services.

The Vancouver Police Department (VPD) has formally adopted a discretionary enforcement strategy,[117] which recognizes the degree of enforcement officers can exercise in cases of drug possession, including seizure of the substance, and/or arrest, and/or charging of an individual. According to this strategy, the enforcement of simple possession laws is left to the discretion of the individual officer but is justified only to the extent that the individual is "engaged in behaviours that harm and/or interfere in the lawful use or enjoyment of public or private property and/or contribute to street disorder."[118]

Acknowledging the ineffectiveness of the ongoing enforcement of the prohibition on simple drug possession, in July 2020, the Canadian Association of Chiefs of Police released a report, *Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety & Policing,* recognizing problematic drug use as a public health issue and concluding that decriminalizing simple drug possession is an effective way to reduce the public health and public safety harms associated with substance use.[119] In August 2020, the Public Prosecution Service of Canada published *Guidelines 5.13 Prosecution of Possession of Controlled Substances Contrary to s. 4(1) of the Controlled Drugs and Substances Act* also acknowledging that "Criminal sanctions, as a primary response, have a limited effectiveness as (i) specific or general deterrents and (ii) as a means of addressing the public safety concerns when considering the harmful effects of criminal records and short periods of incarceration" and directing prosecutors to focus on the "most serious cases" raising public safety concerns for prosecution and to otherwise pursue "suitable alternative measures and diversion from the criminal justice system for simple possession cases."[120]

Relatedly, the VPD also adopted a policy that recognizes that "[a] drug overdose is by its very nature a medical emergency" and that there "is little value in police attendance at a routine, non-fatal overdose." As such, Vancouver police officers are advised to be present only in situations that pose a threat to public safety.[121]

As frontline workers, police could reduce the barriers priority populations face in accessing programs and services that promote their health, including access to HIV and HCV testing, prevention, treatment, care, support, and harm reduction and other health services. Instead of arresting and laying charges, police could familiarize themselves with the work of local public health and harm reduction programs and other appropriate resources in their regions.

If requested, police should be equipped to refer people in their communities to local organizations that provide services including, but not limited to, sterile drug use equipment, supervised consumption, overdose prevention, substance use treatment, HIV, HCV, and STI testing, HIV and HCV prevention programming, HIV and HCV treatment, and sexual health information/counselling.

Reflection: Am I aware of the HIV and HCV prevention programs and services in my community to which I might provide a referral? How might I go about learning more about the services offered at a local supervised consumption site?

Practice 2. Reduce stigmatizing language and behaviour when providing service to people living with/affected by HIV or HCV:

Using respectful language and behaviour when engaging people living with or affected by HIV or HCV upholds their right to freedom from discrimination under the law. Respectful language could include person-first language, which emphasizes a person's individuality, equality, and dignity, but ultimately, people should be referred to in the terms they prefer. This includes their preferred pronouns and whether they choose to identify as a member of a priority population. When considering priority populations, there are numerous outdated and harmful terms that should be avoided. These terms can reinforce stigma and increase vulnerability to HIV or HCV. Some of these terms, along with more acceptable language, are presented below.

Priority Population	Terms to Avoid	Terms to Use
LGBTQ2S community	"Homosexual," "Queer," "Dyke," "Fag/ Faggot," "Transgendered," "Transvestite"	"LGBTQ2S people," "Gay," "Lesbian," "2 Spirit" (if Indigenous), "Transgender"
Indigenous community	"Indian"	"Indigenous," "Aboriginal," or more specifically, "First Nations," "Inuit," or "Metis" as applicable
People who use drugs	"Drug abuser," "User," "Addict," "Junkie"	"Person who uses drugs"
Sex workers	"Prostitute," "Hooker," "Whore," "Slut"	"Sex worker" or "Person who sells or trades sex"
People living with HIV	"AIDS carrier," "HIV carrier," "HIV infected"	"Person living with HIV"

Practice 3. Incorporate cultural safety into service delivered to Indigenous Peoples and other priority populations

Police should ensure that their provision of service to Indigenous people is sensitive to the history and unique needs of this priority population. Beyond their role in colonial schemes like the Sixties Scoop, police are frequently criticized for their contributions to the over-policing, under-protection, and over-incarceration of Indigenous people, including with respect to Canada's current crisis of missing and murdered Indigenous women and girls (MMIWG). At a deeper level, punitive Western modes of justice are understood to fundamentally clash with Indigenous approaches, which place less emphasis on criminal punishment and more on collective healing, restorative justice, and a return to community balance/harmony.[122]

Officers should always practice cultural safety in their delivery of service to Indigenous people. **Cultural safety** is a philosophy that was developed for use in healthcare settings but has since been applied to policing. Cultural safety is premised on the recognition that in providing service to an Indigenous person: the service user's way of knowing is valid, the service user is an active partner in the decision-making process, and the service user can understand when the service they receive is safe for them.[123]

In the context of policing, cultural safety includes communicating clearly, respecting differences in culture and values, avoiding harmful stereotypes or stigmatizing language, and recognizing that everyone has a unique history and set of experiences that might affect their engagement with the law.

These interpersonal interactions help contribute to a "big picture" idea that focuses on the policing system as a whole. (See figure below.) Given the historical and ongoing colonial trauma perpetuated against Indigenous communities, there is a clear need for systemic change.

This cultural spectrum is adapted from *A Journey We Walk Together: Strengthening Indigenous Cultural Competency in Health Organizations.* Cultural awareness, sensitivity, and competency all contribute to the overall cultural safety of the policing system.

- Acknowledges differences
- Doesn't seek broader context or understanding
- Very limited behaviour change

- Acknowledges different ways of seeing the world
- Integrates some changes in practices or behaviour

- System elements are aligned with and respect other cultures
- Represents action on the part of an individual or organization

Meaningful, practical, and day-to-day recommendations for police in relation to Indigenous Peoples have been made in reports such as *Broken Trust: Indigenous People and the Thunder Bay Police Service Review,* the *National Inquiry into Missing and Murdered Indigenous Women and Girls* (MMIWGR) and the *OPP Framework for Police Preparedness for Aboriginal Critical Incidents.* For example, police officers should acquaint themselves with the history and culture of the Indigenous communities with which they work.[124] Cultural practices, teachings, languages, and experiences differ greatly between communities — so there is no one-size-fits-all approach. This type of education aligns with **cultural awareness** — the first building block for developing cultural safety. By acknowledging and understanding the uniqueness of Indigenous communities, police officers can become more effective listeners. However, adopting this behaviour alone is insufficient. A deeper sense of **cultural sensitivity** and competency should be cultivated, which ultimately promotes **cultural safety.**

Police officers should use physical descriptors instead of racial ones.[125] Using physical descriptors including height and weight, hair and eye colour, body type, and facial hair discourages the use of harmful stereotypes or stigmatizing language.

Further, police should avoid disclosing sexual orientation when investigating crimes. The MMIWGR highlights that when victims of crimes are identified as members of the LGBTQ2S community, it can reinforce a "homosexual panic defence" that implies the perpetrator was triggered by the victims' sexual orientation as opposed to recognizing their own actions as hate crimes.[126] Police should also be conscious of not misgendering trans and non-binary people. For more discussion of policing in the context of LGBTQ2S communities, see *Best Practices in Policing and LGBTQ Communities in Ontario.*[127]

Police officers should also abstain from subsuming Indigenous Peoples into their anti-racism and anti-oppression training. The unique experience of settler colonialism in Canada sets Indigenous people apart from other groups that might be discussed in anti-racism and anti-oppression trainings including immigrant Canadians and refugees, and this warrants separate training. As stated in the *Thunder Bay Report,* "we cannot 'welcome' Indigenous people" — i.e. it is not Indigenous people who need to be welcomed into police settings, rather the opposite.[128] "Tokenization" of Indigenous Peoples ignores fundamental cultural differences and acknowledging the importance of this separation is critical to the provision of police service.

Police officers should actively acknowledge that Indigenous people have a level of expertise that would be helpful in determining the types of service that would enhance safety and justice in their communities. These individuals should be regularly and meaningfully consulted in decision-making processes about the design, delivery, and evaluation of police services.[129] Consultation with members of Indigenous communities directly aligns with **cultural competency.** This type of practice goes beyond simply acknowledging differences and changing some practices or behaviours, but actively works towards eliminating harmful systems in order to uphold the rights of Indigenous people.

Conclusion

This manual was developed by the HIV Legal Network, in consultation with a group of community and police stakeholders, to improve the health and safety of people living with or affected by HIV or HCV. With a deeper understanding of HIV and HCV biology, occupational health and safety, HIV and HCV vulnerability, and the complex health-determining dimensions of the legal environment in which they work, police services across Canada can use their enhanced knowledge and this document as they perform their duties.

Appended to this manual (Appendix C) is a short facilitator's guide that explores how officers in a leadership role can improve the circulation and implementation of this manual in their own departments.

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Appendix A – Stakeholder List

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Appendix B - HIV Vulnerability from the Cellular to the Societal Levels

Scale of Influence	Description	Examples
Cellular	Factors that increase the body's biological susceptibility to HIV infection at the cellular or molecular level	• The presence of certain sexually transmitted infections (e.g. chlamydia, gonorrhea, syphilis) can increase inflammation and immune response in genital areas. This increases the potential for HIV to infect the body during exposure. • Open sores in the mouth, anus, penis, or vagina can create openings through which HIV can pass during sexual contact.
Individual	Personal, psychological, or behavioural factors such as knowledge, attitudes, and skills that affect HIV risk. It is crucial to note that while many of these factors might seem like matters of individual choice, they are often influenced by social and structural determinants beyond an individual's control.	• A lack of knowledge about how HIV is transmitted • How and with whom you have sex • How and with whom you consume or share drugs • Internalized stigma (the process whereby people begin to take on or believe negative attitudes about HIV held by others around them)
Interpersonal	HIV risk factors that function between people in everyday social interactions	• Stigma (negative attitudes and beliefs about people living with or affected by HIV) • Discrimination (prejudiced treatment of people living with or affected by HIV, often based on stigma) • Social isolation/exclusion (resulting from stigma and discrimination)
Community	Local factors that affect an entire community's HIV risk	• Social norms about condom use or drug use within a community • Availability and accessibility of HIV testing in a geographic neighbourhood • Availability and accessibility of HIV prevention resources (supervised consumptions sites, PrEP clinics) in a geographic neighbourhood • Quality and coverage of HIV prevention, testing, and treatment services in a geographic neighbourhood
Societal/Structural	Laws, policies, and systemic forces that directly or indirectly affect HIV risk at all other levels	• Economic policy that reinforces poverty among priority populations • Laws that stigmatize and violate the human rights of priority populations • Laws and policies that limit accessibility of HIV testing, treatment, and prevention resources • Racism, sexism, homophobia, and other deeply entrenched societal beliefs that reinforce stigma, discrimination, and violence against priority populations

Appendix C: Best Practice Guidelines for Implementation and Uptake

Introduction

This training manual presents some key educational content for police, to increase knowledge and awareness about HIV, HCV, and related issues, with a view to reducing the ways in which stigma affects their work.

This appendix provides some **guidelines for the implementation and uptake of the training. It is intended for use by senior police officers or those in leadership positions who wish to improve training among their staff or in their respective divisions.** It draws heavily on the principles of the Trans-contextual Model (TCM) for Autonomous Motivation and the philosophy of Community Policing. As such, this document is divided into two sections:

- The first section presents the core components of the TCM, to help senior officers increase autonomous motivation on the part of officers, leading to behaviour change among their personnel.
- The second section suggests ways to create institutional environments that support officers in modifying practice to minimize the impact of policing on priority populations' access to health services.

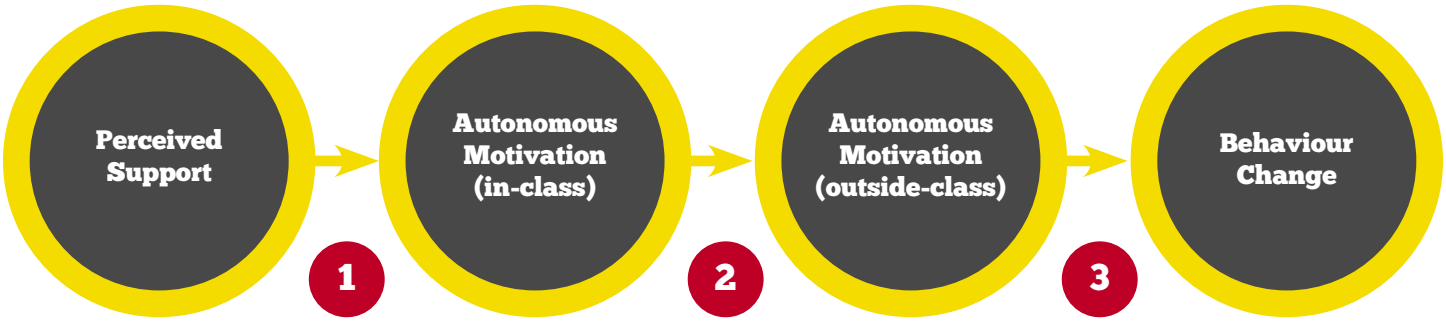
Section I: The Trans-contextual Model – A Theory of Change

A recent scoping review of harm reduction training for police officers found that such programming frequently fails to draw on relevant theories to enhance educational outcomes and behavioural change (ref. 1). Grounding police training in theories of adult learning, behaviour, and/or organizational change can help identify concrete goals and potential impacts when designing educational programs, implementing them, and evaluating their effect on practice (ref. 1). One positively evaluated educational program on HIV prevention and police occupational safety is Project ESCUDO, based in Tijuana, Mexico (ref. 2), which is based on the Trans-contextual Model (TCM) of Autonomous Motivation (ref. 3).

"Autonomous motivation" is a sense of personal agency when doing something without the need for external reinforcement. The TCM helps understand how to generate this in a learning environment and then translated it into actual behavioural change outside that learning environment. Originally developed for use in physical education, the TCM has since been applied and successfully evaluated in a variety of educational settings, including programs for police injury prevention and education (refs. 2 and 4).

The TCM is founded on three central propositions, explained further below. Taken together, these propositions form the **Theory of Change** for this educational intervention, explaining how certain conditions or factors can lead to intermediate outcomes which can then lead to the ultimate desired outcome — in this case, policing practices that support, rather than impede, access to health services by people living with or affected by HIV or HCV (ref. 5). Below, we show the TCM as it applies to this educational intervention. We also identify where and how officers in leadership roles can support progression through to this desired outcome.

TCM Theory of Change:



Proposition 1 — Perceived support from senior officers/ police in leadership roles predicts autonomous motivation in educational settings: Officers who perceive that their seniors or superiors support their learning will be motivated to engage in educational activities. If staff feel supported to learn about HIV or HCV in the context of policing, they will be more motivated and likely to partake in this training.

What leaders can do — Guideline 1: While the targets of education should be those officers most engaged with priority populations on the frontlines of practice, the TCM suggests a role for senior officers in providing, facilitating, or at least encouraging training. Officers in leadership roles can: actively and vocally support this training in their respective departments, including by providing a relevant and compelling rationale for the training (e.g. a need to align police practices with public health or a need to respect the health and human rights of priority populations); avoid patronizing directives or commands that undermine training goals; and provide consistent feedback throughout training (ref. 6).

Proposition 2 — Autonomous motivation experienced within educational settings predicts autonomous motivation to carry out learned activities outside educational settings: Officers who are motivated to learn about HIV and HCV, stigma reduction, and health promotion within a learning environment are more likely to feel motivated to apply what they've learned outside the learning environment (i.e. on the frontlines of service provision).

What leaders can do — Guideline 2: If possible, deliver an in-person training to complement circulation of the training materials. This in-person training should involve active and dynamic learning activities that stimulate autonomous motivation in-class. Such activities might include knowledge checks, group discussion, brainstorms, and realistic role-plays (refs. 7 and 8). The United Nations Office on Drugs and Crime Training Manual includes a number of engaging activities that instructors may draw from (ref. 9). To establish and enhance collaborative partnerships, trainings might also be co-facilitated with representatives from priority populations and public health.

Proposition 3 — Autonomous motivation outside educational settings predicts intention to carry out learned activities and promotes actual behavioural change: Officers who feel motivated to pursue the type of practices learned in-class are more likely to adopt favourable attitudes, beliefs, and intentions towards practices that do not perpetuate stigma and respect health and human rights outside of class. These psychosocial factors predict actual behavioural change on the frontlines — i.e. policing practices that support, rather than impede, access to health services by people living with or affected by HIV and HCV.

What leaders can do — Guideline 3: As with all learning, ensuring actual behavioural change is the most difficult aspect of the TCM. Officers in leadership roles should take steps to verify that the preconditions of behavioural change, as specified in the TCM, are satisfied throughout training. For instance, survey front-line officers about whether they feel supported or encouraged to participate in such training. Get them to evaluate the training materials and methods and share their views about whether they felt motivated to learn about the issues. Get them to complete a survey to see how their knowledge of HIV and HCV has changed as a result of the training and if they feel more equipped to interact with members of priority populations and to carry out their work as policing professionals in ways that support access to health services. Officers in leadership positions can also enhance behavioural change by adopting key principles from the philosophy of Community Policing, namely creating community partnerships and enabling institutional environments (see Section II).

Section II: Creating more supportive institutional environments to modify police practices to minimize the impact on priority populations' access to health services

What leaders can do – Guideline 4: Officers in leadership roles are tasked with fostering an institutional environment that enables police to do their jobs in ways that support, rather than impede, priority populations' access to health services. Below, we outline some practical next steps that an individual senior official can take to help create more enabling institutional environments (ref. 9):

1. Participate in HIV and HCV education or training, sending a signal from senior leadership that these issues are important as part of professional development for officers.
2. Encourage training for all staff, but particularly front-line officers. Create a plan for the delivery of the training, including the contents of this Training Manual. Consider the following:

a. Who will facilitate the training?

b. Where will the training happen?

c. Will the training require a slide deck or other education materials such as handouts or a video?

d. How might I involve public health experts, members of priority populations, and community organizations working with those populations in the delivery of the training?

e. Are there organizations in your community with which you might form viable and mutually beneficial partnerships? How might you go about contacting them?

3. Work with other senior officers, including in other divisions and departments as applicable, in advocating for enhanced training, community partnerships, and organizational change

What leaders can do — Guideline 5: As support for such training builds, there are additional concrete measures senior officers can take to promote an enabling institutional environment (ref. 9). These include:

1. Formally adopting a divisional mission that recognizes the professional responsibility of police to respect public health and safety, especially among priority populations

2. Designing and implementing standard operating protocols (SOPs) or department-wide policies to direct the provision of police service so as not to hinder access to HIV or HCV treatment/support for priority populations

3. Designing and implementing SOPs or department-wide policies reducing risk of HIV or HCV infection on the job, protecting officers' health and safety

4. Designing and implementing SOPs or department-wide policies that guide officers in the exercise of their discretion so as to minimize the negative impacts of police interaction on priority populations' access to HIV and HCV services

5. Providing flexible working conditions to help sustain the health and wellbeing of officers and/or their family members who might be living with HIV or HCV

6. Providing voluntary counselling and HIV and HCV testing, access to prevention resources, and access to treatment (as necessary) for officers exposed to or living with HIV or HCV

7. Establishing ongoing channels of communication with community and public health partners, including with organizations representing or working with priority populations

8. Conducting ongoing evaluations of community and/or public health partnerships in which evaluation indicators, methods, analysis, and dissemination of results are collaboratively designed with partners

9. Advocating for any changes listed above that are not currently in place or accessible to staff

What We Heard: A Renewed Approach to Policing in Indigenous Communities

As described in the training manual, police services should engage in efforts to enhance their provision of culturally safe policing to Indigenous communities. Based on *What We Heard: A Renewed Approach to Policing in Indigenous Communities,* this final section explores how police can better align current practices with more responsive and sensitive modes of law enforcement (ref. 12).

What leaders can do — Guideline 6: Three key components are presented here, which, based on *What We Heard,* describe what some Indigenous communities look for in a community policing model:

1. **A Problem-oriented Approach:** Current models of policing are excessively punitive and oriented towards arrest and incarceration. This narrow focus sidelines Indigenous modes of justice, which are focused more on restorative justice, collective healing, and returning harmony to a community. Communities suggest instead a proactive problem-oriented approach that concentrates less on control and more on public safety, prevention, and collaboration.

2. **A Dual-Tiered Policing Approach (Enforcement and Prevention):** If conventional enforcement-based policing cannot be abandoned, there is a need to adopt a dual-tiered approach. Rather than only reacting to allegations of crimes or issues of immediate public safety, police should invest resources into preventing such issues from occurring (for example, by referring people who use drugs to supervised consumption services).

3. **A Collaborative/Integrated Approach:** Both Approaches 1 and 2 can be enhanced by forming collaborative partnerships with key service providers and stakeholders in the local Indigenous community. Such relationships could also bolster trust among community while improving police referrals to critical services for community members. However, care must be taken to avoid blurring the lines between police and community service providers working with priority populations, as this can also undermine trust in, and access to, services.

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